

AGENDA FOR THE ANNUAL GENERAL MEETING OF
THE RENAL ASSOCIATION

HIC, Harrogate

Thursday 4th May 2006
07:45-08:25am, Queen Suite 1

- 1 PRESENT
- 2 APOLOGIES
- 3 MINUTES 2005 [enc A]
- 4 MATTERS ARISING FROM MINUTES NOT COVERED IN THIS
AGENDA
- 5 PRESIDENTS REPORT [enc B]
- 6 CVP AND CAB REPORT [enc C]
- 6 TREASURER'S REPORT [enc D]
- 7 SECRETARY'S REPORT [enc E]
- 8 CHAIRMAN OF THE REGISTRY'S REPORT
- 9 EDUCATION, MANPOWER AND TRAINING INITIATIVES
- 10 NSF UPDATE [enc F]
- 11 ELECTIONS TO EXECUTIVE COMMITTEE
- 12 RESULTS OF ELECTIONS, AND NEW APPOINTMENTS
- 13 AOB
- 14 DATE / TIME FOR NEXT MEETING

Papers for this meeting will be posted on the RA website www.renal.org

Prepared by David Goldsmith, Hon Secretary, 14th March 2006

MINUTES FROM THE ANNUAL GENERAL MEETING OF
THE RENAL ASSOCIATION

HIC, Harrogate

Thursday 4th May 2006
07:45-08:25am, Queen Suite 1

1 PRESENT

John Feehally (President) ; Chris Winearls (Clinical VP) ; David Goldsmith (Hon Sec) and Donal O'Donoghue (Hon Treasurer)

34 other full (voting) members of the RA. The meeting was declared quorate.

2 APOLOGIES

None received.

3 MINUTES 2005 [enc A]

Accepted as an accurate record

4 MATTERS ARISING FROM MINUTES NOT COVERED IN THIS
AGENDA

None raised

5 PRESIDENTS REPORT [enc B]

Received

6 CVP AND CAB REPORT [enc C]

Received

7 HON TREASURER'S REPORT [enc D]

Received. 2005 Accounts, and financial plans, approved.

8 HON SECRETARY'S REPORT [enc E]

Received. New members approved.

9 CHAIRMAN OF THE REGISTRY'S REPORT

Received. Comments from the floor about future funding strategies for the Registry.

10 EDUCATION, MANPOWER AND TRAINING INITIATIVES

Explained (as per RA Executive 177). Approved.

11 NSF UPDATE [enc F]

Received.

12 ELECTIONS TO EXECUTIVE COMMITTEE

Donal O'Donoghue assumes the position of President-Elect
Phil Kalra, Gordon Bell and Tim Johnson join the Executive

13 RESULTS OF ELECTIONS, AND NEW APPOINTMENTS

Charlie Tomson becomes a Trustee on taking over from Terry Feest as Chair
of the Registry

14 AOB

None raised

15 DATE / TIME FOR NEXT MEETING

2nd May 2007, Brighton Conference Centre.

Prepared by David Goldsmith, Hon Secretary, 24th May 2006

ENCLOSURES:

Enclosure A: Minutes 2005

MINUTES OF THE ANNUAL GENERAL MEETING OF THE UK RENAL ASSOCIATION

Held at 9am on April 6th 2005

The Waterfront Hall, Belfast

In attendance John Feehally (JF), President
 Chris Winearls CW, Clinical Vice-President
 David Goldsmith, Honorary Secretary
 Donal O'Donoghue, Honorary Treasurer

32 members of the RA

1. Minutes of the last meeting

Accepted as an accurate record of the meeting held on 1st April 2004 in Aberdeen

2. Matters arising from the minutes not covered in the current agenda

None

3. President's Report

John Feehally explained that he had five main priorities during his tenure as President. These comprised three internal goals – committee and board restructuring, visiting every renal unit in the UK, and plans for future meetings; and two external goals – external relationships with other partners and stakeholders in the renal community, and National Service Framework initiatives.

JF explained how the Clinical Affairs Board and Education and Research Board would operate to achieve many of the above aims. In particular the new committee structures were put in place to co-ordinate clinical and research/education activities and to ensure that no areas were left uncovered.

JF hoped that by the time of the next AGM (see below) he would have completed his visits to all of the 71 UK renal units (he had made 34 visits to date).

There were no questions

4. Treasurer's Report

D O'D took the meeting through a financial spreadsheet (see summary sheets at the start of the 2004 Trustees' Report and website) which outlined the financial position of both the RA and the UK RR.

D O'D pointed out sums of money involved with Renal Patient View. RA Income was mainly through membership fees, industrial sponsors and from the scientific / clinical meetings. Income was £331,390 in 2004. RR Income in the main comes from capitation fees levied on dialysis patients. Income was £537,300 in 2004.

In 2004 after expenditure, the RA carried over to 2005 more than £85,000 (but some of this was Patient View money not yet spent), while the UK RR carried over to 2005 more than £32,000. In general the UK RR aims to keep a higher proportion of funds as accessible reserves as it has salary obligations.

There was a question from the floor about how reserve funds were kept. The answer was a judicious mix of 6 and 12 month high-interest accounts as recommended by the financial advisers to the RA

Another question posed was what was the cost of the new committee structures. The precise cost was not (yet) known, as the committee structure was nascent, but every effort was being made to minimise costs, through use of telephone conferencing and emailing.

In general the Treasurer's view was the finances were in a satisfactory state to permit present levels of activity and spending. Major new / expensive projects would not be possible without new funding streams.

The financial statement and strategy were endorsed by the membership.

5. Membership matters

DG reported that there were 842 members of the UK RA now. Over 100 more members had applied (and been accepted) to join the UK RA in the last 12 months

The recent election to the executive committee was won by Jonathan Kwan. The voting results were shown to the meeting.

DG also showed the names of the 2004 Lockwood Award and Raine Award winners, the Cilag OrthoBiotech bursary recipients, and the RA student elective bursary recipients.

The 2005 and 2006 Raine award winners would be announced at the meeting in May 2006.

There were no questions

6. ISN Collective Membership

Despite several vigorous previous attempts to engender enthusiasm in this laudable aim, the necessary majority of eligible members (75%) did not indicate their willingness to participate. Despite these setbacks, the President was asked to try once **(and once only)** more.

7. Report of CAB

CW reported that the CAB had meet three times in 9 months, the latter two times under his chairmanship. The main purpose of the CAB was to co-ordinate activities of the three committees, to support and advice the RA Executive, and the Registry. Important activities had included the CD Forum at Guy's Hospital in January 2005, the vascular access survey (just sent to all UK renal units), and guidance to the Clinical Standards committee, as they are about to start revising and re-writing, in modules, previous clinical standards as Guidelines for Good Practice.

8. Report of ERB

This had just recently met (14th March 2005) for the first time under the chairmanship of the President. There were now 4 not 5 committees – the main change from previous plans being a new committee – Education and Training – covering all aspects of nephrology training and education (chaired by Edwina Brown). It was expected that the ERB would meet every 6 months.

9. Future Meetings.

Date	Sponsor	Location	Theme
14/6/2005	RCP	RCP (London)	Facing the Epidemic of CKD
21/9/2005	RA	RCP (London)	Ethical Issues in RRT
30/11/2005	RSM	RSM	Proteinuria
3-5/5/2006	RA-BRS	Harrogate	Annual Congress
Autumn 2006	BHS	RCP (London)	Hypertension (clinical)

Full details can be found on the RA website

The RA-BRS meeting in Harrogate in May 2006 would be a three-days events, fully integrated. Programme committee was David Goldsmith, Caroline Savage from the RA and Colin Jones and Natasha McIntyre for BRS.

10. NSF related matters

D O'D gave a detailed report of the many UK-wide initiatives and projects that relate directly to the NSF Parts 1 and 2, under the umbrella title Modernisation Initiatives.

One area which needed consistency and clarity was the adoption of a single formula for the classification of CKD. The RCGP and RCP joint document was recommending the four-variable MDRD formula, and D O'D asked for opinion as to whether this would receive support from the membership of the RA. While recognising the deficiencies of ALL formulae, the preferred use of this formula was endorsed by a very clear majority of those present at the meeting. D O'D reported that it was very unlikely that there would be national harmonisation about the way in which creatinine was assayed (at least until mass spectroscopy was uniformly in use).

11. Workforce Information

JF talked about the RCP UK consultant census, which showed that the rate of expansion of UK consultant nephrology numbers was just above the average for UK consultant physicians of all specialties, and below what would be required to fill all the present and projected workforce requirements.

David Carmichael (Chair of SAC Nephrology) explained next that in 2003/4 40 new nephrology NTNs were created. There was difficulty using these numbers in the ways the Deaneries had allocated them. In 2004/5 there were 20 more NTNs, but badged exclusively as EWTD related. Only 13 had been used. In 2005/6 20 more numbers, this time without utilisation restrictions, were available, and the remaining 7 from 2004/5 would be available too. Educational approval from the SAC, and robust funding, were essential pre-requisites of a successful application for an NTN. It would now also be possible to use NTNs instead of LATs or LASs to cover OOPE (eg research), but clearly, an NTN space had to be available within a deanery for anyone returning from OOPE .

12. AOB

None

13. Date of next meeting

4th May 2006, Harrogate

Prepared by David Goldsmith, Honorary Secretary, 9th April 2005

Renal Association

President's Report

Annual General Meeting

4th May 2006

I am now completing the second of my three years as President of the Renal Association and it has been just as enjoyable as my first.

A main reason for that enjoyment is the commitment and support I receive from the many of you involved in various aspects of the Renal Association's work. Of course elected members of the Executive Committee, and the chairs and members of our Committees and Boards make particularly key contributions, but many of you in no such formal position have also given us much time and enthusiasm, and I appreciate that very much.

I want to thank the Clinical Vice President, Secretary, and Treasurer who have each taken on very substantial areas of work with great energy and efficiency, and have provided me with much support and wise advice.

And especially I want to thank Andy Rees, who now stands down after his two years as Past President. Most of the changes you see in the style, organisation and strategy of the Renal Association were put in place by Andy during his Presidency making it all the easier for his successor to keep things moving. Andy has also taken on the important new role of Chairman of the Registry Management Board helping to see it through a period of great expansion and change. I am personally very thankful to Andy for all his wise counsel. And now we have a new President-Elect who I can assure you from today is getting to work!

I set myself three specific goals a year ago and I need to report to you on progress.

1. Renal Unit Visits

I am pleased to say there are now only four adult renal units which I have not yet visited, and dates are in the diary for each of those. I have also now visited half the paediatric units and likewise there are plans for the remainder. It is difficult to measure directly the value of the visits, but you do all seem to have appreciated that I have come, and from my point of view it has been incredibly informative. I feel I understand UK nephrology in a way I never did before, and I hope that in one or two places I have been able to provide a nudge as an outsider to help move on service developments which were not progressing. I am preparing a report about these visits; although it is not easy to make this useful while maintaining confidences and avoiding unhelpful comparisons. You will receive the report later this year.

2. Renal Association Meetings

I have made it a priority to try and improve still further the quality of our meetings. I hope you agree that the move to a three-day meeting is proving a success and that our meetings in Belfast and now in Harrogate are beginning to provide the range and quality which you expect. It is important the Renal Association meetings increasingly become “something not to be missed” and only the quality of the meeting content will ensure that.

I know that a number of you have also appreciated the series of one-day meetings we are putting on, and I expect that these will continue at the rate of two or three a year, some with a more clinical and some a more experimental focus. I have personally been slightly disappointed by attendance at some of these meetings given the excellence of the programmes, but I think it is too early to see whether this reflects “meeting overload” or whether as the word gets round you will increasingly be able to make these meetings a priority.

3. Working collaboratively to improve renal services

It remains my view that these few years following publication of the NSF in England provide us with a unique opportunity to develop our renal services towards the excellence to which we aspire, and which our patients deserve. I have seen real progress since the publication of the NSF, and there is no doubt that all of you are grasping the opportunity it gives. However there is still remarkable variation in existing resources, and pace of change, in different parts of the country, which for some of you is a very considerable source of frustration.

Our strategy continues to be to build effective coalitions with other organisations within the renal community so that we can press our case together to the Department of Health and other parts of government. I am also a member of the Department of Health Renal Advisory Group, which as the name implies advises the Department of Health on implementation of the NSF in England. I am a member of that group by personal invitation not directly representing the Renal Association, but it gives me an opportunity to ensure the concerns of the Renal Association membership and renal community are heard, and the information and background knowledge I have gained from my unit visits have been proving very valuable.

The Clinical Affairs Board has been very active in many areas, most prominently in the Vascular access survey, and now increasingly in the vexed issue of Payment by Results and you can read their report on these and other issues elsewhere. I have continued to chair the Renal Information Exchange Group which has representation right across the renal community and we have seen progress in a number of areas, including the implementation of RenalPatientView, involvement in improving the protocols and algorithms of NHS Direct, and the much delayed Renal Specialist Library of the National Electronic Library for Health, originally given to the Renal Association to lead three years ago but now at last getting under way. There remain many serious risks in IT as Connecting for Health rumbles on, the position of the Registry in particular needs to be cemented. Many of you are actively involved in the IT work and I think we are doing the best we can at present to influence the national agenda effectively.

The energy which we are putting into clinical affairs must in no way detract from our commitment to education, training and research. We continue to work to ensure the Renal Association is meeting the varying needs of our increasingly broad

membership. You can read more about progress in the report of the Education & Research Board.

Membership

I particularly want to emphasise that the Renal Association values all its membership. Virtually all consultant nephrologists in the UK are members of the Renal Association. However it is a concern to me that only about a third of Specialist Registrars are members, and we are actively working to increase this proportion; it is crucial that the future of the specialty is properly represented in our Association. We are also seeing an increasing number of renal scientists joining the Association which I warmly welcome. Alice Smith, during her time as representative of this constituency on the Executive Committee, has been very energetic in identifying renal scientists around the UK and helping them to feel more involved in the affairs of the Association. Our scientists are significantly disadvantaged by the poor career structure in which they work, and it is very important that the Association does all it can to encourage them to remain in renal science and contribute to our progress. We also continue to emphasise the enormous breadth of renal scientific research in this country all of which we welcome at our meetings – this includes the whole range of laboratory research, clinical research, epidemiology and health services research.

Finally let me assure you that I will give the third year of my Presidency the same energy and commitment I have managed thus far. Please never hesitate to contact me personally over any matter relevant to the Renal Association - jf27@le.ac.uk.

John Feehally

May 2006.

REPORT OF THE CLINICAL AFFAIRS BOARD

The Board has met three times since the last AGM as a forum for co-ordinating the work of the Registry, Clinical Services and the Guidelines Committees. Professor Feest and Dr Rodger have retired as chairs of the Registry and Clinical Services committees respectively and been replaced by Dr C Tomson and Dr K Harris. Professor Feest and Dr Rodger were thanked for their constructive contributions to CAB and the RA.

1. It was agreed that the management of the **Registry** is independent of CAB but the Registry will be advised on scope and content of the report. A review of the 2004 report by Dr Kwan stressed the need for access audit which will appear in the 2005 report.
2. **The Clinical Services** Committee has been involved in successful meetings on eGFR, The Epidemic of CKD and organised a lively CD forum on 3rd March 2006. Dr R Fluck who led the project presented the National Access survey.
3. **The Guidelines** Committee has commissioned 5 modules:
 - i) CKD
 - ii) Complications
 - iii) Dialysis
 - iv) Transplantation
 - v) Acute Renal Failure

The haemodialysis module is complete and out for consultation.

4. **The Clinical Vice President**, advised by CAB has been represented the RA in the following areas:
 - i) NICE: commissioning and reviewing responses to: Cinacalcet; Anaemia management; Hypertension treatment assessments.
 - ii) PBR: correspondence with DoH and Dr Kwan attended a meeting at the RCP.
 - iii) Transplantation Unit Peer Review – CAB has provided advice to the President who will respond to this initiative of the BTS.
 - iv) He is chairing the Access Working Party with the Vascular Society of Great Britain and Ireland and the Society of Interventional Radiologists.
 - v) He attended a meeting of KDIGO on harmonisation of Clinical Practice Guidelines internationally.
 - vii) “National Horizon Scanning” – giving notice to NHS if developments in clinical practice.
 - vii) The Clinical Vice President has represented the President at meetings of the Kidney Alliance.
 - viii) Meeting at the DoH with Mr Gerry Lynch to be briefed on the work of RAG on PBR, ISTCs, Specialist Commissioning and the Acute Renal Failure Summit.

Enclosure D: Treasurer's Report

Renal Association Treasurers Report for 2006 AGM

Prepared on 31 March 2006

1. Financial Statements

1.1 The draft financial statements for the year ending 31 December 2005 were received on 21 March 2006 and have been reviewed by the trustees. They are available as an annex to this report.

1.2 Summary of Renal Association (RA + RR) draft accounts:

	Renal Association (RA + RR)	
	2005	2004
Brought Forward	£367,764	£249,142
Income	£884,224	£868,690
Expenditure	£786,610	£750,068
Net Incoming / Outgoing	£97,614	£118,622
Carried Forward	£465,378	£367,764
Percentage of Expenditure	59%	49%

1.3 Summary of Association draft accounts:

	Association	
	2005	2004
Brought Forward	£179,794	£93,971
Income	£304,282	£331,390
Expenditure	£290,859	£245,567
Net Incoming / Outgoing	£13,423	£85,823
Carried Forward	£193,217	£179,794
Percentage of Expenditure	66%	73%

1.4 Summary of Registry draft accounts:

	Registry	
	2005	2004
Brought Forward	£187,970	£155,171
Income	£579,942	£537,300
Expenditure	£495,751	£504,501
Net Incoming / Outgoing	£84,191	£32,799
Carried Forward	£272,161	£187,970
Percentage of Expenditure	55%	37%

1.5 The above funds include restricted funds for patient view (approximately £36K in 2005 at £50K in 2004) and the Registry contingency fund.

- 1.6 In our report of March 2005 (concerning the 2004 accounts) the trustees commented that the reserves at that time are approximately six months of expenditure. To align with good practice for a charitable company the trustees declared an intention to increase reserves to at least 12 months of expenditure to ensure a secure financial footing. By the end of 2005 the reserves have increased from 49 to 59% of annual expenditure.

2. Meetings 2005

- 2.1 Final income and expenditure accounts for the 2005 annual general meeting with the British Transplant Society were:

Total income	£209,665.55
Total expenditure	£213,989.36
Deficit	£4,323.81

The deficit for the Renal Association was £2,551.90. This included Renal Association specific advertising via email (£1,000) and a publication of the abstracts online on the Renal Association website (£1,000).

- 2.2 The joint RA RCP meeting 'Facing an Epidemic of Chronic Kidney Disease' in June 2005 was an RCP conference and therefore the College organised and took the financial risk.

- 2.3 Final income and expenditure accounts for Ethical Dilemmas in RRT Conference at the RCP were:

Total Income	£13,557.66
Total Expenditure	£7,932.18
Surplus	£5,625.48

- 2.4 The joint meeting with the RSM section of Nephrology on the 30 November 2005 was a joint meeting with shared financial risk. The RSM provided the logistic support. Overall the meeting was in surplus of £12,662.42 and 50% of that i.e. £6,332.21 has been credited to the Renal Association accounts.

Enclosure E: Secretary's Report

REPORT FROM HONORARY SECRETARY

Dear RA Members

Membership numbers are growing steadily - we have (as of 1/4/2006) 952 members of the UK RA. Of these, 575 are consultants, 165 are trainees, and 86 are renal scientists / academics. 51 are retired and 18 are honorary. Since the last meeting in Belfast we have had abc applications for membership which we shall consider in Harrogate (see attached list for names).

We have tried to encourage junior members to join - junior clinicians and junior renal scientists. We have offered (and will only offer for a limited time) a free registration to a meeting in one of the first two years after joining the RA. We are also increasing the educational and CPD content of our meetings, and starting out on an ambitious project with Doctor.Net - all of which will we hope prove of interest and use to junior nephrologists.

Last June we had a very successful shared R College of Physicians London meeting (organised by Stuart Rodger) on CKD. In the Autumn again at the RCP, London, we had a well-attended and very stimulating meeting on end-of-life issues and palliative care in renal failure (organised by Aine Burns and Rob Higgins). In November we had a joint meeting with the RSM on proteinuria (organised by Nigel Brunskill). This main meeting in Harrogate with the BRS resulted in 391 submitted abstracts and 357 presentations and has been attended by > 1000 people. We have an excellent programme too on 28.11.06 with the British Hypertension Society at the RCP London.

Neil Turner's efforts with the website continue to be much appreciated - it is a well-visited site and set to get even more popular as the "Standards" modules start to get posted.

Advance warning of the 2007 Raine Award - applications for this, and the Lockwood and Walls bursaries, and the Cilag-Orthobiotech AAN bursary scheme, will all be "live" from the end of this conference - May 5th 2007.

We are continuing with eNEWS on a monthly basis, which I hope you do not find too irritating clogging up your inbox.

Please do let me have suggestions for things we can do better

Best wishes

David Goldsmith

David.Goldsmith@gstt.nhs.uk

Enclosure F: NSF Update

NSF Implementation Update - Estimating GFR and the QOF

The Department of Health is recommending implementation of routine eGFR reporting by all NHS Clinical Biochemistry laboratories by the 1 April 2006 to fit in with the Quality Outcome Framework (QOF) coming into effect on the same date.

The CKD Domain of QOF

	Points	Payment Stages
CKD 1 A register of patients aged 18 years and over with CKD (Stage 3 -5 CKD)	6	
CKD 2 Percentage of patients with a record of blood pressure in the previous 15 months	6	40-90%
CKD 3 Percentage of patients with a BP of 140/85 or less	11	40-70%
CKD 4: Percentage of patients who are treated with an ACEi or ARB (Unless a contraindication)	4	40-80%

To support the introduction of eGFR standard reporting we have:

- Put together an information package consisting of fact sheets for laboratories and GPs, explaining how to calculate and interpret eGFR, together with a note on frequently asked questions.
- Commissioned the UK National External Quality Assessment Scheme (NEQAS) to set up a scheme to facilitate eGFR reporting.

My colleagues in the Renal and Pathology policy units at the Department have written to their counterparts in the devolved administrations in Wales, Northern Ireland and Scotland for information and to facilitate consistency.

David Colin-Thome National Clinical Director for Primary Care, Ian Barnes Pathology National Clinical Lead and myself have written to every general practitioner and all clinical chemistry laboratories in England explaining the K/DOQI classification, its adoption by the NSF and the NSF recommendation that a formula based estimation of GFR should be calculated and reported automatically by all clinical biochemistry laboratories. Information packs will also be sent to all Renal Units Directors and the information will be available on the DH and Renal Association websites.

We have emphasised that one of the difficulties in introducing eGFR is the lack of standardisation of serum creatinine methods and the concern that any bias in reporting eGFR could lead to over or under referral of patients.

The expert working party chaired by Ian Barnes and working under the auspices of the Modernising Pathology Team have produced clear guidance and have recommended the use of the isotope dilution mass spectrometry (ID-MS) traceable version of the Modification of Diet in Renal Disease (MDRD) equation:

$$\text{GFR (mL/min/1.73 m}^2\text{)} = 175 \times [\text{serum creatinine (umol/L)} \times 0.011312]^{-1.154} \times [\text{age}]^{-0.203} \times [1.212 \text{ if black}] \times [0.742 \text{ if female}]$$

The astute amongst you will note that the constant factor of 175 in this equation differs from that of 186 which has been in widespread use over the last few years. Further information on the derivation of this equation can be found on the NKDEP website at http://www.nkdep.nih.gov/resources/laboratory_reporting.htm.

The Group were particularly concerned with the significant effect of inter-laboratory variation in bias of creatinine estimation on eGFR. The UK NEQAS has established a pilot external quality assessment scheme to monitor relative performance of eGFR and facilitate improved inter-laboratory comparisons. A programme of work aimed at improving inter-laboratory agreement in eGFR by overcoming variation in laboratory methods for creatinine has been undertaken and in the near future recommended correction factors for the MDRD equation will be available through the scheme to adjust the method related differences compared to the ID-MS reference method.

This will mean that a ‘home’ calculated eGFR done in the clinic or in the GP surgery based on the reported serum creatinine will differ slightly from the eGFR reported by the laboratory that will be indirectly standardised to the global ID-MS standard.

Using the eGFR reported by the laboratory will avoid errors and reduce the risk of confusion in what is actually quite a complex area. eGFR should be multiplied by 1.212 for African/Caribbean patients, unless ethnic origin was available to the laboratory and this correction has been already applied.

In keeping with the UK guidelines for identification, management and referral of chronic kidney disease in adults it has been recommended that when the eGFR exceeds 89 mL/min/1.73 m² it should be reported as greater than 90 mL/min/1.73 m² rather than an exact number. We have also emphasised the GFR estimates between 60 and 89 mL/min/1.73 m² do not indicate CKD unless there is other existing laboratories / clinical evidence of disease.

The frequently asked questions include:

- What is eGFR?
- Why should eGFR be measured in clinical practice?
- How should I calculate the eGFR?
- Can I use other formulae?
- Can I use the published tables to determine the eGFR?

- Can I apply the formulae to retrospective creatinine data?
- What is the significance of eGFR measurements?
- Are there any situations in which the MDRD eGFR could be misleading?
- Where can I obtain more information about eGFR and CKD?

The guidance makes clear that there is a decline in eGFR as people age, that this is predominantly related to disease and recommends the monitoring frequency advised by the UK CKD guidelines. The information for general practitioners informs them that chronic kidney disease is common affecting about 10% of the population and that it is important as it represents risk factor for coronary heart disease. It emphasises that the majority of patients with stable CKD should continue to be managed by primary care.

The guidance also makes clear that the equation is only an estimate and is not validated for use in:

- Children
- Acute renal failure
- Pregnancy
- Oedematous states
- Muscle wasting diseases
- Amputees
- Malnourished patients

I am of course aware that many renal teams have already introduced eGFR reporting. The straw poll conducted by Hugh Gallagher and Jonathan Kwan at the Clinical Director's Forum showed that of 32 units responding 31 were liaising with their biochemical leads with regard to eGFR implementation at the base hospital and 23 (72%) were in liaison at peripheral hospitals. 75% had a launch date for eGFR or were already using it in the base hospital, 44% had a launch date at peripheral hospitals. 20 units had established an education programme and I would recommend looking at the posters and presentations from the CD forum that are available at the Renal Association website on the Clinical Services page.

These demonstrate evidence of excellent work across the whole UK. It was reassuring to find out that the local renal systems hadn't been overwhelmed. The keys to success seem to be establishing good working relationships with general practitioners and PCTs, instituting educational programmes responsive to the needs of primary care and testing referrals to our renal clinics using the added value question i.e. does this patient need to come to see a specialist renal service and what added value am I bringing to their care plan? It was interesting to see that units that were applying this added value question to their long standing clinic attenders found that they were able to discharge many patients back to primary care colleagues with clear recommendations based on the UK guidelines.

If you have any questions or queries regarding the above or indeed any aspects of the Renal NSF process and objectives please do contact me. I would also like to hear from individuals and groups who would like to contribute to the NSF implementation. I am available on 0161 206 3489 or email: Donal.o'Donoghue@srht.nhs.uk