



Kidney Care

**Kidney Disease Clinical
Commissioning Group Profile 2012**

NHS Barking and Dagenham CCG

Better Kidney Care for All

Kidney Disease Clinical Commissioning Group Profile NHS Barking and Dagenham CCG

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Key information about NHS Barking and Dagenham CCG

- In 2011/12 there were 4,142 people aged 18 years and older included on the QOF CKD registers in Barking & Dagenham CCG. It is estimated that there are 3,110 people with CKD in the CCG who are currently undiagnosed.
- Barking & Dagenham CCG improved to some degree across four of the eleven CKD and CKD-associated QOF clinical achievement indicators between 2010/11 and 2011/12. There is a wide variation in the achievement of these indicators at practice level within the CCG.
- It is estimated that the annual primary care expenditure directly attributable to CKD in Barking & Dagenham CCG is £755,364 and the total direct cost of CKD in primary and secondary care is estimated to be £3,813,437.

1 Introduction

Chronic kidney disease is a common long term condition. It is strongly associated with other important causes of morbidity and mortality, such as cardiovascular disease and diabetes. In some cases, it may progress to end stage renal disease (ESRD). The Kidney Disease Clinical Commissioning Group (CCG) profiles bring together a wide range of information on kidney disease in adults. A kidney disease profile is now available for every CCG in England. Further details of all the data sources used in this profile and links to the primary data are available in the data guide, which can be found at: http://www.kidneycare.nhs.uk/CCG_profiles

CCGs represent new health geographies, built up from individual GP practices. The total population of Barking & Dagenham CCG is 201,600 and 146,500 of these people are aged 18 years and older. The proportion of people aged over 65 in the CCG is lower than across England as a whole. The CCG is relatively deprived compared to the national picture.

CCG configurations may differ from previous GP clustering and commissioning arrangements, making it difficult to interpret trend data. The profiles will be useful as baseline information to measure future trends in health and the provision and quality of services. The three kidney centres identified as closest to Barking & Dagenham CCG are Barts and The London Hospital, Basildon Hospital and Guy's and St Thomas's Hospital. A summary of information on these centres using UK Renal Registry and other data is included in this document.

The NHS Outcomes Framework aims to improve quality and outcomes in the NHS. It is structured around five domains (see appendix 3). Each section in these profiles relates to one or more of these domains which are listed at the beginning of each section.

2 Benchmarking CCGs

As CCGs are new health geographies there is currently no standard way of benchmarking against similar CCGs. For these profiles, CCGs have been benchmarked against CCGs with a similar level of deprivation (in the same national decile). See appendix 2 for a list of comparator CCGs. Deprivation has been estimated using the Index of Multiple Deprivation (IMD) 2010 score. The IMD combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single score for each area in England. This allows each area to be ranked relative to one another according to their level of deprivation. Areas of similar deprivation are likely to experience similar levels of kidney disease and kidney disease risk factors [i]. Where possible, national level data have also been included as a comparator.

3 Quantifying chronic kidney disease

NHS Outcomes Framework Domains 1 & 5

Chronic kidney disease (CKD) is classified into stages one to five. These kidney disease CCG profiles describe the prevalence and management of moderate to severe CKD (i.e. CKD stages 3–5 as defined by the National Institute for Health and Clinical Excellence (NICE)). This is consistent with the Quality and Outcomes Framework (QOF), but this simplified grouping misses some important detail within stages. Stage 3 CKD can be sub classified into 3a and 3b with stage 3b experiencing a higher risk of cardiovascular disease and ESRD than those in 3a. The presence of proteinuria is also important, as it is associated with a higher risk of ESRD and death independent of CKD stage, and may lead to further treatment options being considered.

Patients diagnosed with CKD benefit from treatment proven to reduce mortality and slow progressive decline in kidney function. Diagnosis also highlights patients at risk of greater harm due to medication side effects and acute kidney injury.

In figure 3.1, the observed number of people with CKD (red bar) represents the number of people with a diagnosis of CKD on the Barking & Dagenham CCG QOF registers. The expected number is the number of people who are likely to have CKD if the estimates from the Health Survey for England (HSE) data are applied to the local population (blue bar). The expected figures are adjusted for age and gender, but do not include ethnicity and deprivation adjustment. Age has the single greatest influence on CKD prevalence. However, some of the variability may be due to ethnicity and deprivation and this should be considered when interpreting the expected figures at CCG and GP level.

In 2011/12 there were 4,142 people aged 18 years and older included on the QOF CKD registers in Barking & Dagenham CCG (a prevalence of 2.8% compared to 3.9% in the CCG comparator group). It is estimated that there are 3,110 people with CKD in the CCG who are currently undiagnosed. Figure 3.2 shows the observed prevalence compared to the expected prevalence at practice level. Identified QOF prevalence varies from 0.2% to 8.2% by general practice within the CCG.

Fig 3.1: Observed and expected CKD prevalence CCG, CCG comparator group and England (QOF 2011/12)

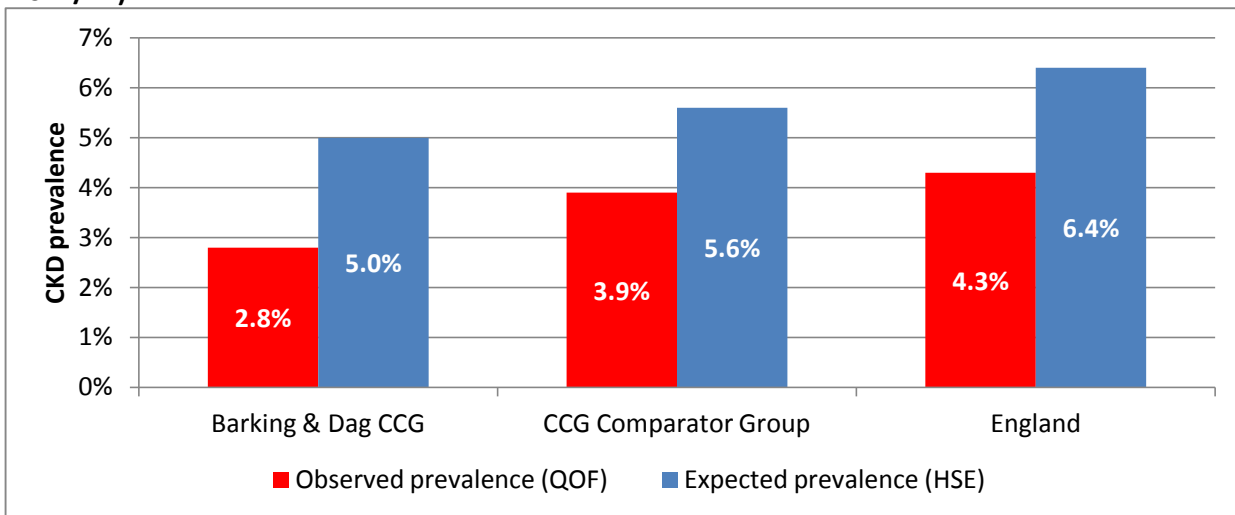
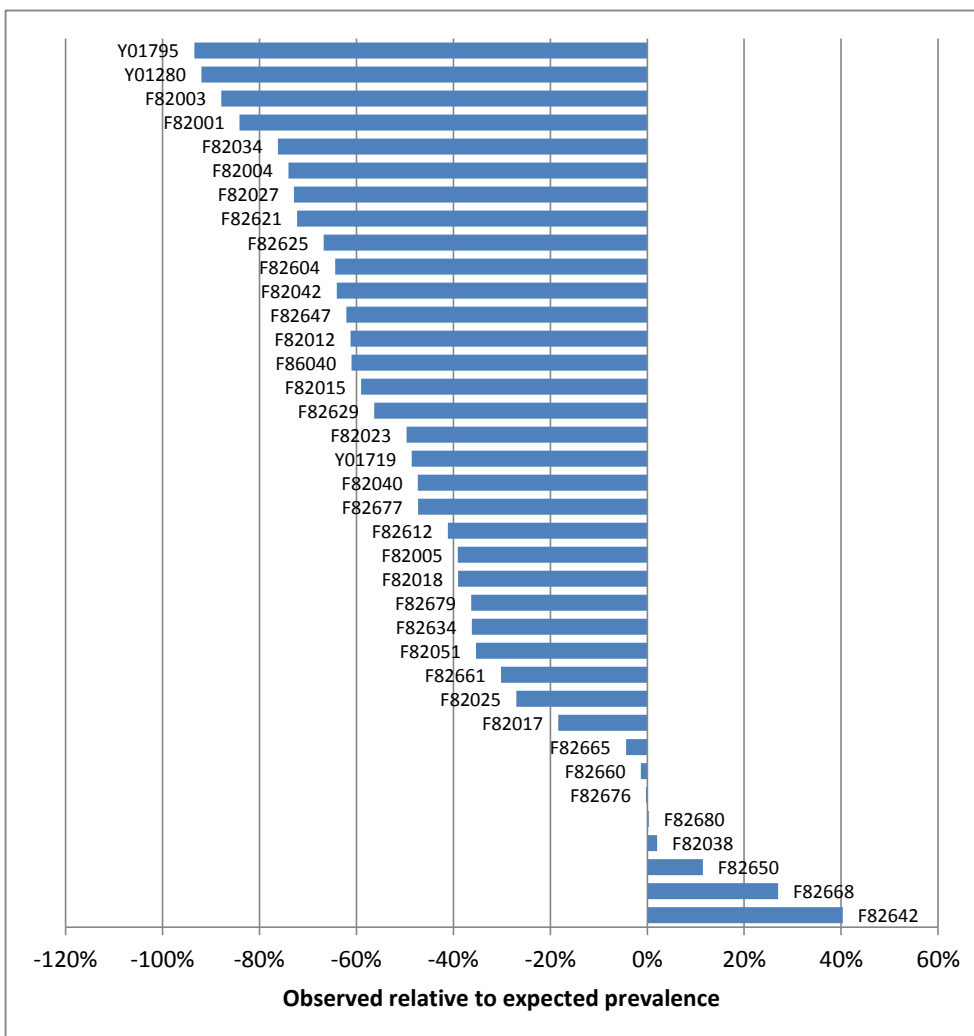


Fig 3.2: Within CCG variability in CKD prevalence GP practice observed relative to expected (QOF 2011/12)



The key to any GP codes included in this report is in appendix 1. The CKD prevalence data are available from the National General Practice Profiles <http://www.apho.org.uk/PRACPROF/>.

4 Clinical management and achievement – QOF CKD indicators

Figures 4.1 and 4.2 below present achievement against the following QOF CKD clinical indicators for Barking & Dagenham CCG, the CCG comparator group, and England:

- CKD2 - % of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months
- CKD3 - % of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less
- CKD5 - % of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) unless a contraindication or side effects are recorded
- CKD6 - % of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months

Note: The QOF indicators described in this profile do not include patients who are ‘excluded’ from the indicators in the denominator. Patients can be excluded from QOF if they are unsuitable or ineligible for the care described in an indicator. The exclusion rate varies between CCGs and practices within CCGs.

Barking & Dagenham CCG improved to some degree across one of the four CKD QOF clinical achievement indicators between 2010/11 and 2011/12 (figure 4.2).

There are a large proportion of people on CKD QOF registers. Even so, the registers do not include the non-diagnosed and exception coded patients and if these were added QOF CKD clinical indicators achievement would be lower. In Manchester and Leicestershire, two projects funded by CLARHC have investigated under-registration and developed tools and resources to help practices find and manage patients. Further detailed information is available at <http://www.clahrc-lnr.nihr.ac.uk/>. Over the next three years this approach will be offered nationally through the implementation of an HQIP funded early CKD audit (<http://hqip.org.uk/chronic-kidney-disease/>) which will collect information on achievement of NICE CG73 (CKD) and also offer practices patient level information to improve management.

Fig 4.1: QOF CKD clinical indicators achievement CCG, Fig 4.2: QOF CKD clinical indicators change, CCG 2010/11 CCG comparator and England 2011/12 – 2011/12

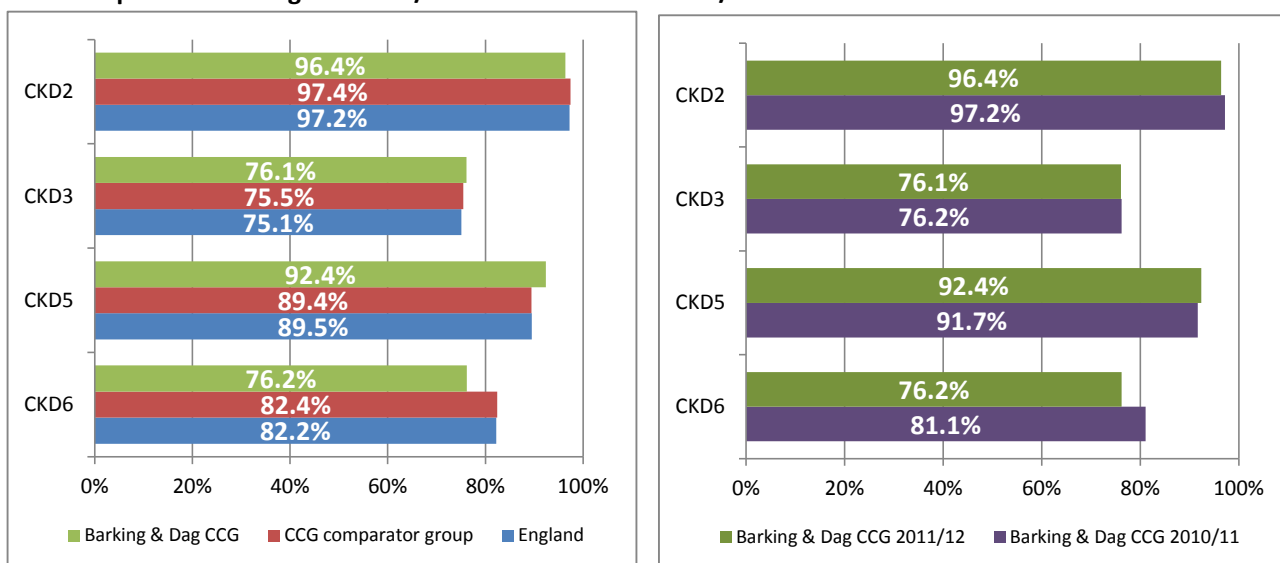


Table 4.3: CKD QOF clinical indicators trend and variation within CCG

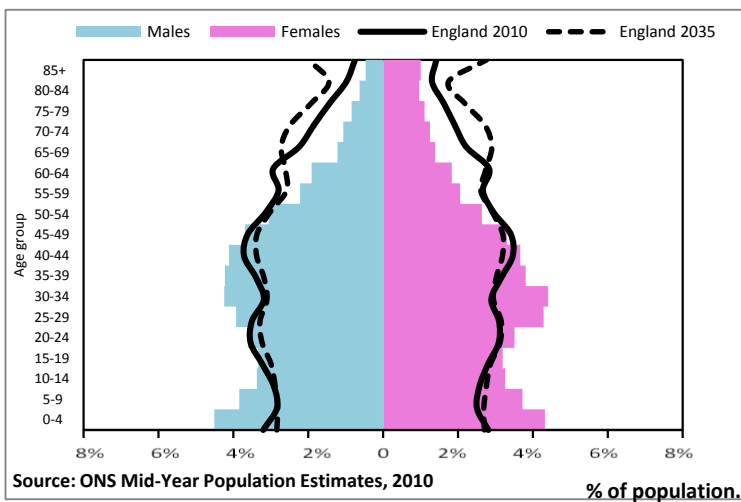
Indicator	Year	CCG value	CCG comparator	England value	Within CCG lowest practice value	
CKD2 BP measurement	2011/12	96.4%	97.4%	97.2%	Y01795	83.3%
	2010/11	97.2%	97.7%	97.5%	Y02575	90.0%
	% change	-0.8%	-0.3%	-0.3%		
CKD3 BP<140/85	2011/12	76.1%	75.5%	75.1%	Y01795	50.0%
	2010/11	76.2%	74.6%	74.2%	F82621	45.7%
	% change	-0.1%	+0.9%	+0.9%		
CKD5 Hypertensives with proteinuria receiving ACE-I/ARB	2011/12	92.4%	89.4%	89.5%	F82665	75.0%
	2010/11	91.7%	90.5%	90.5%	F82665	66.7%
	% change	+0.7%	-1.1%	-1.0%		
CKD6 Creatinine measurement	2011/12	76.2%	82.4%	82.2%	F82004	32.1%
	2010/11	81.1%	82.4%	82.2%	F82634	28.7%
	% change	-4.9%	0.0%	0.0%		

The codes relate to GP practice codes which are listed in the appendix.

5 Demographic characteristics and predictive factors for kidney disease

Age structure

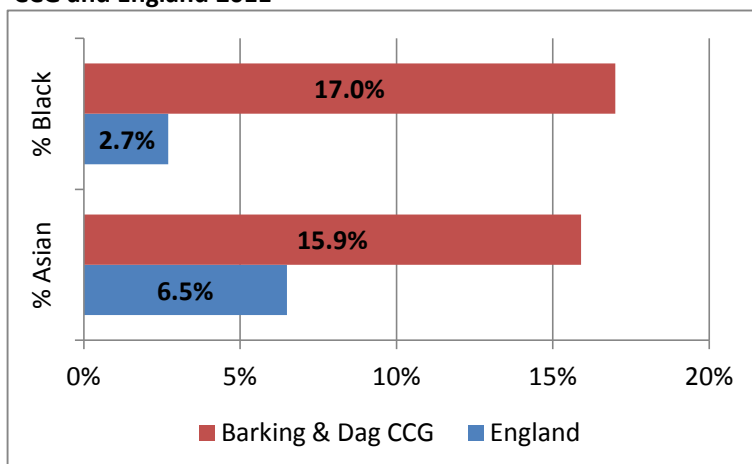
Fig 5.1: Proportion of people by age, CCG and England 2010. England population projected to 2035



In general, CKD risk increases markedly with age, which is important in light of an ageing population. Across England in 2010 15.8% of the population were aged over 65 years but this is projected to increase to 22.8% of the population by 2035. In 2010 the proportion of people aged 65 and over in Barking & Dagenham CCG (blue and pink bars in figure 5.1) was lower than across England as a whole.

Ethnicity

Fig 5.2: Proportion of people in Black and Asian population groups, CCG and England 2011

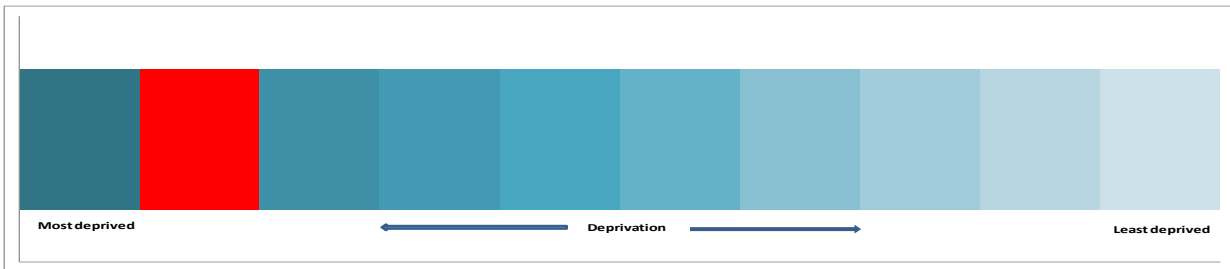


There is evidence that the progression of CKD to more severe forms including end stage renal disease is more rapid in people from Black, Asian and other minority ethnic groups [i]. In the CCG an estimated 32.9% of the population are from Black or Asian groups, compared to 9.2% across England.

Deprivation levels

CKD prevalence shows a socio-economic gradient with the most deprived populations at higher risk compared to the general population. Deprivation levels have been estimated using the Index of Multiple Deprivation 2010, which combines a range of social and economic indicators into a single score. All the national CCG scores have been ranked in order of deprivation and split into ten equal groups. Barking & Dagenham CCG is in the second most deprived group nationally (shown in red in figure 5.3).

Figure 5.3: Deprivation score (IMD 2010) CCG compared to England



6 Prevalence of kidney disease risk factors in the CCG

NHS Outcomes Framework Domains 1&2

Cardiovascular disease, hypertension and diabetes are common risk factors for CKD, and they often co-exist with other factors such as obesity. If these risk factors are well managed the prevalence of CKD will decrease. Nationally the prevalence of obesity and diabetes has been increasing over the past ten years. Results from the Health Survey for England [ii] suggest an increase in overweight and obesity from 19.4% in 1998 to 26.2% in 2010 and in diabetes from 2.8% to 5.8% over the same period. The prevalence of obesity and diabetes is higher in Barking & Dagenham CCG compared to England.

Figure 6.1: QOF prevalence of obesity, diabetes, hypertension and CHD: CCG, CCG comparator group and England 2011/12

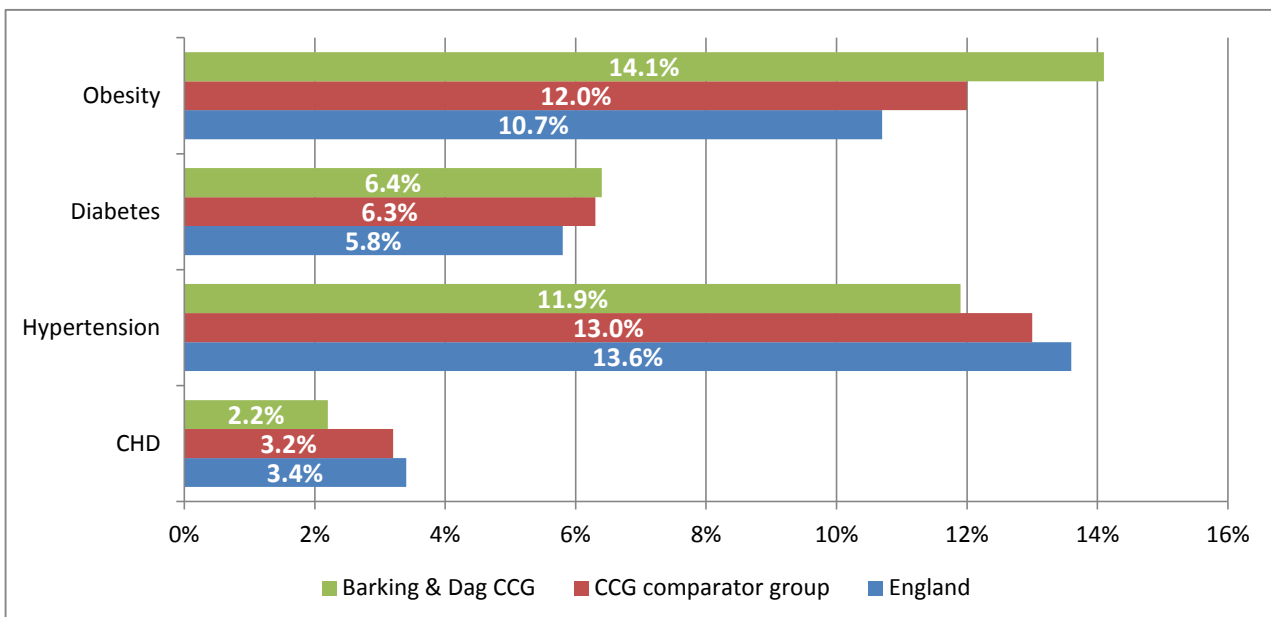


Table 6.2 gives details of the practices within the CCG with the highest and lowest prevalence of the CKD risk factors. Practice names relating to the GP practice codes are listed in appendix 1.

Table 6.2: Variation in QOF risk factor prevalence

	Within CCG variation			
	Lowest		Highest	
Obesity	F82647	6.5%	F82678	21.5%
Diabetes	Y02583	2.7%	F82665	10.7%
Hypertension	Y02583	4.2%	F82025	16.7%
CHD	Y02583	0.4%	F82612	3.7%

7 Clinical management and achievement – kidney disease risk factors

NHS Outcomes Framework Domains
1&2

Figures 7.1 and 7.2 below present achievement against a selection of the QOF CKD risk factor clinical indicators for Barking & Dagenham CCG, the CCG comparator group, and England. These indicators have been selected as they impact on the prevalence, ascertainment and management of people with CKD in primary care.

Diabetes is a key risk factor in the development of CKD. Diabetes is largely managed in primary care and several diabetes QOF indicators are summarised below. More information on diabetes management in both primary and secondary care is included in the National Diabetes Audit <http://www.ic.nhs.uk/nda>. The definitions of the diabetes-related indicators are:

- DM27 - % patients with diabetes and IFCC-HbA1c value of 64 mmol/mol or less in last 15 months
- DM15 - % patients with diabetes and proteinuria or micro-albuminuria treated with ACEI
- DM22 - % patients with diabetes with record of eGFR/serum creatinine test in previous 15 months

Barking & Dagenham CCG improved to some degree across one of the three CKD-related QOF diabetes indicators between 2010/11 and 2011/12 (Figure 7.2).

Fig 7.1: Diabetes QOF clinical indicators achievement CCG, CCG comparator and England 2011/12

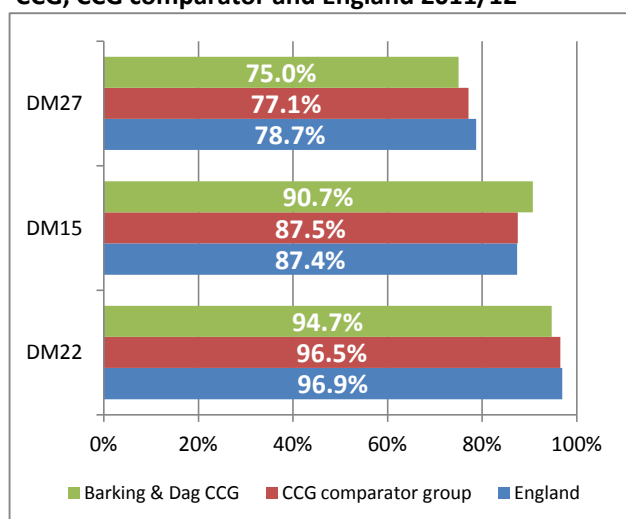


Fig 7.2: Diabetes QOF clinical indicators change CCG, 2010/11 – 2011/12

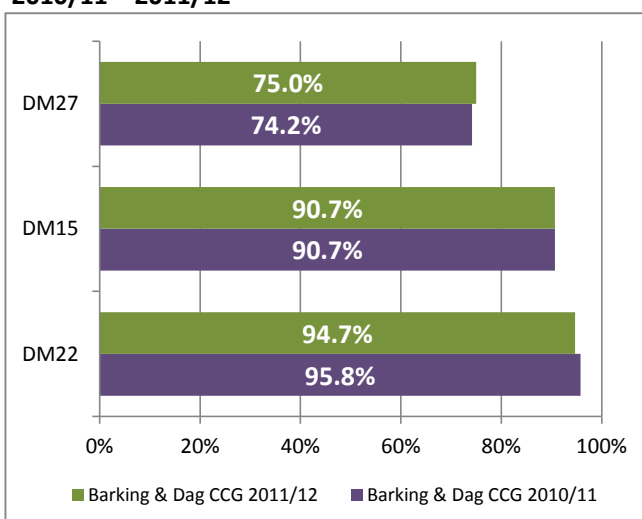


Table 7.3: Variation within CCG on CKD related diabetes QOF indicators

Indicator	Year	CCG value	CCG comparator	England value	Within CCG lowest practice value	
DM27 Patients with DM and IFCC-HbA1c level of 64 mmol/mol or less	2011/12	75.0%	77.1%	78.7%	Y01795	30.6%
	2010/11	74.2%	76.4%	78.0%	Y01795	2.7%
	% change	+0.8%	+0.7%	+0.7%		
DM15 Patients with DM and proteinuria/micro-alb treated with ACEI	2011/12	90.7%	87.5%	87.4%	Y02575	0.0%
	2010/11	90.7%	88.4%	88.2%	Y01795	78.1%
	% change	0.0%	-0.9%	-0.8%		
DM22 Patients with DM & record creatinine/ eGFR in last 15 months	2011/12	94.7%	96.5%	96.9%	Y01795	78.1%
	2010/11	95.8%	96.7%	97.2%	F82004	90.0%
	% change	-1.1%	-0.2%	-0.3%		

The codes relate to GP practice codes which are listed in the appendix.

The definitions of the additional QOF CKD risk factor clinical indicators are:

- Smoke4 - % of patients with any of several conditions (including CKD) who smoke where cessation advice or referral to a specialist service has been offered
- PP1 - In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA): the % of patients aged 30-74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment tool (in 2010/11 this indicator included all ages)
- PP2 - % of people diagnosed with hypertension, who are given lifestyle advice for increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
- AF3 - % of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy

Barking & Dagenham CCG improved to some degree in two of the four CKD-related QOF risk factor indicators between 2010/11 and 2011/12 (Figure 7.5).

Fig 7.4: CKD risk factor QOF clinical indicators performance CCG, CCG comparator and England 2011/12

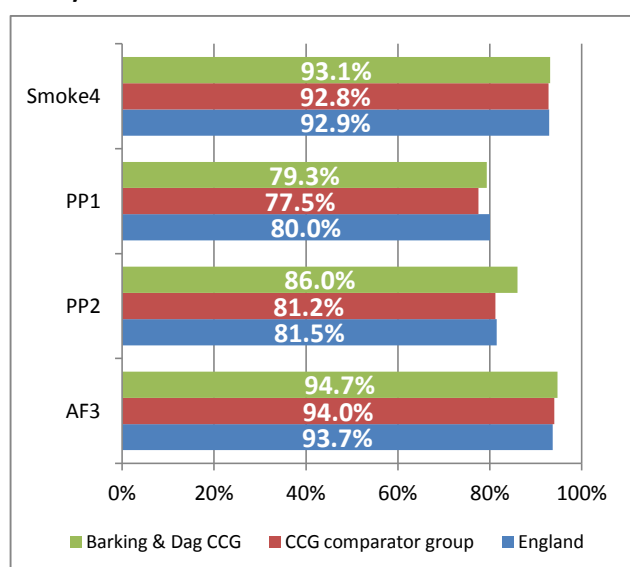


Fig 7.5: CKD risk factor QOF clinical indicators change, CCG, 2010/11 – 2011/12

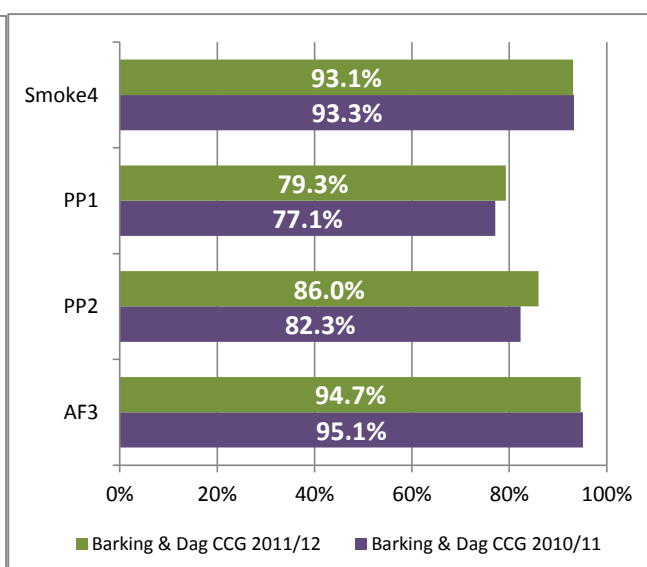


Table 7.6: Variation within CCG on CKD related QOF indicators

Indicator	Year	CCG value	CCG comparator	England value	Within CCG lowest practice value	
Smoke4 Patients with specific conditions who smoke where cessation advice/referral offered	2011/12	93.1%	92.8%	92.9%	F82018	87.3%
	2010/11	93.3%	92.6%	92.9%	F82665	85.9%
	% change	-0.2%	+0.2%	0.0%		
PP1 Patients with new hypertension with CVD risk assessment	2011/12	79.3%	77.5%	80.0%	F82634	0.0%
	2010/11	77.1%	78.6%	80.2%	F82634	2.8%
	% change	+2.2%	-1.1%	-0.2%		
PP2 People with hypertension given lifestyle advice	2011/12	86.0%	81.2%	81.5%	F82650	65.0%
	2010/11	82.3%	81.7%	81.9%	F82621	38.1%
	% change	+3.7%	-0.5%	-0.4%		
AF3 Patients with AF treated with anti-coagulant or anti-platelet	2011/12	94.7%	94.0%	93.7%	Y01719	80.0%
	2010/11	95.1%	94.0%	93.6%	F82665	85.7%
	% change	-0.4%	0.0%	+0.1%		

The codes relate to GP practice codes which are listed in appendix 1.

8 Acute kidney injury

NHS Outcomes Framework Domains 1, 3 & 4

Acute kidney injury (AKI) is a common and serious problem amongst hospitalised patients. The NCEPOD report 'Acute Kidney Injury: Adding Insult to Injury' [iii] highlights the process of care of patients who died in hospital with a primary diagnosis of acute kidney injury and takes a critical look at areas where the care of patients might have been improved. The AKI Capacity Survey (England and Wales) [iv] concluded that 'there is much variation in the model of nephrology AKI management across England.'

Despite AKI representing a significant cause of preventable patient harm, the exact incidence of AKI in hospitals is unclear, as is the quality of care such patients receive. A survey of acute trusts at the end of 2011 showed many had or were about to develop alert systems to identify patients with biochemical results consistent with AKI (an example of how to do this is available at http://www.kidneycare.nhs.uk/howto_guides1/aki_ealerts/). Building on this, NHS Kidney Care is working in collaboration with 47 acute trusts in England to establish a mechanism for collecting and comparing this information. The high cost of AKI to the health service is known however, with an estimated cost of over half a billion pounds in 2010-11 (work in progress M Kerr). Research to investigate where AKI is occurring in the care pathways shows that much of it is present in emergency and admitting departments, highlighting that the beginning of the injury is commonly in primary care, before admission to hospital [v].

Table 8.1 outlines some CCG level analysis of AKI admissions. The CCG is compared to the CCG comparator group and England. These data rely on the completeness of AKI coding within HES and are likely to represent an underestimate of the true number, as it is known that AKI tends to be under recorded.

Table 8.1: Analysis of AKI admissions 2010/11

	Barking & Dag CCG	CCG Comparator group	England
AKI admission rate per 1,000 emergency admissions	5.7	5.6	6.7
Median length of stay for AKI admission	9	9	9

Admissions refer to inpatient spells where AKI appears as the primary diagnosis within one of the episodes

9 Local kidney units facts and figures

This section summarises some of the key outcome indicators for the three kidney centres which are nearest to the CCG (data taken from the UK Renal Registry (UK RR)). It is hoped that by using three centres all those that provide a service for the CCG have been included, and sufficient centres have been provided to allow benchmarking between different centres. However, local referral patterns may mean that other kidney centres may be used by the CCG. If this is the case, please let us know by email to admin@kidneycare.nhs.uk.

The three nearest centres to Barking & Dagenham CCG are Barts and The London Hospital (L Barts), Basildon Hospital (Basldn) and Guy's and St Thomas's Hospital (L Guys). Barts and The London Hospital and Guy's and St Thomas's Hospital are transplant centres.

10 Renal replacement therapy (RRT) acceptance rates, prevalence and patients who are late presenters to specialist kidney services

*NHS Outcomes Framework Domains
1, 2 & 4*

There is variability between acceptance and prevalence rates between the different centres close to the CCG. These figures vary for a number of different reasons, reflecting demand for and supply of RRT services within localities.

Capacity and occupancy rates vary between centres and findings from the 2011 Dialysis Capacity Survey [vi] are included in this section to describe this variation. The figures should be interpreted with local knowledge in mind, and in particular local differences in the logistics of using all the spaces in some shift patterns where local demand or patient characteristics do not allow this. Across England there has been an increase in the number of people on RRT over time.

It is clinically advantageous for people with ESRD to be referred to kidney services early to allow time for consideration of the different treatment options and for kidney disease and any related complications to be managed adequately before RRT is commenced [vii]. Late referral may result in increased morbidity and mortality. It is estimated that 90 days is sufficient time to receive optimum treatment and preparation by the kidney care team prior to starting RRT. Late presentation or late referral is therefore defined as being under the management of the specialist kidney team for less than 90 days before commencement of RRT. There are a number of reasons why 90 days of specialist care may not be achieved, due to either clinical or service provision issues.

Table 10.1: RRT acceptance, prevalence, late presenters to services and unit occupancy rates

	RRT acceptance rate# per million pop (2010)	Number of people on RRT 31/12/10	% average change in no. people on RRT 2006–2010	% late presentation kidney services## 2010	Patients per station (Oct 2011)	Vacant unstaffed capacity (people) 2011	Vacant staffed capacity (people) 2011
L Barts	123	1,778	+5.9%	*	5.5	86	0
Basldn	78	214	+3.4%	+30.0%	4.6	43	49
L Guys	125	1,618	+5.1%	+14.5%	4.2	173	28
England	110	42,660	+4.0%	+20.2%			

Acceptance rates are based on newly calculated catchment areas, for details of the methodology see the data guide. ## Late presentation or late referral defined as being under the management of the specialist kidney team for less than 90 days before commencement of RRT.

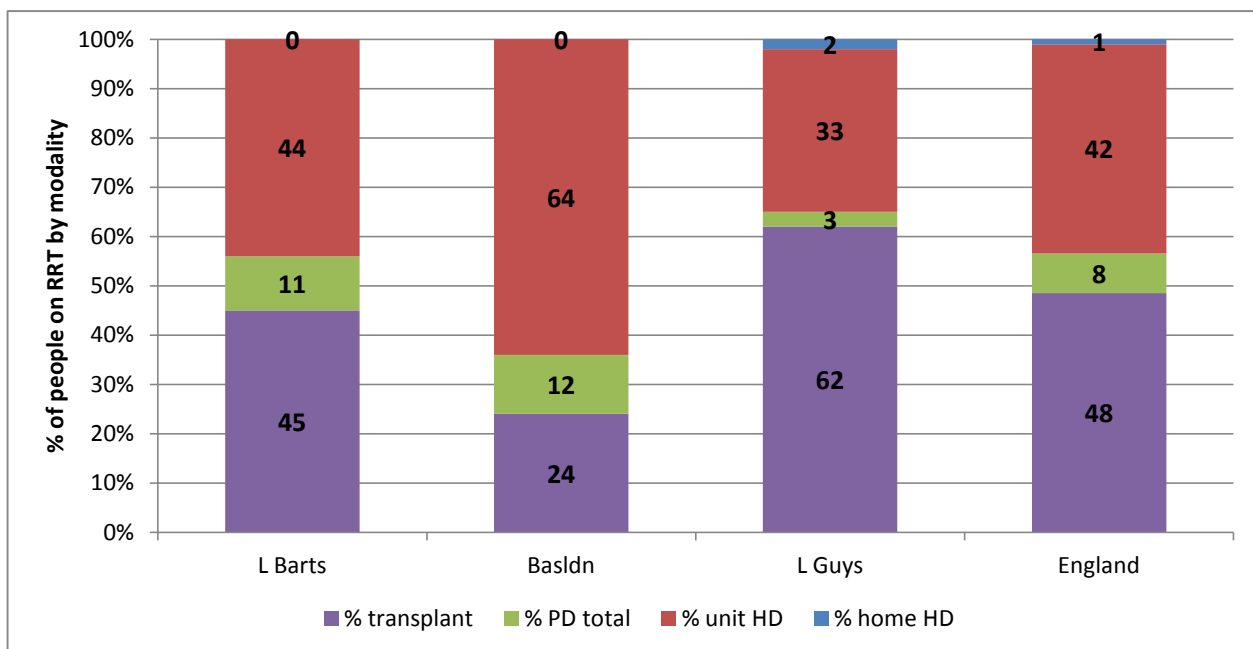
*Data not submitted to UK Renal Registry or Capacity Survey (if applicable).

11 Proportion of people on different types of RRT

NHS Outcomes Framework Domains 2 & 4

It is important that patients receive enough information to make an informed decision about RRT treatment options, including conservative care. The different types of dialysis are peritoneal dialysis (PD), and haemodialysis (HD) which can be either home or unit-based. There are variations in the type of RRT received by patients in different kidney centres.

Fig 11.1: Proportion of people on RRT by modality in closest kidney units



For some patients with ESRD, renal transplantation is recognised as the optimal RRT modality. Many patient specific factors, including age, gender, ethnicity and co-morbidity, have been reported to influence access to kidney transplantation. The time spent on dialysis prior to transplantation can also affect the transplant outcome, with patients who have been on dialysis for longer experiencing poorer transplant outcomes [viii].

Table 12.1 shows the proportion of people who are entered onto waiting lists prior to or within two years of starting dialysis along with the median length until wait listing. The table also shows the transplant rate within two years of registering on the transplant list for patients, either from brain stem death donors or live/cardiac death donors. Please note this represents historical data (2004–06), as no more recent analysis is currently available.

Table 12.1: Transplant listing waiting times and transplants within two years of registration on the list

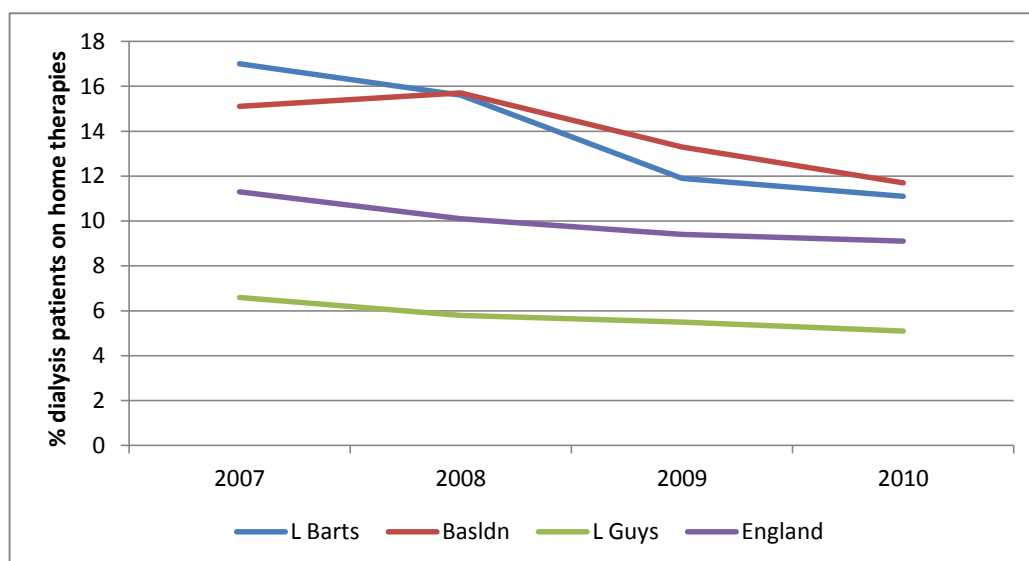
	% patients wait listed before or within 2 years of RRT start	Median time on RRT before wait listing (days)	% patients undergoing transplant from a brain stem death donor within 2 years of RRT commencing	% patients undergoing transplant from a living or cardiac death donor within 2 years of RRT commencing
L Barts	49.0%	608	19.7%	26.8%
Basldn	42.5%	774	7.9%	36.1%
L Guys	45.5%	726	20.3%	38.9%

*Data not submitted to UK Renal Registry (if applicable).

13 Access to home based dialysis

The NICE Kidney Disease Quality Standards [ix] suggest that people should have the option to choose where they receive dialysis, but ideally this should be from home. Figure 13.1 below outlines the variation and the change over time, by centre, in the proportion of dialysis patients on home based dialysis (home haemodialysis and peritoneal dialysis combined).

Fig 13.1: Proportion of dialysis patients on home therapies, 2007–10



If points are missing the data have not been returned to the UK Renal Registry.

Anaemia (low levels of haemoglobin in the blood) commonly coexists alongside CKD and this section summarises some of the information about its management. Clinical guidelines recommend optimum haemoglobin (Hb) levels in kidney disease and during RRT. For people with CKD, guidelines suggest that an Hb of at least 10 g/dl should be achieved within six months of being seen by a kidney specialist [x,xi]. As this information is not readily available, for these profiles the Hb at the start of dialysis is used to estimate this measure.

Anaemia associated with kidney disease can be treated using several different methods including iron supplementation and erythropoiesis stimulating agents (ESAs). ESAs can substantially improve quality of life for patients on dialysis. They are expensive drugs and so other approaches to achieve normal levels of Hb should also be explored. Not all centres submitted information about the proportion of patients on HD and PD requiring ESAs, although there can be substantial variability between centres.

Table 14.1: Haemoglobin levels starting and during HD and PD, proportion of people on ESAs

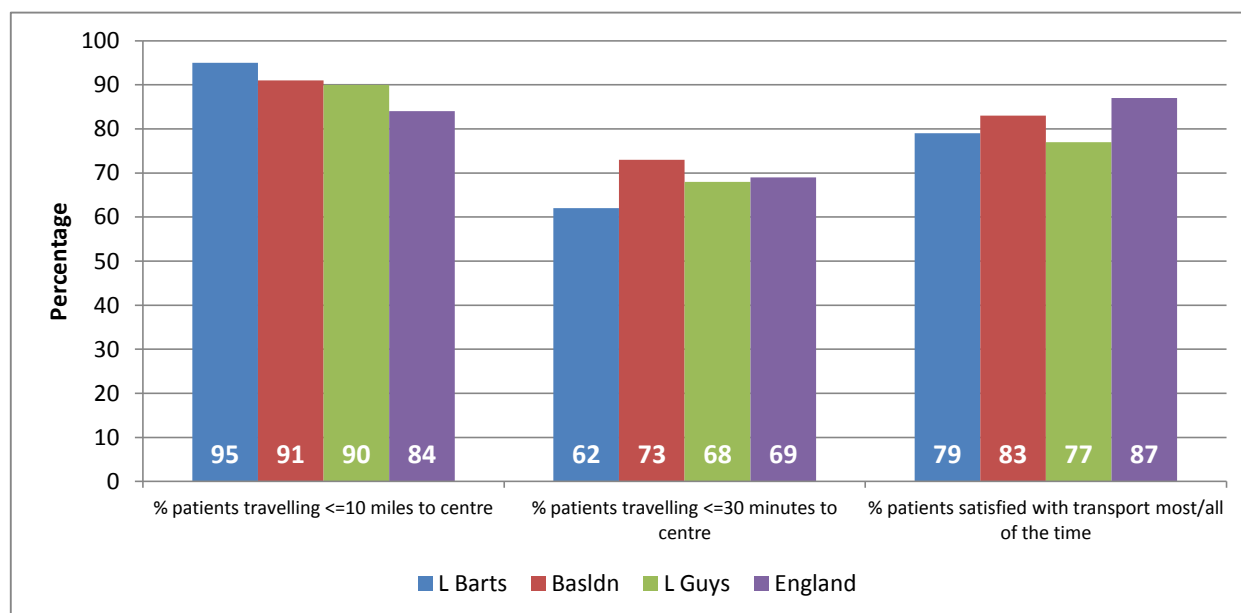
	% new patients with Hb>10g/dl	% prevalent HD patients with Hb 10-12g/dl	% prevalent PD patients with Hb 10.5-12.5g/dl	% patients receiving ESA on HD	% patients receiving ESA on PD
L Barts	46%	54%	49%	*	*
Basldn	42%	51%	50%	91%	50%
L Guys	34%	50%	57%	*	*
England	54%	52%	54%	91%	75%

*Data not submitted to UK Renal Registry (if applicable).

15 Transport to kidney centres for people requiring RRT

Transport issues have a large impact on quality of life of people requiring RRT. This section summarises some of the main findings from the National Patient Transport Audit conducted in 2010. The Renal Association haemodialysis clinical practice guidelines [xii] recommend that ‘except in remote geographical areas the travel time to a haemodialysis facility should be less than 30 minutes or a haemodialysis facility should be located with 25 miles of the patient’s home.’

Fig 15.1: Travel times and distances, and satisfaction with transport services



*Data are missing if the centre did not take part in the Transport Audit 2010.

16 Mortality from kidney disease

There are no mortality statistics for kidney disease available at CCG level and the national mortality statistics currently available are under review as they are thought to underestimate the true number of deaths which are attributed to kidney disease. It is anticipated that as CCG geographical boundary development improves, CCG level mortality statistics will become possible.

17 The cost of chronic kidney disease

It is estimated that the NHS in England spent £1.45 billion on CKD in 2009/10, equivalent to £1 in every £77 of NHS expenditure. This estimate covers both direct (renal care and prescribing to reduce disease progression) and indirect (e.g. treatment of non renal issues such as strokes in people with CKD) costs.

The report 'CKD in England: The Human and Financial Cost' [xiii] estimates the direct costs of CKD in England. The methodology has been replicated at CCG level to estimate the cost of CKD in primary care, outpatient clinics and for people admitted to hospital. Primary care costs include the management and prescribing costs for people with established and newly diagnosed CKD, calculated using QOF performance indicator information. The outpatient and inpatient costs are based on data obtained from Hospital Episode Statistics. More details on the costing methodology can be found in the accompanying CCG profiles data guide.

Table 17.1: Estimates of annual direct costs of CKD in Barking & Dagenham CCG

	Estimated cost in £ Barking & Dag CCG
Expenditure on primary care tests and consultations for CKD as specified in QOF	£319,986
Expenditure in primary care of hypertensive medications in people with CKD and hypertension	£346,636
Expenditure in primary care on prescribing for vitamin D, EPO/ESAs and phosphate binders *	£88,742
Expenditure on Nephrology Outpatients for CKD stages 3-5 *	£202,617
Expenditure on hospital admissions for CKD HRGs and directly associated HRGs *	£250,355
Expenditure on kidney transplants *	£753,203
Expenditure on dialysis (including transport for dialysis) *	£1,851,897
Total	£3,813,437

*Apportioned from national data. Total may not sum due to rounding.

Appendix 1 List of GP Practices in NHS Barking and Dagenham CCG

F82001 DR BB QUANSAH'S PRACTICE
F82003 DR M FATEH'S PRACTICE
F82004 DR IA MOGHAL'S PRACTICE
F82005 DR M GOYAL'S PRACTICE
F82012 FIVE ELMS HEALTH CENTRE
F82015 DR SN AHMAD'S PRACTICE
F82017 DR TC MOHAN'S PRACTICE
F82018 DR TOLIA
F82023 DR PERVEZ
F82025 DR BK JAISWAL'S PRACTICE
F82027 DR P PRASAD'S PRACTICE
F82034 DR N NIRANJAN'S PRACTICE
F82035 PRIMARY CLINICAL PARTNERSHIP LTD
F82038 DR SZ HAIDER'S PRACTICE
F82040 JOHN SMITH MEDICAL CENTRE
F82042 DR K JOHN'S PRACTICE
F82051 DR AK SHARMA'S PRACTICE
F82604 DR KP KASHYAP'S PRACTICE
F82612 DRS SHARMA & RAI
F82621 DR OLA
F82625 DR MF HAQ'S PRACTICE
F82629 THE LAWNS MEDICAL CARE
F82634 DR BILA
F82642 GABLES SURGERY
F82645 DR F. ISLAM
F82647 DR R CHIBBER'S PRACTICE
F82650 DR AA ANSARI'S PRACTICE
F82660 DR V GORIPARTHI'S PRACTICE
F82661 DR NPS TEOTIA'S PRACTICE
F82665 DR VK CHAWLA'S PRACTICE
F82668 DR AK MITTAL'S PRACTICE
F82676 DR GS KALKAT'S PRACTICE
F82677 DR A MOGHAL'S PRACTICE
F82678 DR M ROY'S PRACTICE
F82679 DR DP SHAH'S PRACTICE
F82680 DR JP LAWRENCE'S PRACTICE
F86040 DR UA AFSER'S PRACTICE
Y01280 SHIFA MEDICAL PRACTICE
Y01719 BROAD STREET MEDICAL CENTRE
Y01795 DR EHSAN
Y02575 PORTERS AVENUE HEALTH CENTRE
Y02583 CHILD & FAMILY HEALTH CENTRE

Appendix 2 List of comparator CCGs for NHS Barking and Dagenham CCG

NHS BARKING AND DAGENHAM CCG
NHS BIRMINGHAM CROSSCITY CCG
NHS BLACKBURN WITH DARWEN CCG
NHS BOLTON CCG
NHS BRADFORD DISTRICTS CCG
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG
NHS EAST LANCASHIRE CCG
NHS GREENWICH CCG
NHS HALTON CCG
NHS LAMBETH CCG
NHS LEICESTER CITY CCG
NHS LEWISHAM CCG
NHS NEWCASTLE WEST CCG
NHS NORTH KIRKLEES CCG
NHS NOTTINGHAM CITY CCG
NHS OLDHAM CCG
NHS ROTHERHAM CCG
NHS SOUTH SEFTON CCG
NHS SOUTHWARK CCG
NHS STOKE-ON-TRENT CCG
NHS WALSALL CCG

Appendix 3 NHS Outcomes Framework

The NHS Outcomes Framework five domains

Domain 1 Preventing people from dying prematurely

Domain 2 Enhancing quality of life for people with long term conditions

Domain 3 Helping people to recover from episodes of ill health or following injury

Domain 4 Ensuring that people have a positive experience of care

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm

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Kidney Care