House Keeping

- Please ensure your microphone and video are turned off during the session. This is to avoid any disruption during presentations and to assist with the quality of the connection.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- The event is being recorded and will be shared.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don't manage to do this we will follow up after the event.
- If you cannot see the chat, please email your question/s to sarah.black@healthinnovationnenc.org.uk

Health Innovation
North East and North Cumbria

The Health Innovation Network

The Academic Health Science Network for the North East and North Cumbria has changed its name to Health Innovation North East and North Cumbria (HI NENC).

The new name – which came into effect on 1st October following the start of our new five-year licence – reflects the organisation's key role to continue to support the development and spread of innovation across the region's health service.

But while our name has changed, our vision remains the same: to improve health outcomes, reduce inequalities, and boost the regional economy. Working alongside partners across the system, we will continue to accelerate health innovation in the region, and beyond.

Established in 2013 by NHS England we are one of 15 Health Innovations.

Health Innovation
North East and North Cumbria

Agenda

12.00 – 12.05 facts.ckd and HIN Strategic Priorities NENC
Prof Julia Newton (Chair)

12.05 – 12.15 Renal Network STP Priorities
Alex Wood

12.15– 12.50 Multimorbidity QoF fulfillment
using CKD CDRC Toolkit
Gareth Forbes

12.50 Q&A for Panel

13.00 Close

NENC Renal Network Priorities
Early CKD Identification and Optimised Treatment

23rd April 2024
Alexander Wood, NENC Renal Network Manager

The NENC Renal Network

A formal and permanent strategic Operational Delivery Network of NHS Trusts, Renal Centres, Referring centres, NHSE Specialised Commissioning, Kidney Patient Associations and patient representatives and other stakeholders including:

- Clinicians and Nurses
- Clinical Directors and Business Managers
- ICS and local Government
- Charities
- Allied Health Professionals and Social workers
- Primary Care Professionals (please get in touch if you want to collaborate)

Led by the Renal Network Executive Management team, the NENC Renal Network is commissioned and mandated by NHSE Specialised Commissioning to:

- Improve the quality of renal care across the North East and North Cumbria and the experience of patients across the whole Adult Renal Care Pathway

- Reduce health inequalities and eliminate unwarranted variation in renal care to ensure equity of access to care for all patients in the population

- Ensure the sustainability and value of renal services

Delegated into 5 major Workstreams covering the entire Adult Renal Care Pathway:

Acute Kidney Injury **Chronic Kidney Disease**   **Dialysis**   **Transplantation**   **Equity**

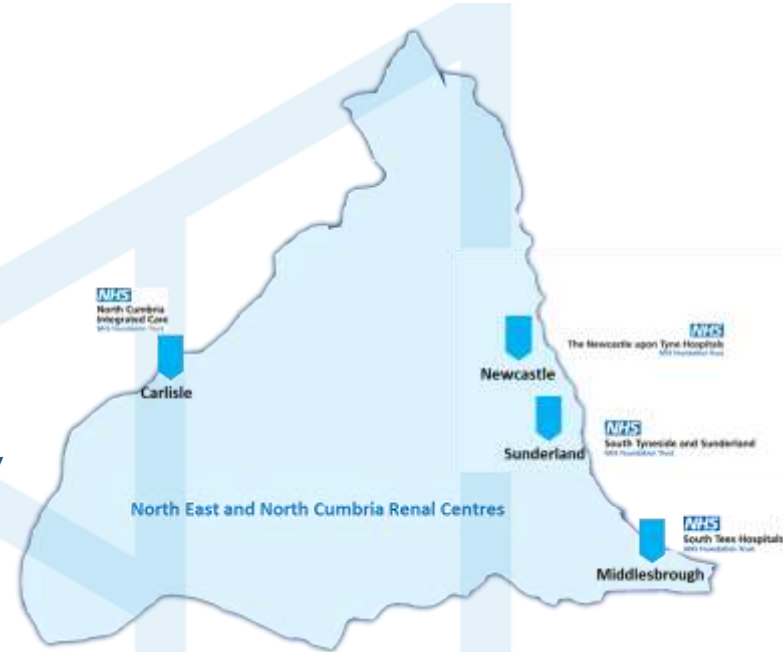North East and North Cumbria Renal Centres
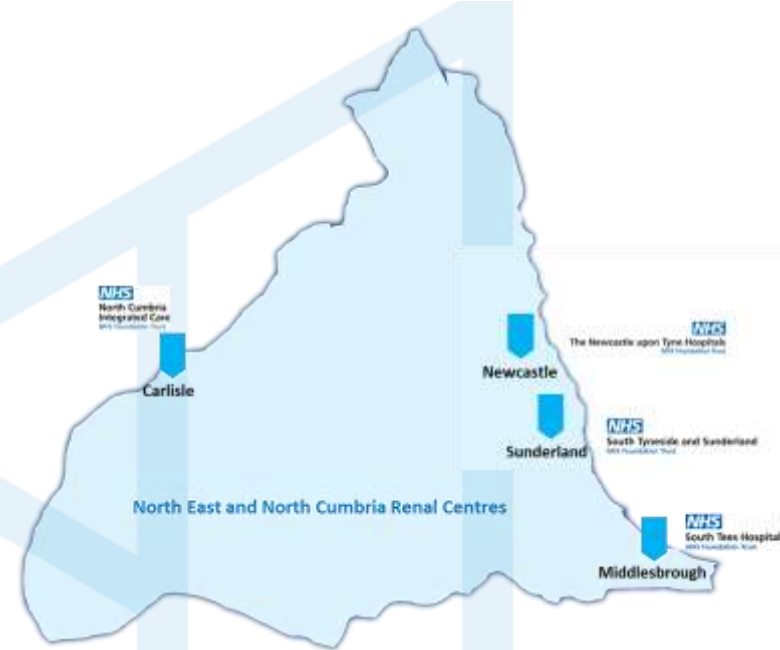
The NENC Renal Network Remit

Non-statutory body but empowered to provide strategic guidance to NHS providers, ICB, and to collect and assess patient feedback from Kidney Patient Associations and representatives.

Facilitate communications between multiple stakeholders across the NHS Renal Specialist care and associated MDTs, charities, patient representatives, research organisations and academia to facilitate best practice or streamline care pathways and improve situational awareness-Breaking down silos.

Fund and lead targeted Quality Improvement programs to improve quality of care, patient experience.

Example: Network securing and distribution of Digital Tablet devices to renal units to combat digital exclusion to permit Kidney PREM feedback of patients.
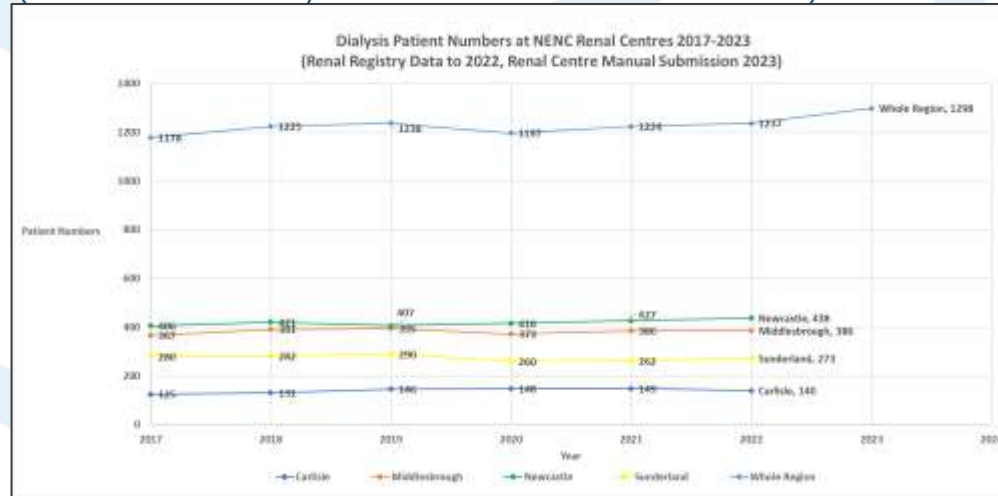

North East and North Cumbria Renal Centres

Carlisle — NHS North Cumbria Integrated Care NHS Foundation Trust

Newcastle — NHS The Newcastle upon Tyne Hospitals NHS Foundation Trust

Sunderland — NHS South Tyneside and Sunderland NHS Foundation Trust

Middlesbrough — NHS South Tees Hospitals NHS Foundation Trust

The NENC Kidney Patient Population

Known Adult CKD Patients: 127,181, 4.9% QOF 18+ Prevalence (Vs. 4.2% in England as a whole)   (PHE Fingertips Figures for NENC ICB Region and England in 2023)

Adult Kidney Transplant Patients: 1,828 Transplant patients according to the Renal Registry Data Portal (2022 data)

Adult Dialysis Patients: 1298 Dialysis patients (2023 Data returns by Renal Units to NENC Renal Network)

Dialysis Patient Numbers at NENC Renal Centres 2017-2023
(Renal Registry Data to 2022, Renal Centre Manual Submission 2023)

The **NENC** Dialysis Patient Population: Deprivation

NENC REGION DIALYSIS PATIENTS BY DEPRIVATION DECILE, RENAL REGISTRY 2021

■ 1 (Most Deprived) ■ 2 ■ 3 ■ 4 ■ 5 (Least Deprived)

UK AND NI DIALYSIS PATIENTS BY DEPRIVATION DECILE, RENAL REGISTRY 2021

■ 1 (Most Deprived) ■ 2 ■ 3 ■ 4 ■ 5 (Least Deprived)

North East and North Cumbria Renal Centres
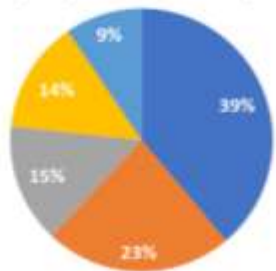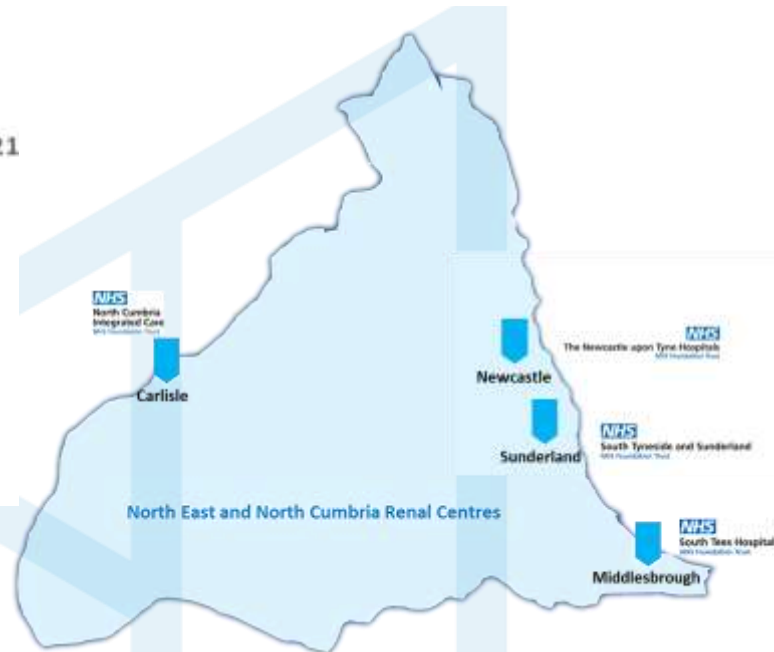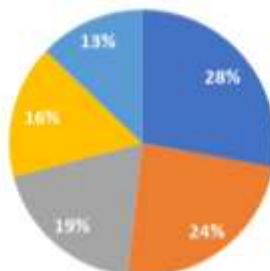
	Number of Dialysis Patients (all modalities) by IMD Quintile NENC Region, 2021 Renal Registry					
Renal Centre	1 (Most Deprived)	2	3	4	5 (Least Deprived)	Total
Carlisle	36	44	32	20	15	147
Middlesbrough	165	76	53	49	43	386
Newcastle	160	96	62	66	43	427
Sunderland	114	66	33	34	15	262
NENC Region	475	282	180	169	116	1222

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Projections of Dialysis Therapy Demand in the NENC Region

Dialysis Patient Numbers (All Modalities) at NENC Renal Centres 2017-2023
(Renal Registry Data to 2022, Renal Centre Manual Submission 2023) And Projections 2024-2030
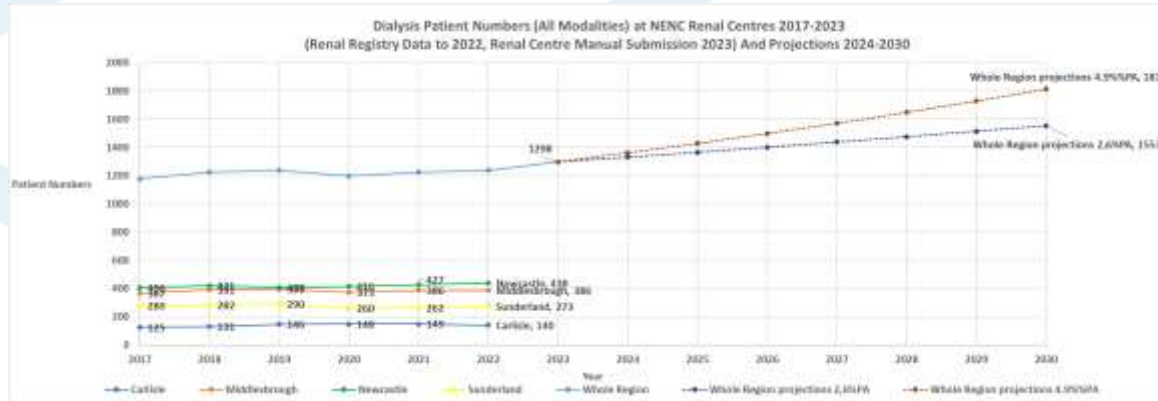
- Renal centres currently at or near full capacity, NHS funding and Renal Workforce not able to keep up
- Costs for dialysis a growing burden which will be unsustainable, regionally and nationally (REF)
- **Slowing the growth of End Stage Kidney Disease is essential for the sustainability of NHS services**

NENC Renal Network-Priority in CKD

Mitigate the rise in Dialysis demand to ensure sustainability of NHS Renal Services

Promote equitable access to optimised renal care across the whole region and eliminating unwarranted variation in the quality and care of all patients with CKD

Work with Primary and Specialist care professionals and patient representatives to make this a reality

Mitigating the Growth of RRT Demand (and the consequences of failing to do so)

Kidney Research UK Report 2023 highlighted the threat to the NHS if current CKD growth trends continue and if they are unconstrained.

Predictions:
2023 costs of Kidney disease to the UK:£7.0 billion
2033 costs of Kidney Disease to the UK (unconstrained):£13.9 billion
(Costs and management of Renal Care are being delegated to regions through the ICBs so this challenge will be both national and regional)

Key interventions recommended by KRUK
- Early/improved diagnosis
- Improved CKD management
- Use of SGLT-2 inhibitors
- Increased rates of transplantation (out of scope of this talk but the NENC Renal Network is actively working to streamline the Kidney Transplant pathway, increase transplantation numbers and equity)

Kidney disease: A UK public health emergency

The health economics of kidney disease to 2033

June 2023

Economics-of-Kidney-Disease-full-report_accessible.pdf (kidneyresearchuk.org)

www.healthinnovationnenc.org.uk

NENC Renal Network Response- CKD Workstream Programs

As Discussed in Session 1:

NHS
South Tyneside and Sunderland
NHS Foundation Trust

CKD Webinar
Dr Sarah McCloskey
Consultant Nephrologist and Physician
NENC Renal Network CKD Lead

The path to
excellence

- Collaboration with Regional Pharmacy Stakeholders, Diabetes and Cardiac Networks to develop SGLT2i Clinical Guidelines to treat CKD, and Patient Information Leaflet (hosted on NTAG website https://ntag.nhs.uk/wp-content/uploads/2023/11/NENC-regional-SGLT2-top-tips-v1.2-NTAG-approved-March-2023-v2-UPDATE-June-2023.pdf?UNLID=50151890520243317475)

- Kidney Failure Risk Equation pilot with Regional Lab

- AZ and Renal Network funded HI NENC Pilot Project, inspired by the work of Dr Gareth Forbes: Embedding of pharmacists in GP practices in a deprived area to..

> CKD code cleanse with CDRC
> Contact patients and optimise treatment including with SGLT2is
> Provide a reproducible and scalable invest-to-save model for wider ICB implementation

- Multiple other programs in various stages of development

Working with the NENC Renal Network

We welcome approaches from interested GPs and PCN colleagues if they have proposals they want to bring to the network to improve CKD care and , represent primary care on our Governing Board or if they wish to work with us on our planned CKD projects

Many other projects planned or underway in all the workstreams of the NENC Renal Network which may be of interest to primary care colleagues including:

AKI: Post-AKI discharge process improvement and standardisation
All Workstreams: Digital inclusion and patient education
Equity: Organ Donation-Ethnicity Equity program

nuth.nencrenalnetwork@nhs.net

NHS North East and North Cumbria Renal Operational Delivery Network

Health Innovation North East and North Cumbria

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Clinical Digital Resources Collaborative
CDRC Pragmatic CKD Management

Gareth Forbes

Clinical Digital Resource Collaborative
CDRC Supporting Clinical Decisions

Join our Journey
North East and North Cumbria

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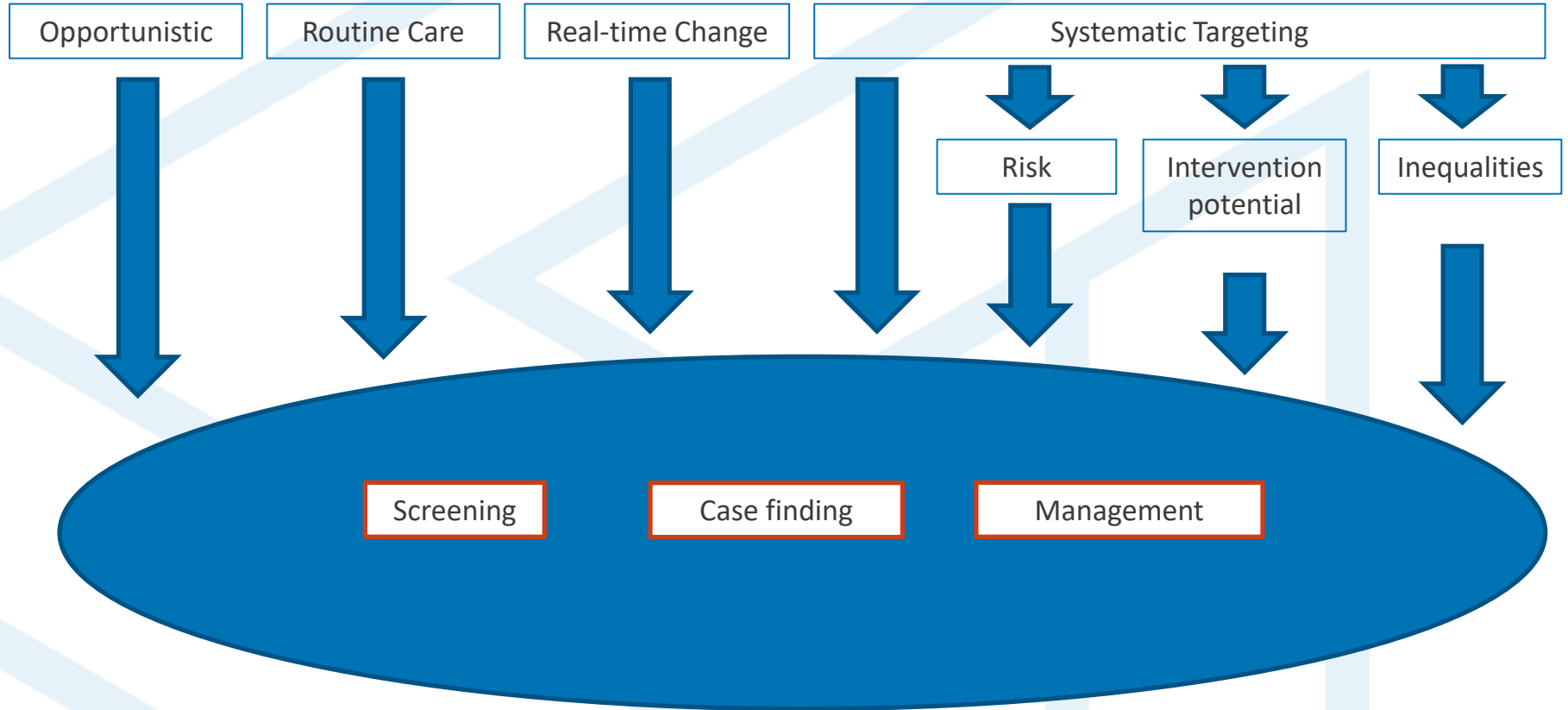
Why: Drivers and Motivation at the Coalface

- Desire to deliver professional service
- Altruism and enthusiasts
- Competition and reputation
- QoF and other incentive schemes
- CQC
- Fear of litigation
- Financial support

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Barriers

- Primary care is completely overwhelmed

- Lack of financial incentives

- Increasing prevalence

- Increasing complexity – multimorbidity and new treatments

Pragmatic Resources

- Integrated into usual systems
- Integrated across diseases
- Make use of the right staff – especially ARRS roles
- Align to financial incentives
- Right sensitivity and specificity
- Allows individual patient care
- Can adapt to local demand/resources

Practice Data

	Count	%
? CKD 2 Casefinding ---	0	0.0 %
? CKD 2.0 Casefinding - All patients with potentially uncoded CKD #	10	0.2 %
? CKD 2.01 Casefinding - eGFR<60 twice, 3 months apart but not coded with CKD3-5 #	0	0.0 %
? CKD 2.02 Casefinding - Repeated ACR>=3 but not coded with CKD #	0	0.0 %
? CKD 2.021 Casefinding - Repeated ACR>=3 but not coded with CKD (excluding diabetic kidney disease) #	0	0.0 %
? CKD 2.03 Casefinding - Diabetic kidney disease but not coded with CKD	9	0.1 %
? CKD 2.1 Casefinding - All patients with possible CKD - need repeat eGFR or ACR #		
? CKD 2.11 Casefinding - eGFR<60 (isolated) over 4 months ago but not coded with CKD 3-5 - Repeat U+E #	10	0.2 %
? CKD 2.111 Casefinding - eGFR<50 (isolated) over 4 months ago but not coded with CKD 3-5 - Repeat U+E #	1	0.0 %
? CKD 2.4 Casefinding - Isolated ACR>=3 not coded with CKD - Repeat ACR	35	0.6 %

County Data

Name ∨	Count	%
? CKD 2 Casefinding ---	0	0.0 %
? CKD 2.0 Casefinding - All patients with potentially uncoded CKD #	9121	1.8 %
? CKD 2.01 Casefinding - eGFR<60 twice, 3 months apart but not coded with CKD3-5 #	4361	0.9 %
? CKD 2.02 Casefinding - Repeated ACR>=3 but not coded with CKD #	3895	0.8 %
? CKD 2.021 Casefinding - Repeated ACR>=3 but not coded with CKD (excluding diabetic kidney disease) #	2134	0.4 %
? CKD 2.03 Casefinding - Diabetic kidney disease but not coded with CKD	3093	0.6 %
? CKD 2.1 Casefinding - All patients with possible CKD - need repeat eGFR or ACR #	6063	1.2 %
? CKD 2.11 Casefinding - eGFR<60 (isolated) over 4 months ago but not coded with CKD 3-5 - Repeat U+E #	3061	0.6 %
? CKD 2.111 Casefinding - eGFR<50 (isolated) over 4 months ago but not coded with CKD 3-5 - Repeat U+E #	359	0.1 %
? CKD 2.4 Casefinding - Isolated ACR>=3 not coded with CKD - Repeat ACR	3116	0.6 %

Set these as batch searches!!

CKD Dashboard

Prevalence / Diagnosis

CKD G1-5	390	6.5%

CKD G1-2	1.8%	CKD G3-5	279	4.6%

G1	G2	G3??	G3A	G3B	G4	G5
0.6%	1.2%	0%	3%	1.2%	0.3%	0.1%

G1				G2				G3??				G3A				G3B				G4				G5			
A1	A2	A3	A?	A1	A2	A3	A?	A1	A2	A3	A?	A1	A2	A3	A?	A1	A2	A3	A?	A1	A2	A3	A?	A1	A2	A3	A?
1	34	3	1	12	53	6	1	0	0	0	1	129	42	7	8	38	22	11	0	4	8	5	1	0	2	4	0

Casefinding and Coding

Patients with potentially missed CKD	2
Patients with possible CKD - repeat testing needed	22
Patients with incomplete/incorrect CKD coding	18
Patients with condition needing renal check WITH renal check in last 12 months	90.6%

Renal Monitoring

Creatinine checked in last 6/12 months (as appropriate)		95.1%
Lower risk CKD - Creatinine checked in last 12 months	318	96.5%
Higher risk CKD - Creatinine checked in last 6 months	72	88.9%
Higher risk CKD - KFRE checked in last 12 months	72	70.2%
ACR checked in last 12 months		77.7%

BP Control

		Last BP	Last 12 months
BP checked in last 12 months	97%		
Has personal BP target set	49.4%		
▽ Achieving NICE control		84.2%	80.9%
▽ Personal target achieved (or NICE)		79.3%	76.8%

Medication

	Eligible Patients	% Treated	% Treated or reason why not
▽ Lipid Lowering	387	83.2%	91.7%
▽ Renin-Angiotensin Blockade	186	76.3%	84.9%
▽ SGLT2i	183	47.5%	51.4%
▽ Finerenone (% treated figure include all MRAs)	7	28.6%	28.6%

Specialist Care

KFRE >=5% - had nephrology involvement	21	84%
Current nephrology involvement	34	8.6%
Current dialysis	2	
Renal transplant	2	

rg.uk

Finding People With Undiagnosed/Uncoded CKD

1. Patients with repeated results suggesting CKD e.g. Repeated low eGFRs OR raised ACRs OR DKD without CKD

All patients	Review results and consider adding a CKD code	2	➡
Persistently low eGFR	Review results and consider adding a CKD code	0	➡
Persistently raised ACR	Review results and consider adding a CKD code	2	➡
Coded diabetic kidney disease but not CKD	Review results and consider adding a CKD code	0	➡

2. Patients with isolated results suggesting possible CKD e.g. low eGFR OR raised ACR

All patients	Review results and consider repeating tests	22	➡
Low eGFR	Review results and consider repeating U+E	4	➡
Raised ACR	Review results and consider repeating ACR	18	➡

Patient With CKD Coding Issues

1. Patients with repeated results suggesting CKD G code is incorrect

All patients	Review results and consider updating the CKD G code	2	➡
Last 2 eGFRs 60-89 not consistent with the current G code	Review results and consider updating the CKD G code to G2	0	➡
Last 2 eGFRs 45-59 not consistent with the current G code	Review results and consider updating the CKD G code to G3A	0	➡
Last 2 eGFRs 30-44 not consistent with the current G code	Review results and consider updating the CKD G code to G3B	1	➡
Last 2 eGFRs 15-29 not consistent with the current G code	Review results and consider updating the CKD G code to G4	1	➡
Last 2 eGFRs 0-14 not consistent with the current G code	Review results and consider updating the CKD G code to G5	0	➡

2. Patients with CKD A code issues

Last 2 ACRs 0-2.9 not consistent with the current A code	Review results and consider updating the CKD A code to A1	1	➡
Last 2 ACRs 3-30 not consistent with the current A code	Review results and consider updating the CKD A code to A2	1	➡
Last 2 ACRs >30 not consistent with the current A code	Review results and consider updating the CKD A code to A3	0	➡
Last (isolated) ACR not consistent with current A code	Review results and consider repeating ACR	10	➡
Not coded with an A code	Review results and consider adding A code and/or checking ACR if needed	9	➡

Engagement Issues

1. Patients with suboptimal monitoring

		All		Inequalities	
BP Overdue	Measure blood pressure	5	♥	3	♥
U+E Overdue	Measure U+E	10	♥	3	♥
ACR Overdue	Measure ACR	69	♥	25	♥
2 out of 3 elements overdue	Measure missing tests	6	♥		
3 out of 3 elements overdue	Measure missing tests	2	♥		

2. Patients with possible low medication concordance

	Consider lipid lowering concordance	4	♥
	Consider RASi concordance	3	♥
	Consider SGLT2i concordance	3	♥

Optimisation Issues (BP control, medication issues, KFRE assessment)

Engagement and Optimisation Issues (Monitoring, BP control, medication issues, KFRE assessment)

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Optimisation Issues

1. Patients with suboptimal management

		All		Inequalities	
BP Not Controlled	Consider treatment to lower BP	61	🔻	3	🔻
Consider Lipid Lowering Issues	Consider lipid lowering optimisation	89	🔻	34	🔻
	Consider starting lipid lowering	32	🔻		
	Consider lipid lowering concordance	4	🔻		
	Consider lipid lowering intensification	54	🔻		
Consider Renin-Angiotensin Blockade	Consider RAS Optimisation	30	🔻	13	🔻
	Consider starting RASi	27	🔻		
	Consider RASi concordance	3	🔻		
Consider SGLT2i	Consider SGLT2i Optimisation	94	🔻	27	🔻
	Consider starting SGLT2i	91	🔻		
	Consider SGLT2i concordance	3	🔻		
Consider Finerenone	Consider Finerenone Optimisation	3	🔻		
	Consider starting finerenone	3	🔻		
	Consider finerenone concordance	0	🔻		
Consider KFRE	Consider calculating KFRE	14	🔻		
KFRE>=5% without renal team involvement	Consider renal team referral	5	🔻		

Engagement and Optimisation Issues (Monitoring, BP control, medication issues, KFRE assessment)

1. Overall Prioritisation - Based on CKD stage, outstanding monitoring, BP control, medication interventions

		All
Highest Priority	Review patient	27
High Priority	Review patient	51
Lower Priority	Review patient	106

CKD G3aA1 - chronic kidney disease with glomerular filtration rate category G3a and albuminuria category A1

Comorbidity

BP	Non HDL-C	Hba1c	Creatinine	eGFR	ACR
135 / 74 Standard	4.3 mmol/L		138 umol/L [50 - 110]	49 mL/min/1.73m*2	0 mg/mmol [0 - 3]
08 Oct 21	08 Oct 2021			06 Dec 23	

eGFR graph: 200.0 / 42.0 mL/min/1.73m² from 21/05/18 to 11/12/23

Urine albumin:creatinine ratio
08 Oct 21
08 Oct 21

CONSIDER STARTING LIPID LOWERING | Lipid Vis | LLT Declined | LLT Not ind / Cfd | LLT ADR

AKI Risk Moderate - AKI Score 9

CKD G3aA3 - chronic kidney disease with glomerular filtration rate category G3a and albuminuria category A3

Comorbidity

Diabetes

Hypertension

BP	Non HDL-C	Hba1c	Creatinine	eGFR	ACR
140 / 70 Standard	4.1 mmol/L	51 mmol/mol	98 umol/L [50 - 110]	45 mL/min/1.73m*2	
05 Jan 24	09 Nov 2023	05 Jan 2024		04 Aug 23	34.8 mg/mmol [0 - 3]

Target | 3.9 mmol/l | Target

Urine albumin:creatinine ratio

69.0 — 26.0 24/05/10 — 07/06/23

06 Jun 23
06 Jun 23

KFRE 5y Risk | 03 Oct 23 | 1.3 % | Estimate KFRE
03 Oct 23

LIPID TARGET NOT ACHIEVED | Lipid Vis | Max tolerated LLT

CONSIDER FINERENONE

AKI Risk Very High - AKI Score 17 | 19 Nov 21 | Acute kidney injury stage 1

BP	Non-HDL Cholesterol	Hba1c	Creatinine	eGFR	ACR
140 / 70 Standard	4.1 mmol/L	51 mmol/mol	**98 umol/L [50 - 110]**	45 mL/min/1.73m*2	34.8 mg/mmol [0 - 3]
05 Jan 24	09 Nov 2023	05 Jan 2024		04 Aug 23	

Target | 3.9 mmol/l

190.0 — 62.0 24/07/02 — 11/01/24

6.5 — 3.3 23/03/05 — 15/11/23

51.0 — 20.0 01/06/11 — 10/01/24

465.0 — 0.0 14/04/03 — 07/06/23

69.0 — 26.0 24/05/10 — 07/06/23

60.1 — 0.0 17/06/13 — 12/06/23

BP			Non-HDL		Hba1c		Creatinine		eGFR		ACR	
05 Jan 24	140 / 70	Standard	09 Nov 23	4.1 mmol/L	05 Jan 24	51 mmol/mol	04 Aug 23	98 umol/L [50 - 110]	04 Aug 23	45 mL/min/1.73m*2	06 Jun 23	34.8 mg/mmol [0 - Urine albumin:creatinine ratio 3]
13 Jul 23	140 / 70	Standard	04 Aug 23	4.2 mmol/L	04 Aug 23	50 mmol/mol	13 Jul 23	113 umol/L [50 - 110]	13 Jul 23	38 mL/min/1.73m*2	06 Jun 23	Urine albumin:creatinine ratio
20 Jun 23	156 / 69	Standard	11 May 23	4 mmol/L	11 May 23	49 mmol/mol	11 May 23	98 umol/L [50 - 110]	11 May 23	45 mL/min/1.73m*2		
25 Jan 23	130 / 70	Standard	19 Jul 22	4.2 mmol/L	19 Jul 22	45 mmol/mol	13 Dec 22	98 umol/L [50 - 110]	29 Dec 22	54 mL/min/1.73m*2	25 Aug 22	60.1 mg/mmol [0 - Urine albumin:creatinine ratio 3]
29 Dec 22	112 / 80	Standard	23 Feb 21	3.6 mmol/L	10 Sep 21	46 mmol/mol	26 Oct 22	87 umol/L [50 - 110]	13 Dec 22	45 mL/min/1.73m*2		
13 Dec 22	155 / 85	Standard	05 Jun 20	3.3 mmol/L	23 Feb 21	47 mmol/mol	19 Jul 22	101 umol/L [50 - 110]	26 Oct 22	52 mL/min/1.73m*2		
30 Nov 22	160 / 90	Standard			05 Jun 20	47 mmol/mol	24 Jan 22	106 umol/L [50 - 110]	19 Jul 22	44 mL/min/1.73m*2		
19 Jul 22	130 / 82	Standard			21 Jun 19	45 mmol/mol	11 Jan 22	98 umol/L [50 - 110]	24 Jan 22	42 mL/min/1.73m*2		
16 Feb 22	174 / 88	Standard			11 Jun 18	45 mmol/mol	20 Dec 21	148 umol/L [50 - 110]	11 Jan 22	46 mL/min/1.73m*2		

Potential Missed CKD
Recommend U+E

Asthma	Diabetes	Epilepsy
Bronchiectasis	High Risk of DM	
COPD	Hypothyroidism	Dementia
Pulm Fibrosis		LD
	CKD	Mental Health
AF AF		
CHD	NAFLD	Palliative Care
Heart Failure	RA	Frailty
BP Hypertension		
PAD		Is a Carer
Stroke / TIA		

Check U+E
Check Lipids/LFTs
    if would consider statin
Check Hba1c
Check ACR

‼ CONSIDER LIPID LOWERING ‼

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Real Time Filing Alerts

Some Local Interventions

- Opt-in Resources – gradual roll-out over ~8 years
  - LTC Management System to prompt U+E/ACR checking at LTC review
  - ? Missed CKD flags
  - Systematic searches
- Derwentside only – QASI scheme - since 2017
  - Incentive to code missed CKD (eGFR)
  - Incentive to repeat U+E in those with isolated lower eGFR
  - Realtime alerts when filing U+E and ACR results (since late 2022)
  - Ensuring high risk CKD patients have KFRE recorded
- Durham Diabetes ACR project 2022 – incentivised ACR coding
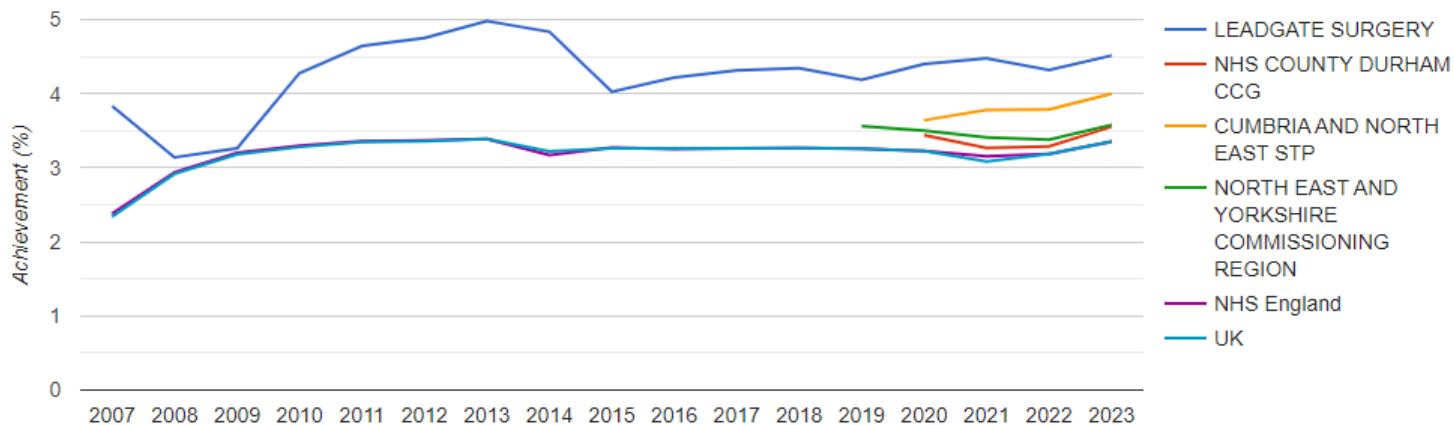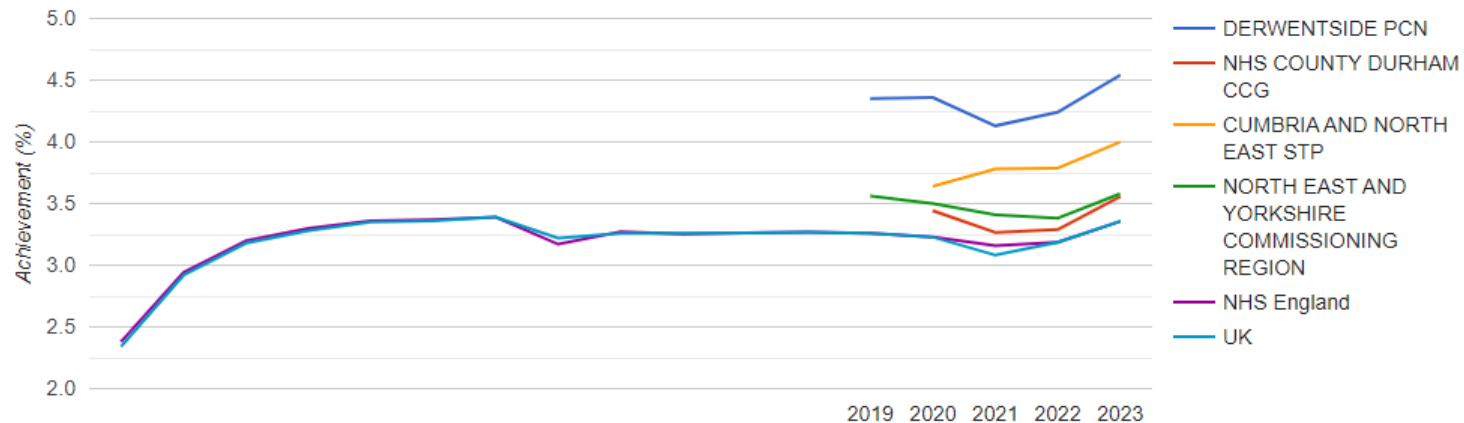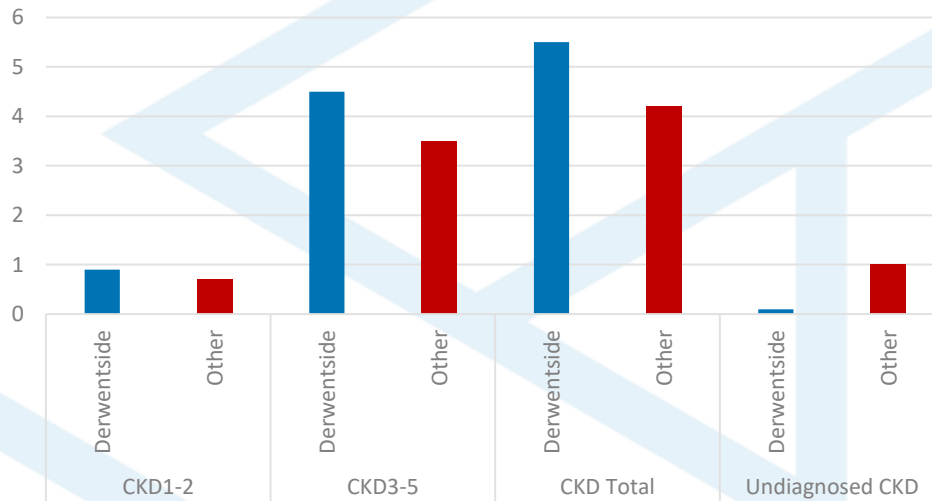
Proportion of CKD Patients With Incorrect G Code
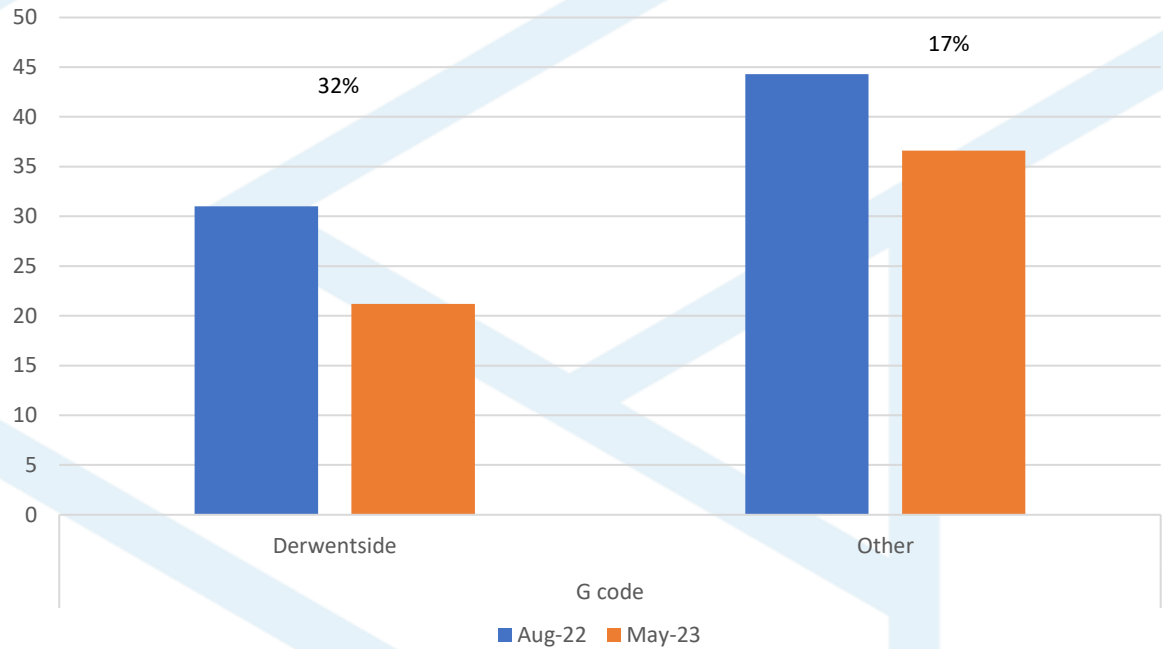
Proportion of patients with diabetes coded with microalbuminuria/albuminuria

County Durham % Microalbuminuria / Albuminuria coded Trend By Snapshot Month

Patients Eligible: 4,761 · 4,961 · 5,026 · 5,137 · 5,432 · 5,557 · 5,667 · 5,750 · 5,874 · 5,914 · 5,969 · 6,072 · 6,304 · 6,315 · 6,324 · 6,347 · 6,360 · 6,426 · 6,450 · 6,552 · 6,585 · 6,614 · 6,647 · 6,807

% Microalbuminuria / Albuminuria coded — from 12.0% to 15.9%

% Microalbuminuria / Albuminuria coded Trend By Snapshot Month And PCN (Ranked)

PCN Name	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024
Derwentside	18.8%	21.1%	21.1%	21.2%	21.2%	21.3%	21.2%	21.3%	21.3%	21.2%	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	20.9%	20.9%	20.9%	21.6%	21.6%	21.6%	21.5%	22.0%
North Easington	15.3%	15.5%	16.3%	16.3%	16.5%	17.0%	17.4%	17.6%	18.8%	19.0%	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	_(obscured)_	20.0%	20.2%	20.3%	20.1%	20.2%	20.3%	20.8%	21.1%
Teesdale	15.9%	16.0%	15.9%	16.1%	16.3%	17.1%	17.8%	18.2%	18.9%	19.5%	19.8%	20.1%	19.4%	19.5%	19.5%	19.8%	19.8%	19.8%	19.9%	19.9%	19.8%	19.6%	19.6%	19.7%
Chester le Street	10.5%	10.6%	10.9%	11.3%	13.3%	13.5%	13.5%	13.6%	13.7%	13.6%	13.5%	14.8%	15.0%	14.9%	14.9%	14.7%	14.6%	15.8%	15.7%	15.9%	15.9%	15.9%	16.0%	16.1%
Bishop Auckland	10.1%	10.2%	10.3%	10.3%	10.4%	10.9%	13.0%	14.1%	15.1%	15.3%	15.7%	15.7%	15.6%	15.8%	15.8%	15.8%	15.9%	15.7%	15.5%	15.7%	15.9%	16.0%	16.0%	16.0%
Easington District	12.1%	12.1%	12.1%	12.2%	12.6%	12.8%	12.6%	12.6%	13.1%	13.1%	13.4%	13.5%	13.5%	13.5%	13.5%	13.5%	13.7%	13.6%	13.8%	13.9%	13.8%	14.9%		
Sedgefield North	8.3%	8.4%	8.3%	8.4%	9.1%	9.3%	9.5%	9.9%	10.2%	10.4%	10.6%	10.7%	14.8%	14.7%	14.6%	14.5%	14.5%	14.5%	14.4%	14.4%	14.4%	14.3%	14.4%	14.4%
Durham East	10.0%	10.1%	10.1%	11.4%	12.2%	12.2%	12.4%	12.4%	11.3%	11.6%	11.6%	11.6%	11.6%	11.8%	11.9%	11.9%	12.0%	13.5%	13.5%	13.6%	13.8%	13.9%		
Easington Central	7.1%	7.3%	7.3%	7.6%	10.1%	11.2%	11.3%	11.4%	12.1%	12.2%	12.2%	12.4%	12.4%	12.5%	12.6%	12.7%	12.6%	12.7%	12.6%	12.7%	12.8%	13.0%	13.1%	
Wear Valley	11.5%	11.7%	11.8%	11.8%	12.3%	12.2%	12.2%	12.1%	11.8%	11.6%	11.9%	11.8%	12.4%	12.3%	12.3%	12.3%	12.4%	12.6%	12.6%	12.6%	12.6%	12.7%	12.6%	12.7%
Sedgefield 1	11.9%	11.8%	11.9%	12.0%	12.0%	12.2%	12.1%	12.0%	12.0%	11.7%	11.7%	11.6%	11.4%	11.5%	11.4%	11.6%	11.5%	11.7%	11.7%	11.8%	11.7%			
Durham West	8.5%	8.6%	8.6%	8.8%	10.3%	10.3%	10.3%	10.3%	10.3%	10.2%	10.1%	10.1%	10.3%	10.3%	10.2%	10.2%	10.1%	10.0%	10.0%	10.2%	10.1%	10.1%	10.0%	10.0%
Claypath & University	2.7%	2.7%	3.5%	7.1%	7.8%	8.7%	8.4%	8.4%	10.1%	10.0%	10.1%	10.0%	10.0%	9.9%	9.8%	9.8%	9.9%	9.8%	9.7%	9.5%	9.6%	9.4%	9.0%	9.1%
Durham Average	12.0%	12.5%	12.6%	12.9%	13.6%	13.8%	14.1%	14.2%	14.5%	14.6%	14.7%	14.8%	15.3%	15.3%	15.3%	15.2%	15.2%	15.3%	15.3%	15.6%	15.6%	15.6%	15.7%	15.9%

CVD Integrated Prevention Dashboard

Atrial Fibrillation		Blood Pressure		Cholesterol - Secondary		Cholesterol - Primary		CKD	
AF Prevalence	2.6%	HT Prevalence	23.2%	ASCVD Prevalence	6.1%	On Lipid Lowering (not ASCVD)	15.4%	CKD Prevalence	4.6%
						Eligible for primary prevention LLT	20.8%		

		Blood Pressure		Cholesterol - Secondary		Cholesterol - Primary		CKD	
		BP in Last 12 Months	95.6%	Lipids in Last 12 Months	93.5%	On LLT + Lipids in Last 12 Months	89%	U+E in Last 6/12 Months All CKD	95.1%
								ACR in Last 12 Months All CKD	77.7%

Atrial Fibrillation		Blood Pressure		Cholesterol - Secondary		Cholesterol - Primary		CKD	
High/Mod Risk - Anticoagulated	94%	BP <140/90 <80y BP >150/90 >=80y In the last 12 months	80.4%	Very High Intensity LLT	42.5%	High / Very High Intensity LLT	61.5%	On LLT	82.7%
High/Mod Risk - Anticoagulated or Reason Why Not	98%	NICE Target Achieved In The Last 12 Months	81.1%	High / Very High Intensity LLT	84.8%	On LLT	71.8%	NICE BP Target Achieved In The Last 12 Months	76.9%
				On LLT	94.3%				

		Blood Pressure				Cholesterol - Primary		CKD	
		BP >=140/90 - Not on hypertension register	3.8%			Eligible for CVD Risk Assessment	3.2%	eGFR <60 - Not on CKD register	0.4%

Diabetes		Heart Failure		Obesity		Smoking	
Diabetes Prevalence	7.7%	Heart Failure Prevalence	1.9%	Obesity Prevalence	28.4%	Smoker Prevalence	13.2%
				Overweight Prevalence	26.4%		

Integrated CVD Prevention - Optimisation and Engagement

Currently **excluding** interventions which have been excepted - use dropdown to toggle

Intervention Score	All Patients		Probable Inequalities	
>=1	2,611		558	
>=2	1,769		462	
>=3	945		323	
>=4	484		216	
>=5	284		147	
>=6	140		78	
>=7	70		48	
>=8	36		27	
>=9	24		19	
>=10	7		6	
>=11	2		2	
>=12	1		1	
>=13	0		0	
>=14	0		0	

Diabetes	Type 2 Diabetes
Hypertension	
Stroke / TIA	Non-haemorrhagic stroke

| Smoker | 14 Nov 23 | Smoker | None or very low exercise | 05 Sep 18 | Enjoys light exercise |

BP		Non HDL-C	BMI	Hba1c	eGFR	ACR
138 / 80	Standard	4.5 mmol/L	25.71 Kg/m²	83 mmol/mol	> 90 mL/min/1.73m*2	
28 Apr 23		28 Apr 2023	10 Oct 2023	28 Apr 2023	28 Apr 23	
		Target	3.1 mmol/l	Target		

CONSIDER SMOKING INTERVENTION	Smoking Mx	
CONSIDER WEIGHT INTERVENTION	Weight Mx	
SUSPECTED POOR CONCORDANCE WITH LIPID Rx		
LIPID TARGET NOT ACHIEVED	LLT Optimisation	Max tolerated LLT
ASCVD AND nonHDLC >2.5 OR LDLC >2	LLT Optimisation	Max tolerated LLT
CONSIDER LIPID Rx INTENSIFICATION	LLT Optimisation	Max tolerated LLT
Consider very high intensity Rx		
POTENTIAL CRITERIA FOR INCLISIRAN	LLT Optimisation	Inclisiran Declined	Inclisiran Not Ind / CI'd	Inclisiran ADR
SUSPECTED POOR CONCORDANCE WITH ANTIPLATELETS		
CONSIDER SETTING BP TARGET		
SUSPECTED POOR CONCORDANCE WITH ACE/A2RB		
SUSPECTED POOR CONCORDANCE WITH SGLT2I		
CONSIDER PROMPT REVIEW OF GLYCAEMIC CONTROL		

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Q&A session

- Any questions?

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Upcoming events…