

**The Renal Association
Executive Meeting
Meeting minutes**

Location: Roben's suite, Guy's Hospital, London
Date 15th January 2009

Agenda

No. Item

1. Present - Lorraine Harper (Honorary secretary), Charlie Tomson (chair of renal registry committee), John Feehally (past-president), Caroline Savage (academic vice president), Stuart Rodger (treasurer), Peter Mathieson (president and chair), Kevin Harris (clinical vice-president), Billy Nelson (representing Northern Ireland), Mark Taylor (representing BAPN), Andy Lewington, Martin Rafferty (chair CD committee), Phil Kalra, Steve Powis (chair SAC), , Martin Rafferty, Shabbir Mochala (representing SpR club), Rob Lewis, Rob MacTier (guidelines committee), Neil Turner (chair RPV), Sue Carr (chair education and training committee) Tim Johnson (representing laboratory renal scientists), Rob MACTier (chair clinical guidelines committee) Laurie Salmon, Kevin Hirst, Suzanna Petty and Jenna Horner were in attendance from MCI
2. Apologies Jo Adu, Magdi Yaqoub, Paul Rylance
3. Point of Information –
 - 3.1. Mike Cassidy Consultant Nephrologist Nottingham, died on Sunday 11th January after a long illness. A minute silence was held as a mark of respect. An announcement will be made in eNews.
 - 3.2. Julia Philips has left MCI. Formal thanks were given by PM. Suzanna Petty has taken over the role as RA Programme Manager
4. Minutes of the previous meeting were accepted as an accurate representation of the meeting. Exceptions were the committees of the RA are not sub-committees and the sub should be removed from point 11. Point 13.3 there will be no separate day for the RA 60th birthday celebrations at the 2010 joint meeting with the BRS. The celebrations will form part of the meeting. The minutes need to be amended to reflect this.
5. President's report (see papers attached) – there were no major comments and the president's report was accepted. Progress was made with the NCSE (new name for the KBA) Concessions were conceded by the RCP when signing the MOU; the risk of the NSCE will be spread over 3 years with a maximum of £42K risk to the RA. The MOU will be reviewed at 3 years. SR stated the first payment has been made of £8K. The figures of £42K had been calculated on STR numbers based in UK but it is unknown how many overseas people will sit the exam. There was however no reduction in cost and trainees will have to pay £800. Nephrology as a specialty is much further advanced in the arrangements for the NSCE than other specialties due to the hardwork of Jonathan Fox and all others involved. The first diet of the exam is 18/3/09. Trainees need to be encouraged to sit the exam as it is in the financial interests of the RA. Feedback from the SpRs is that they are unprepared for the date in March and the cost is high; it is unclear how many will sit in March. It is a one off fee so even if fail will not have additional costs. There are links from the RA website and in eNews to practice questions for the exam. PM noted that 50 nephrologists have been involved in the development of the exam, the Association has been very proactive and the renal medicine is ahead of most other specialties. SP noted that PMETB is applying pressure on specialties not providing a NSCE – nephrology should escape this pressure. CT wondered if existent SpRs would take up the exam as an advantage for future consultant interviews. SM thought it was too early to know but the cost was prohibitive. Discussion noted that it would be unlikely that having this exam would influence consultant appointments. Its an assessment and not meant to be discriminatory. PM noted that a positive outcome of negotiations around the NSCE has been an alliance of medical specialty societies within which the RA has played an active part. The alliance is about to draw up a constitution and needs a name. PM noted that the Association should be proud of its ability to exert influence.

6. Treasurer's report – The RA finances are healthy – partly due to profits from Glasgow. No final account from Glasgow has been raised as yet £40K has been received but it is expected an additional £20K is due. The executive recognise that the profit from Glasgow needs to be justified to the members. The meeting was more successful than expected due to the number of delegates. It is expected there will be a loss on the Liverpool meeting as the registration fees are being kept artificially low subsidised by profit from the Glasgow meeting. There remain identifiable risks to the RA finances which include the NSCE, RPV and the Liverpool annual conference. In the current economic climate corporate sponsorship may also be a risk. SM noted that the SpR club has recently lost one of their sponsors. SR suggested that if there was a crisis with the SpR club the RA would help in the short-term. It is likely the Manchester meeting will be more expensive than the Liverpool meeting due to the 60th anniversary celebrations and need to cover BRS costs. PS noted that the Glasgow meeting despite higher registration fees joint meetings was very successful. PM agreed that the model for Glasgow meeting worked well and would be replicated for the Manchester joint RA/BRS meeting. RM asked if registration could be reduced for trainees. PM replied that there would be clarification of costs with fees discriminated on seniority and position with prices adjusted accordingly. SR was keen for trainees to join the RA and commented that there were considerable cost savings for the meeting with membership of the RA which outweighed the joining fee. SM will promote benefits of joining RA at SpR club as will CS when she presents at next meeting.

7. Clinical matters
 - 7.1. RM reported that the 5th edition of guidelines is due to go on the website. There has been a change in the way guidelines are reported. A grading system to describe the quality of evidence has been introduced which will fit with other international guidelines. BMJ and NICE will use a similar grading system. The advantages of the new grades are it combines strength of recommendation with a statement about the quality of the evidence. The first guideline to use the grade will be Blood borne viruses. There was general agreement that this was a good move and was supported by the RA. The guidelines page on the website will change as there are now a large number of guidelines both past, present and from associated societies: Page 1 current guidelines, page 2 past guidelines, page 3 associated guidelines. PS noted that development of these guidelines was a significant amount of work and could money come from the RA to support grading evidence. RM responded that often the work of grading had been done, for example KDQI published their list of references and grades. It was also realised that national societies performed less in-depth reviews than organisations such as KDQI. RM commented that the guideline page has the second biggest hit on the RA website. The website is searchable and appears on a Google search.
 - 7.2. MR reported that due to the concerted action of members of the RA, renal replacement therapy (RRT) will stay on the specialised services list following the specialised services consultation. The DH had suggested in the consultation that RRT should come off the list but following a deluge from renal consultants they have reversed that decision support was also provided by the Kidney Alliance. The next Clinical Director's forum has been organised for the 6th February.
 - 7.3. CT reported on the Renal Registry. The next annual report is due in February developments for this year's report will include a chapter on paediatric nephrology and hospital associated infection. Research activities are good. The registry has been asked to help support a rare disease registry in association with the BAPN who have been awarded a grant from the MRC. There are opportunities for research in primary care. NHS Choices is up and running which the registry is supporting with uncontentious data. FL noted that there is a place on NHS Choices that can assess your risk of kidney disease.
 - 7.4. AL reported on acute kidney injury (AKI). The British consensus guidelines on AKI are now on the website and will be reviewed in 3 years time. The European Society of Nutrition has decided to adopt the guidelines and the BMJ will have an editorial highlighting them. The NCEPOD study – a draft report has been issued for comment and a full report is due June 2009. The renal Tsar, Donal O'Donoghue is keen to raise the profile of AKI. A RCP meeting, chaired by Paul Stevens, with representations from many societies with an interest in AKI has been convened. Hopefully this will develop pathways of care for AKI. CT identified a potential funding stream offered by the Health Foundation for closing the gap between guidelines and implementation. Deadline March for registration of interest. JF and AL have collaborated with the Scottish Surgical Mortality Group who have produced a report on AKI.

Guidelines have been developed on infusion practice; these differ substantially from current practice. They have been presented to other societies with a positive response. They will be included in the next ANC course. It will be difficult to assess implementation and feedback is required.

- 7.5. RPV report by Neil Turner, who has taken over the chair. Unlikely to be a risk to the RA. First invoice to go out next month with 50% of units signed up to RPV. Bureaucratic issues remain in Northern Ireland for use of RPV. MR noted that RPV needs to be compatible with CRS. Although CRS is currently not fit for purpose and will not be rolled out this year. Capitation fee £2.50/dialysis dependent patient/year plus £3000 for a new unit joining. The devolved nations will pay a lump sum. Satisfaction surveys will be done to provide users with feedback. Usage by patients between units varies. Patients have to sign up individually to be enrolled but this does not give actual information on how much the patient uses the system. Therefore usage may relate to how much the doctor promotes the system rather than patient involvement.
 - 7.6. PD working group chaired by Edwina Brown has drafted a report which is being put on the website and publicised in eNews. The Home Haemo working group is due to report later this year.
8. Devolved nation report –
- 8.1. Northern Ireland Billy Nelson reported there were 850 patients in 6 units covering 1.7million patients. All HD units are central and no satellite units exist. 20 nephrologists care for the patients and most have been appointed in the last 5 years, includes 2 academics that organise training. The dynamic nature and growth of units was enabled by support from the NI administration. Take up rate is greater than in England and it is not clear why. Problems include vascular access which is being addressed by vascular access moving into transplant training. Organ retrieval is good but changes in UKT organ allocation has resulted in increased waiting times. No major living or non-heart beating (NHB) programme. Suggestion that there should be an alliance with the Southern Irish nephrologists was warmly received by the Executive. **ACTION Billy Nelson to approach Southern Irish nephrologists.** CT noted that the IT system that sends data to the RR works well in adult units but not paediatric units **ACTION Billy Nelson to try to unblock problems**
 - 8.2. Scotland Mark MacGregor not in attendance- SR reported that a national procurement system has been very effective in driving down costs. There is multi-disciplinary involvement with health board, medical, nursing and technical representation with decisions clinically based. A meeting next month will discuss procurement in PD. The Scottish RA meets twice/year and all are welcome.
 - 8.3. Wales John Williams - significant changes have occurred in management of renal services in Wales; 6 months ago there was speciality commissioning without clinical input. Now a Network board has been formed which is led by a clinician and the board leads commissioning. Funding for renal services has been ring-fenced and will be controlled by the Network. In future the network will apply to the Welsh assembly for continuation of funding. This is being piloted for dialysis care but will be rolled out, if successful, to the whole renal pathway. It is expected transport costs will also be transferred into the Network. Wales will no longer have any private facilities. Systems maybe developed through NPR that will buy renal services from the private sector through the Network. It is expected that renal services will expand by 50% in 3 years. New consultant posts will be funded with each new unit. The network will utilise the work performed by MR in rebutting the case to remove renal services from the specialist commissioning list as a similar suggestion regarding commissioning has arisen in Wales. Transplant unit in Cardiff has NHB programme but not one covering north Wales. Pathways in conservative and HD will be developed and these will be integrated with the Map of Medicine.
9. Academic Affairs
- 9.1. Academic affairs board met in December
 - 9.2. Clinical Trials committee due to meet on 16th Jan. Kirsty Reith, Colin Baigent's clinical fellow, has compiled database of all active clinical trials. Resource is available on RA website.
 - 9.3. International Committee RA has sponsored a speaker, Paul Harden, to discuss renal transplantation at African Renal Association meeting. John Feehally will also be talking (sponsored by ISN) RA interested in helping support renal educational initiatives for

developing nations. It was suggested that the Education and International committees may develop some eModules that would be sympathetic to the needs of clinical nephrology in developing nations. Although it was noted that not all have good IT access.

- 9.4. Research committee has organised a genetics meeting to brainstorm ideas supporting genetic initiatives in renal research. A commercialisation and biotechnology session has been organised for the Liverpool annual meeting.
 - 9.5. Education and Training committee – CPD sessions (Science for clinicians, bone and mineral disorders and urine proteomics) are organised for the annual meeting in Liverpool. Future CPD sessions should be mapped to the renal curriculum. The Advanced Nephrology Course continues to be successful. A minor review of the Renal Specialty Curriculum has been completed, a major re-write will begin at the end of the year. RA supported development of On-line-academy run by John Firth and hosted by Dr's.net. John Firth engaged in a revamp of the resource to make more accessible. Has corporate sponsorship for site. An application has been made to eLearning For Health to support. Sue Carr presented a proposal to develop eLearning/on-line materials via a Moodle platform. Sue noted a lot of educational activity occurs around meetings that would be ideal for training. But significant funding issue to have filmed for a webcast, £9000 estimate by MCI. Executive noted that it's important not to re-build the wheel, many sites produce education that's useful for renal training such as HCDN and dr's.net also do podcasts. MR noted that content should come from the ANC but needs to be interactive and this takes considerable support. Most contributors to the ANC are likely to be prepared to provide slides but editing needs to be sensitively handled. A champion in the Education committee is required to drive the initiative and a scoping exercise with options is required. FL said she was happy to help as she worked as an elearning consultant. HD masterclass in March has little sponsorship and minimal registration. Endorsement rules have been established
 - 9.6. UKKRC – CS reported UKKRC and the renal specialty groups of the CLRN do not have similar functions. UKKRC set up by the RA and KRUK to provide a collaborative framework for clinical/translational research within the UK renal community reaching other partner organisations such as the BAPN, BRS etc. The renal specialty groups of the CLRN are more focused on industrial collaborations for adoption of studies into the portfolio, have no remit to work with partner organisations and are not fully representative of the UK. Only 15 CLRNs have identified renal as a specialty group and they are not representative of the devolved nations. Both organisations need supported. Research opportunities provided by the two group needs to be exploited. Of note CLRN studies need to be high recruiting as future allocation of funds will depend on recruitment. 2-3 new clinical trials are required and the clinical trial committee needs to be proactive in helping support development.
 - 9.7. SAC report – Steve Powis. Steve noted he wishes to step down from the chair of the SAC. There are no major issues with the renal curriculum at present but a major re-write will happen at the end of the year. The GIM curriculum may change as a new acute medicine curriculum is wanted. This will require a change in the rules and may affect accreditation in GIM for current trainees.
10. Meetings
- 10.1. The meeting for plans for Liverpool are progressing well. The programme is fully formatted and the abstract review committee is meeting on the 3/02/09 to allocate abstracts to oral or poster presentations. Sponsorship is reaching targets and the registration site is open.
 - 10.2. The first meeting to discuss the joint BRS/RA meeting in Manchester 2010 occurred and agreed to use a similar format as used in Glasgow. It was noted Glasgow was a very successful meeting. A follow up meeting is being organised for early February. The Manchester meeting will coincide with the 60th anniversary of the RA. The executive was asked for suggestions for that celebration. A dinner to celebrate is being organised and past presidents will be invited.
 - 10.3. The ESPN is having a joint session with the RA at its meeting in Birmingham focused on cystic diseases. The RA website and eNews are publicising the meeting and both adult and paediatric nephrologists are encouraged to attend.
11. President's election – call for nominations has gone out. This election will be carried out electronically

12. NSF update – Donal O’Donoghue (see attached report) in the discussion Donal wished to concentrate on the future challenges
 - 12.1. Commissioning and PBR reference costs provided by 16 trusts show enormous variation on costs. This exercise will be repeated in transplantation. Initial costs range from £37 to £64K per transplant. Exercise will result in nationally consistent costs in RRT.

13. AOB
 - 13.1. Mark Taylor as president of the BAPN has approached the RA to discuss taking the BAPN under the RA’s umbrella of governance and management structure. The BAPN is supportive of this move but are concerned about loss of identity. Advantages for the BAPN are that it professionalizes the secretariat function. The RA executive was supportive subject to further discussions on detail. CS noted that it makes sense to develop an ageless approach to renal failure.
 - 13.2. Green nephrology – CT has taken on the mantle to reduce the carbon footprint of renal care. AN initial meeting occurred to develop ideas as to how this should be done. The DH are funding a SpR to develop knowledge to help implement the developing ideas.
 - 13.3. World kidney day is happening on the 12th March. The RA wish to thank LS and JF for their help in promoting and organising events. The website has been redesigned and the key message is bp control. All help in organising events or promoting would be appreciated (see enclosure for further details)

14. Date and Time of future meetings
 - 14.1. April 20th Jury’s Inn Albert Docks Liverpool 11am
 - 14.2. June 23rd Bristol TBA
 - 14.3. Sept 8th Birmingham TBA
 - 14.4. Jan 14th Birmingham TBA