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National Institute for Health Research
Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester

Achieving more effective, quicker implementation of evidence-based healthcare in primary care practices

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Background: Phase 1

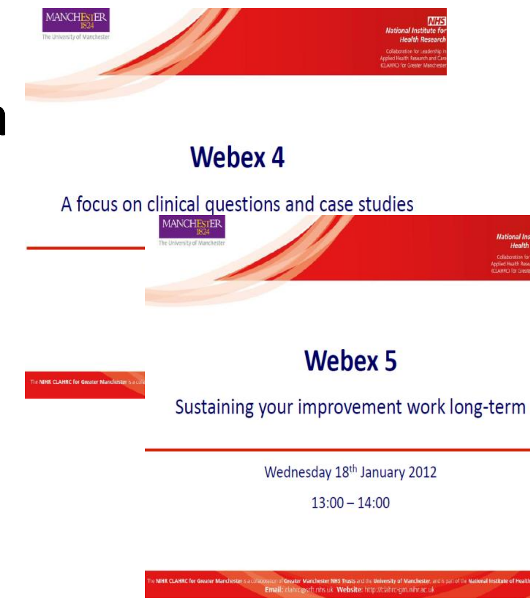
- QOF data from 2008/09[1] combined with published Quality Improvement in CKD (QICKD) study data[2] on expected prevalence suggested a gap of around 2% between local recorded and national estimated prevalence of CKD. This equated to around 41,000 undetected cases missing from primary care CKD registers across the ten Greater Manchester primary care trusts (PCTs).
- Between September 2009—September 2010 the NIHR Collaboration for Leadership in Applied Health Research and Care for Greater Manchester ran a 19-practice Collaborative-style improvement project, based on the Institute for Health Improvement's (IHI) *Model for Improvement*, to halve the CKD prevalence gap on practice registers (Objective 1), and for 75% of CKD patients to be tested for proteinuria and managed to NICE BP targets (Objective 2).
- Teams achieved 92% and 74% against the respective objectives. For the spread phase we introduced some new components to our implementation methodology.

Key changes introduced for Phase 2

1. A CKD Improvement Guide was developed from Phase 1 evidence and lessons to support future facilitated or independently run CKD improvement projects.

2. A practice nurse whose practices took part in Phase 1 joined the team as a facilitator in Phase 2; increasing the skill mix of the team and improving the clinical education teams received in Phase 2.

3. The structure was refined and we were less rigorous in applying the IHI framework; reducing the number of workshops, and instead introducing five one-hour WebEx sessions covering a range of topics.

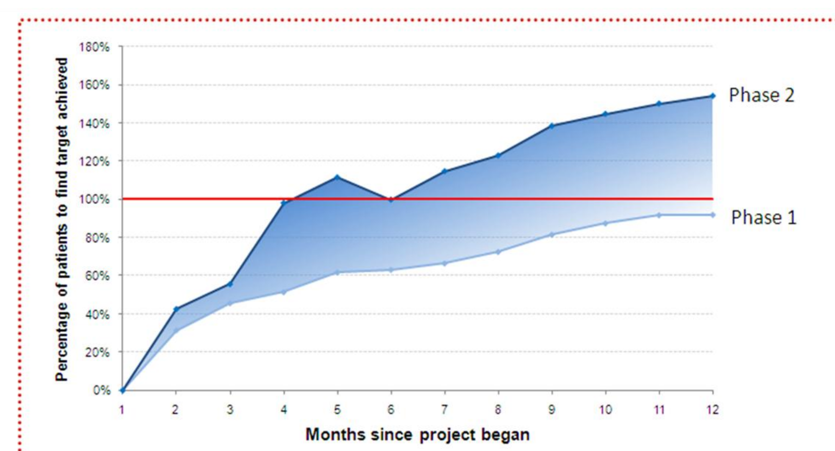


4. We shared resources with the Leicestershire, Northamptonshire and Rutland CLAHRC and began using their CKD audit tool. The audit tool made it easier for teams to identify cases and correct inaccuracies.

CKDAudit-REG – register validation

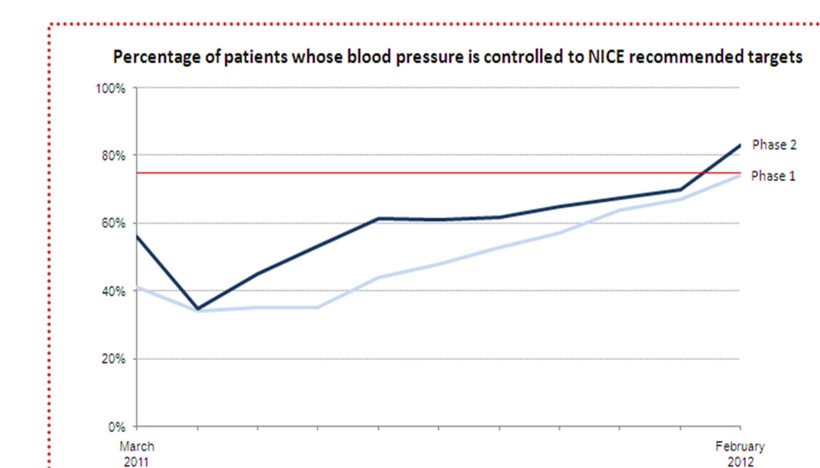
The effect on results & conclusion

Better implementation tools in the form of the Improvement Guide and the audit tool supported Phase 2 teams to achieve much quicker improvements in prevalence gain and a better overall result at project close.



In Phase One, practices achieved 62% by month 5 and 92% by the project close.
In Phase Two, practices achieved 100% by month 3 and 154% overall.
Both phases have identified 1,863 additional CKD patients in 30 practices

A quicker achievement in closing the prevalence gap then gave us more scope to apply clinical lessons from the project and use the skills of the nurse facilitator, and the group learning sessions to improve the levels of care that teams were delivering to patients.



Blood pressure control seemed initially weak in both phases of work – as patients with high blood pressure or no ACR results were added. However, both practices in both phases improved blood pressure control, and the target of 75% was achieved in phase 2 – where final achievement stood at 83%.

Our conclusion is that it is possible to tweak the structure of the project away from given framework to suit the environmental context and deliver project content suitable to the needs of the implementation sites — with improved outcomes.

References. 1. Quality and Outcomes Framework 2008/09, 2. De Lusignan et al 2010, 3. http://www.clahrc-lnr.nihr.ac.uk/impakt

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