Renal Association
Clinical Affairs Board
Wednesday 1st July 2009, 12.30 pm – 4.30 pm
Euston Square Hotel, North Gower Street, London

Minutes

1. Apologies – Phil Kalra

2. Notes of last meeting 1st April 2009. Paper A

3. Matters Arising

The clinical services committee now have representatives from all regions.
Caroline Whitworth is working on a report on dealing with challenging patients

A. PD working party – KH still to update
B. HHD working party - progress remains slow. KH to write to Mark McGregor setting a deadline to receive a draft report; if this cannot be met RM to take over chairmanship of group or nominate a chair from within the group.
C. NCPOD launch - this was broadly welcomed and thought to be to be a tension for the change. For example it may be used to change curriculum, change the assessment, or as a stimulus to devising a system of alerts on those developing AKI.

4. **AKI Issues**
   A. Interim Definition for AKI - a detailed discussion took place on how to progress the AKI agenda. It was agreed that there need to be pragmatic solutions. A L was encouraged to undertake a series of local pilots with no specific action on a definition for AKI pending further studies.
   AL was asked to devise some core competencies for recognising AKI that could be included in both undergraduate and postgraduate curriculum. AL was encouraged to work with the Society for Acute Medicine in developing these competencies.
   DOD reported that a comprehensive action plan was being developed for AKI and should be ready by the autumn.
5. **UK Renal Registry:**
   A. UKRR Chair Report. Paper C was tabled for information. CT highlighted the imminent release of a centre specific performance report on a quarterly basis. Data completeness reports were now going out. CT R reported that the transition of RPV to the control of UKRR was progressing well.
   The report on HES from Aintree was complex and needed more work in order to make it useful for individuals.
   B. 5 year Strategic Plan.Paper D - tabled in error and not discussed.

6. **Clinical Guidelines Committee:**
   A. RA Clinical Practice Guidelines Minutes. Paper E was provided for information
   B. EPS guidelines. Paper F – RM indicated that these guidelines will probably be used by ISPD. Minor suggestions for improvement were made. RM to feed these back to authors.
   C. Update on final drafts of new modules –
      i. Peritoneal access. Paper G - some suggestions on this paper were made. Once a consultation is complete these will be published.
      ii. BBV. The final draft has been received. Once a consultation is complete these will be published.
   D. Hep C KDIGO guidelines in UK. Paper H - these were endorsed by CAB
   E. First draft of Planning, initiating and withdrawal of RRT module and HD update - these will include patient involvement.
   F. Feedback from NICE Evidence – NICE is aware that RA would seek endorsement for its methodology from NICE but no feedback has yet been received

G. Co-ordination with RR re implementation of guidelines and audit measures - there was discussion about the ongoing difficulty of getting guideline authors to come up with operational audit measures. It was agreed that what audit measures must be suitable for local audit, they need not all be necessarily auditable by UKRR. RM should emphasise to authors that if they are considering asking the UKRR to be involved with audit of certain measures, then they must consult with the UKRR at an early stage

H. Past, present and future links with KDIGO – RM indicated that collaboration and response from KDIGO had not been as forthcoming as might have been hoped. It was agreed that the RA should continue with its programme of guideline development working with NHS evidence and NICE. When possible any guidelines would be aligned with KDIGO.

7. **Clinical Services Committee:**

A. MRSA bacteraemias. Paper I - this was endorsed by CAB

B. Pandemic flu. Appropriate drug dosing of Osteltamivirin CKD. Paper J - this was a rapidly changing field in the light of the evolving pandemic. Relenza was going to be recommended for patients with eGFR <30. Following feedback on the RA guidelines it was noted that the prophylaxis and treatment doses for Tamiflu had been transposed for HD, PD and patients with eGFR <10. KH to correct guidelines and continue liaison with DOD to provide update to the renal community as required.

C. Bowel preparation guidelines in CKD. Paper Ki and Kii - feedback to be provided to CT

D. Nominee to work with the Therapeutic Drug Monitoring Working Party – CT to find out the required time commitment and place of the meeting.

8. **Current National Issues:**

A. NICE and QoF. It was agreed that KH should write to Gillian Leng to ask how the RA may best engage with the process particularly linking QOF with CKD guideline 73.

B. NSF update. Paper M – DOD presented a report highlighting the patient transport survey. Feedback was being sought but there had been some technical problems with the use of of iView which could not always be downloaded within Trust IT systems.

9. Any other business

10. Date and Venue for next CAB meeting - Wednesday 18th of November

The Euston Square hotel was felt to be a good venue.