

THE IMPACT OF EGFR IMPLEMENTATION ON CLINICAL PRACTICE: FINDING SOLUTIONS THROUGH A CKD NETWORK.

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PROBLEM:The implementation of eGFR reporting and the publication of national chronic kidney disease (CKD) management guidelines represent a major challenge to health care professionals, particularly in primary care. At the same time secondary care is facing the inception of a 'Choose and Book' system and the 18 week pathway. In 2006 a local CKD network was formed and comprises of: consultant nephrologist, consultant nurse, local general practitioners (GPs), commissioners and representatives from the Primary Care Trusts. The aim being to break down traditional barriers between primary and secondary care, raise awareness of CKD, encourage an integrated, multi-professional approach to patient management and provide education for health care practitioners.

PURPOSE:To evaluate and audit the impact eGFR reporting, guidelines and education have on clinical practice in primary and secondary care.

DESIGN:A two-page version of CKD clinical guidelines was sent to all GP's containing advice on CKD management and guidance for referral including a minimal data required for the referral letter. This was supported by a 6 month programme of educational seminars held throughout the region. Within the renal unit, a triage system, based on the guidelines and a database of all referrals was established. Referrals which were felt to be inappropriate were returned to primary care with a detailed management plan and a copy of the two-page guidelines.

RESULTS:The number of new out-patient referrals doubled following introduction of eGFR reporting (751 in 2005-6 to 1576 in 2006-7). Referrals for stage 1 and 2 remained unchanged (188 vs. 168), stage 3 increased from 323 to 845, and stage 4/5 from 240-563. 90% of stage 4-5 CKD were given outpatient appointments, this compares to 31% of those with stage 3 and above. From April 2006 to the end of 2007, 24% of referrals were returned to GPs with advice, the majority of these (86%) were patients with Stage 1-3 CKD. The percentage returned with advice fell from 30% in 2006 to only 14% in the last six months of 2007. Comparing rejected referrals with those given appointments: Gender 42% male vs. 52% ($p<0.01$), diabetes 19% vs. 27% ($p<0.01$), hypertension 47% vs. 51% ($p<0.05$) and IHD 14% vs. 19% ($p<0.01$). Median age was the same (72 years). Of the 2006 cohort, rejected referrals, 82 % patients with stage 3-5 CKD had repeat eGFR testing. Patients not being tested tended to be younger (median age 66 vs. 75 years), however there was no difference in level of eGFR, gender or co-morbidity. The majority of people being tested have stable CKD. However a few have had a significant decline in their eGFR and have not been referred back to the unit. Post-code mapping showed that there was significant geographical variation in practice.

RELEVANCE:Health care practitioners in primary care have adapted well to the introduction of eGFR and management guidelines. This has been aided by the establishment of a rolling programme of education and changes to working practice within the renal unit. Further work is needed to address variations in practice which can be facilitated through the CKD network.