Chronic kidney disease (QS update)

NICE National Institute for Health and Care Excellence

Consultation on draft quality standard – deadline for comments 5:00pm on 28 March 2017 **email:** QSconsultations@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted. 2. See below for comments on these questions Question 1. Does this draft quality standard accurately reflect the key areas for quality improvement? Question 2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Question 4 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted. Questions about the individual quality statements Question 5 For draft quality statement 1: Is the statement achievable and measurable, or would a narrower and more specific at-risk population be better

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Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):			**UK Renal Association**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.			**No links or funding**
Name of commentator person completing form:			
Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.			**Yes**
Type			[office use only]
Comment number	**Section**	**Statement number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
Example 1	Statement 1 (measure)		This statement may be hard to measure because…
1			

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QS1	Identification and monitoring	Quality Statement	The specific question is – is the standard achievable and measurable?. Yes, with the caveat that there is still work to do on identification and monitoring, with a particular focus on ACR. The CKD classification system and primary care CKD registers have contributed to improvements, but a significant proportion of people with CKD who are not having regular testing (mainly because they have not been put on the CKD register despite having tests indicating CKD) The question about 'would a narrower and more specific at-risk population be better?' is discussed below and should be considered further.
QS1	Structure	a	With reference to 'evidence of local arrangements to ensure that adults…..agree the frequency of eGFRcreatinine and ACR testing with their healthcare professional'. Making the statement in a service specification is fine, but we would suggest that there should be an audit process (this should be locally defined and implemented in the first) to test if the QS is being applied, from the way it is written the quality measure is effectively asking for a statement in the patients care records that this has been discussed and agreed with the patient.
QS1	Sructure	b	This should be stated in a service specification
QS1	Outcomes	b	Stage to include ACR testing
QS1	Source guidance	NICE CG182	The majority of patients with stage 3-5 CKD have stage 3aA1 and are older people (>65). These patients have a negligible 5-year risk of progression to end-stage renal failure. Care should be taken in the QS to emphasise the major differential risk for CKD based on eGFR and ACR. We accept that this is a challenging area and anticipate that risk assessment will be further incorporated in the next update of the guideline. The major area of opportunity for QI in CKD now is around ACR testing and stratification of risk based on ACR. We would like consideration of a 12 monthly check of ACR in individuals with G3-G5 CKD and high or very high albuminuria as change in ACR is a very good risk marker and may identify a need for enhanced assessment and management (e.g. BP/glycaemic control).
Q5	would a narrower and more specific at-risk population be better?'		The simple answer is yes – the majority of people with stage 3-5 CKD have stage 3a, and the majority of these are older people (>65) and have normal albuminuria (A1). The risk of end-stage renal failure for these individuals is negligible and can be checked in the Tangri calculator. One approach may be to state that older people with stable 3aA1 CKD and no other chronic disease comorbidities can be offered the option of no long-term monitoring, following discussion of risk. This would maintain the focus on ACR testing and may have health economic benefits.
QS2			Supported as written
QS3			Supported as written with one specific suggestion, that consideration is given to including a focused discussion of the

			numbers needed to treat in discussion about commencing atorvastatin with people with stage 3a CKD and who have no other cardiovascular risk factors.
2011	QS3 (and QS6)		We have concerns about withdrawing this QS and suggest that it remains in and is assimilated with QS6 from 2011 – as this would combine information with risk counselling……..consider 'People with CKD are provided with information consistent with their stage of CKD and the risk of progression of CKD. This should include documentation of the information provided and the monitoring and management strategy agreed'. This also relates to new QS1. This focus on staging and communication will assist in delivering care that is proportionate to the requirements of patients.
2011	QS 10		..access to psychosocial support……' Whilst this is an area where there may be a limited evidence base, there are multiple signals that identify this QS as needing to continue in the guideline' These include: the very high prevalence of psychological and social problems in patient with ERF; over-representation of these problems in lower socio-economic groups who in complex diseases get less from the healthcare system (' the inverse care law'), the identification by patients and caregivers (AJKD 2016 68 444-454) that they mainly prioritise outcomes relevant to daily-living and well-being. Maintaining this QS would reinforce this.
Q1			Yes, but with an increased overall emphasis on ACR
Q2			This will vary by CCG based on current IT and pre-existing arrangements. The views of stakeholders in primary care are crucial for this question.
Q3			It depends on what resources are currently being committed and how these are offset by the change in emphasis. To be able to answer this question would require detailed work with several CCGs.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about eg. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).

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- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons).We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received from registered stakeholders and respondents during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.