Renal Association
Clinical Affairs Board

Wednesday 18 November 2009, 12.30 pm – 4.30 pm

Euston Square Hotel, North Gower Street, London

MINUTES

Present:

Kevin Harris (Chair)	Robert Mactier	Martin Raftery
Andy Lewington	Donal O'Donoghue	Charlie Tomson
Liz Lightstone		

1. Apologies – Phil Kalra
   The CAB welcomed Liz Lightstone to her first meeting

2. Notes of last meeting. Paper A
   Section 6C ii. " once consultation is complete" these will be published" was added. Otherwise the minutes were agreed at a correct record.

3. Matters Arising

   a. PD working party. Paper B.
   The CAB agreed that to document now read much better. It was felt that the spirit of the working party had been maintained, whilst incorporating feedback from renal association members. It was suggested that all members of the working party should declare any conflicts of interest. The document was approved by CAB and should be published on the RA website. **ACTION KH writes to chair of working party thanking for contribution and asking for declarations of interest.**

   DOD pointed out that a PD tender was going to be let nationally. Baxter had raised some concerns over this, but this was not thought to be a direct concern of the RA.

   b. HHD working party. Paper C.
   This paper was universally welcomed by the committee. There was further discussion about: i) variation in prevalence depending on whether training was a undertaken by that unit or elsewhere ii) differences in New Zealand prevalence not being related to differences in demographics of the population or differences in take-on rates iii) possible patient concerns over blood loss at home whilst undertaking HD unsupervised. **ACTION RM to make the necessary minor adjustments. The documents be posted on the website for the membership to comment by the end of the year. CAB would then sign off electronically.**

   Discussion took place as to whether the RA should develop guidelines for the education of pre-dialysis patients to ensure consistency across the UK. There was general support for the concept of a framework which could be adapted locally. It was felt this was something that the BRS could lead on the in conjunction with the RA. **ACTION KH to write to Jane McDonald.** Suggested names included A Mooney, Robert Elias currently an SpR at St Georges (and a philosophy graduate). DOD pointed out that NHS kidney care was doing a piece of work on the predialysis pathway, led by Colin Jones.

4. **Clinical Guidelines Committee:**

   a. Verbal update – RM
   b. Guidelines for bowel cleansing. Paper D.
   These were endorsed by the CAB. **ACTION RM will arrange for it to be posted on the RA website** (both the full paper and the one-page algorithm, the latter was felt to be particularly helpful)
   c. How do the KDIGO Clinical Practice Guidelines on CKD - MBD apply to the UK? Paper E.

RA response noted. The document generally contains few didactic recommendations. Specific points to be raised were i) bone biopsies were not usual practice in the UK ii) measures of PTH in all patients with CKD 3 was a major departure from UK practice and ran contrary to NICE recommendations. **ACTION RM to amend draft RA response and correspond with KDIGO**.

d. Newsletter of the Clinical Practice Guidelines Committee Paper F.

This was welcomed and its contents noted.

e. 5th edition of RA guidelines to be completed in 2010. Paper G.

RM updated to the group on current progress with new guidelines and the updating of existing guidelines

f. Proposal for guidelines for the prevention of contrast induced nephropathy.

This would include writers from radiology and cardiology as well as nephrology. To be completed by 2010. It was noted that KDIGO have a large section on contrast induced nephropathy in their AKI guideline. This would be available by January 2010 and the RA guidelines would take advantage of their evidence tables on the subject. **Action AL to lead this guideline aiming to produce a first draft in the first half of 2010**

g. Planning, Initiation and Withdrawal of RRT and Haemodialysis modules.

These were discussed and signed off by the CAB **Action RM edit format inconsistencies in the haemodialysis module and archive as the final versions on the website**

h. links with KDIGO AKI, GN & vasculitis and transplant guidelines.

RM informed CAB that is in future he hoped that the authors of RA guidelines would be able to comment on earlier drafts of KDIGO guidelines rather than being presented with a final draft for comment. AL would attend as an observer at the KDIGO AKI workshop and LL would attend is as an observer at the KDIGO GN workshop.

i. links with NHS Renal Library

There was discussion about potential for duplication and the desirability to make the evidence readily obtainable in a single place. **ACTION KH to invite David Goldsmith to next CAB**

j. future accreditation by NICE Evidence

The RA CAB was still waiting to hear about accreditation. It was appreciated that NICE had a long work list to work through (to date they have accredited NICE and SIGN)

5. **Clinical Services Committee:**

a. Verbal update

MR updated CAB on the swine flu work. Vaccination of real staff was now in progress across the UK.

A number of topics have been identified for the CD forum. There was discussion about a session on home therapies since this was felt to be topical. It was also suggested that CDs should be asked about outlier alerts provided by the UKRR. **ACTION MR to continue to develop the program, will ask CT to present the outlier issue and will choose speaker(s) on home therapies**

b. Specialist Diabetic Renal Service. Paper Ha&b.

There was general interest in this work but a strong feeling that there needed to be more coordination with the various initiatives in diabetes. Of note there was the NHS diabetes initiative (? supported by Diabetes UK). It was also pointed out that nephrologists generally did not see patients with CKD-3 as they could add little value. It was also pointed out that GPs had developed specialist expertise in the treatment of diabetes and CKD and this needed to be acknowledged. CT would provide further comments. **ACTION KH to respond**

c. Commissioning templates for integrated care. Paper I.

Nothing further had been heard about this initiative. **ACTION CT to write to Hugh Rayner for an update**

d. QOF Topic Suggestion Facility from NICE.

A number of topics have been suggested. It was generally agreed that a priority at this point should be to implement the existing QOF, rather than develop new indicators. KH would keep a list of potential new indicators that NICE may wish to consider in the future

e. Water purity. Paper Ja&b.

Association of Renal Technologists (ART) to take this forward via Gerard Boyle, St George's. RA will be happy to provide input as required. It was felt an economic analysis of the benefits would be important. **ACTION MR to write to ART indicating**

CAB support and a willingness to comment on an earlier draft and co-badge potentially any guidelines and recommendations.

6. **UK Renal Registry:**
   a. Verbal update – CT
      i. Report – on track
      ii. HCAI linkage – MOU signed with HPA, progress slowed by swine flu
      iii. SUS linkage – MOU signed with Research Capability Programme
      iv. Publications on inequity in access to transplant w/lists submitted/in press
         - Centre level
         - Socioeconomic deprivation

      v. SpR research
         - CKD prior to RRT and not on RRT
         - Death after failed graft
         - Non-medical factors for variation in modality choice and incidence

      vi. Outlier procedure – there was discussion about using 3 or 5y survival as better markers of performance. The alert procedure was discussed and the following agreed:
      ACTION.
         - **UKRR would write to CDs BEFORE the analyses hit the public domain.**
         - **Standard letter to include 1yr after 90 day survival adjusted for age and survival in prevalent patients**
         - **Acknowledge limitations re comorbidity**
         - **Ask for assurance that Clin Gov and Chief Exec aware**

      How alerts on other RA standards would be handled (Hb, PO4, URR, access to transplant waiting list) would be discussed at CD forum. It was felt CDs would value such alerts but that the requirement for formal discussion with CD and CE may not be required. **ACTION MR to include in CD Forum program**
      vii. New Chair and 5-y strategy
      viii. CD or paper version option in eNews
      ix. English National Renal Dataset
      x. HCC/QCQ Vascular Access audit with IC
      xi. Centre-specific reports
      xii. Rare Disease Registry
      xiii. Interactive maps

7. **Current National Issues:**
   a. Verbal update

   DOD pointed out a shortage of hepatitis B vaccine nationally and is seeking CAB support to try and resolve this. **ACTION KH to provide at letter outlining the situation and risks**
   b. Tariff
      i. Work is ongoing on dialysis reference costs and these will be road-tested shortly. An indicative tariff will be introduced in 10/11 with a mandatory tariff in 11/12. A best practice tariff was being developed for dialysis using a fistula and may be introduced in 11/12. There was an estimated gap of between £50-150 million between the reference costs and the current payment for RRT. It was recognised this currently cross-subsidises other services; this would pose a problem for renal units and trusts as PbR was introduced.
      ii. A similar exercise was being undertaken for transplantation. Consideration was being given to a best practice tariff in transplantation for i) laparoscopic donor nephrectomy ii) pre-emptive transplantation iii) short cold ischaemia times.
      iii. NHS kidney care will shortly be making awards for projects on transition of care from paediatric to adult services and end of life care.

   c. AKI.

i. DOD had written to the Academy of Royal Colleges, the Medical School Deans and the GMC about AKI and received positive responses.
ii. An e-learning module on AKI may be developed.
iii. DH was still formulating its response to NCEPOD report but this was likely to recommend a multidisciplinary approach, the development of appropriate tools and audit measures.
iv. There was consideration for AKI being an indicator of co-morbidity and this could be recognised in tariffs. This was felt to be a long-term option.

AL indicated that he had developed core competencies for AKI which could be included in the curriculum. This had been done by a multi-professional group. AL was attending both AKIN and KDIGO AKI meetings and was optimistic that there would be harmonisation of AKIN and RIFLE classifications.

8. Any other business
DOD pointed out the proposed workshop on isolation procedures in HD units on 3rd Dec. CAB felt that this had largely been covered in the RA BBV guidelines and earlier guidelines.

9. Date and Venue for next CAB meeting
Euston Square Hotel
10th February 2010
12:30-4:00