

## CAN A CARE BUNDLE APPROACH BE USED TO IMPLEMENT BEST PRACTICE FOR THE MANAGEMENT OF CHRONIC KIDNEY DISEASE (CKD) IN PRIMARY CARE?

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**PROBLEM:** Efforts have been made in the past four years to improve the community care of people with CKD. Improvements have included the introduction of eGFR for earlier identification of CKD, and the publication of NICE guidance. However it is possible that care of people with CKD with primary care could be improved, partly because a proportion of people with this condition are not being identified by GP practices. The national mean recorded prevalence of CKD by GP practices is around 2.5%, yet epidemiological studies show values of around 8% (Stevens et al, 2007). There is also variability amongst individual practices returning prevalence data. In London PCTs for example, recorded prevalence rates range from 0.1-6.2%.

There is also the problem of reliably delivering evidence-based healthcare. The NHS Institute for Innovation and Improvement (NHSI) has developed a number of strategies and tools to improve the reliability of care provided within hospitals. In particular, the use of ‘care bundles’ – groups of high impact evidence-based healthcare interventions – have yielded quite spectacular results both in terms of the improved reliability of delivered care and better clinical outcomes (Resar et al, 2005). However care bundles have not yet, to the best of our knowledge, been applied outside the hospital setting.

Purpose: A study that aims to improve the management of people with CKD in primary care, using a novel high-impact evidence-based intervention called a ‘care bundle’.

**DESIGN:** The defining and writing of the care bundle for CKD was carried out by an expert group. The expert group comprised a patient representative, hospital and primary care health-care professionals. The process was facilitated by a Fellow of the NHSI and the group met on four occasions during 2008. The bundle components were developed by this group and the process also involved consultation with four independent nephrologists. The bundle components are supported by NICE guidance (2008) for CKD.

**FINDINGS AND IMPLEMENTATION:** The resulting care bundle consists of four practical activities that have to be applied when people with CKD attend for clinic. These include recording people with CKD 3-5 on a register, measuring if there is proteinuria, prescribing blood pressure tablets if necessary, and assessing the risk of cardio-vascular disease. The difference between this activity and normal care, is that all activities have to be carried out at the same time, and it is the simultaneous timing that makes the bundle potentially so effective. One GP practice in SE England has been identified to undertake the implementation of the care bundle. Baseline audit data in this practice will be collected on patients with stage 3-5 kidney disease, and will include co-morbidities and whether on other disease registers. The aim is to achieve >95% compliance with the care bundle (all components carried out at each consultation) through the application of recognised methodologies to achieve systematic reliability.

**CONCLUSION AND RELEVANCE:** A care bundle approach has not yet been undertaken in primary care. It is hoped that this novel approach will improve the community care of people with kidney disease, over and above the CKD components of the Quality and Outcomes Framework.