

# The Renal Association

*founded 1950*

## Minutes of meeting of the Executive, London 25<sup>th</sup> September 2008

Location: Roben's Suite, Guy's Hospital, London

Date 25<sup>th</sup> September 2008

- | No.  | Item  |
|------|---|
| 1.   | Present - David Goldsmith, (Honorary Secretary), Lorraine Harper (Honorary secretary designate), 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), Jane Tizard (representing BAPN), Andy Lewington, Gordon Bell, Martin Raftery (clinical services committee chair), Phil Kalra, Sue Carr (education & training committee chair), Steve Powis (representing SAC renal medicine), Magdi Yaqoob, Paul Rylance (representing Society for DGH Nephrology), Shabbir Mochala (representing SpR club), Rob Lewis, Rob MacTier (guidelines committee), Bruce Hendry (research committee chair, Fiona Loud (Kidney Alliance chair). |
| 2.   | Apologies - Mick Kumwenda (representing non-consultant grades), Paul Stevens (representing BRS), Mark Taylor (BAPN was represented by Jane Tizard), Jo Adu (international committee chair), Donal O'Donoghue (representing England as the Tsar), Tim Johnson, John Williams (representing Wales), Mark MacGregor (website manager and representing Scotland) and Colin Baigent (clinical trials committee chair).   |
| 3.   | Minutes – accepted as a true record except the site of the next meeting needed to be amended. Paul Rylance was ex-officio of the DGH nephrologists not BMA liaison  |
| 4.   | Matters arising not covered in Agenda   |
| 4.1. | Item 11 meeting 13 <sup>th</sup> May 08 – succession planning for the Advanced Nephrology Course has progressed. Alex Crowe was due to demit in Jun 09 and Mark Harber due to demit after the autumn meeting of the ANC. A call for 2 new organisers resulted in 5 high quality applicants. By unanimous agreement Sunil Bhandari and Paul Harden have been invited to take up the roles of course organisers. They will both start immediately and shadow Alex and Mark. It was acknowledged that this would raise issues later when they are due to demit.  |
| 4.2. | Item 15 meeting 13 <sup>th</sup> May 08 Representation for the devolved nations was requested for the Executive. John Williams represents Wales, Billy Nelson Northern Ireland, and Mark MacGregor Scotland. Their roles are not as yet clearly defined but they should highlight issues that are important to their constituents. Peter Mathieson noted that at this meeting the only nation represented was Northern Ireland  |
| 5.   | President's report – enclosed   |
| 5.1. | The election for the new president will be soon, the call for nominations will occur at the end of 2008, nominations announced early in 09 and the vote will be both electronic and paper records organised by the Electoral Reform Society. Decisions will be made to allow representation at the AGM.   |
| 5.2. | This meeting is the last for the current Honorary Secretary, David Goldsmith, who has been doing all the hard work for the last 4 years. Peter Mathieson noted his personal thanks and on behalf of the other trustees for all David's hard work and efforts to maintain the smooth running of the RA. A gift on behalf of the trustees was presented to David. He noted that DG would be a difficult act to follow.  |
| 5.3. | Knowledge based assessment- The timing for the first diet of the KBA is March 09. The announcement of the exam and its publicity will be the responsibility of the Royal College. The Education and Training committee is aware but waiting sign off of the MOU to launch their publicity. The exam will be publicised within eNews, and the SpR club. SM noted that trainees are aware of the exam and it had been discussed at their ARCP. The exam should also be publicised at the ANC course. Concerns about communications with the College were highlighted. The cost of the exam will be £800. Prior to announcement of cost unofficial   |

feedback had suggested that even those who did not have to take the exam may sit it. If most trainees sat the exam it would reduce the risk to the RA. However since the announcement of the cost that may change. Shabbir Moochala noted that SpRs had recently been down banded and were making less money which may lessen the attractiveness of the exam. Peter Mathieson noted that the cardiologists are not participating in the College process but will instead sit a European exam at significantly lower cost to candidates. Uptake of exam is likely to depend on timing of publicity. Need 6 months to publicise for maximum uptake. Concern about speed College moving at.

The KBA is a risk for RA finances with the RA taking on a 25% share of the risk. The maximum risk is 42K spread over 3 years and is based on conservative estimates of the number of trainees taking up the exam. There will only be one diet per year.

The KBA can be taken by overseas trainees but only at sites approved by the College and only those with CCT can use MRCP (nephrology). This will be a source of income generation.

The exam is a pass/fail with a high pass mark – 80% roughly. There is no intention to use this as a competitive pass mark and only forms part of the assessment of competence of trainees for CCT. The exam is mandatory to do at some point during training and suggested timeframe is within the first 2 years of training since the level of knowledge is not too complex. It must be passed to gain CCT. It has been mapped closely to the curriculum. It is mapped to the totality of knowledge of trainees and by end of 2<sup>nd</sup> year trainee should have 80% of knowledge. Trainees can resit and there is no disadvantage for them to take at later points, although this could be a threat for RA finances.

The financial oversight of the exam will be handled entirely by the College but specialist societies are allowed to inspect accounts.

Peter Mathieson agreed to contact the Royal College to try to expedite the signing of the MOU. **ACTION Peter Mathieson**

#### 6. Treasurer's report – enclosed

- 6.1. A summary of the financial status of the RA suggested there are no major problems this year and funds are healthy. There will be a profit generated from the Glasgow meeting split with the BRS, the amount of which is as yet not finalised. The RA has received a £40K reconciliation payment from the BRS. This will offset losses of £21K made at the Brighton meeting and to reduce registration fees at the Liverpool meeting joint with the BTS.
- 6.2. Risks for future RA finances are the Liverpool meeting which is budgeted on third party costs of £325K; KBA maximum loss will be £42K but this can be spread over time; Renal Patient View (RPV) it is proposed that this is taken into the running of the RR and subject to a per capitation fee of £2.50.
- 6.3. The contract between the RA and the secretariat is out for consultation.
- 6.4. Corporate membership remains static and membership fees for 09 will remain static on 08
- 6.5. The RRMB supported an increase in per capitation fee for 09 but the increase in 2010 will be reviewed and probably deferred as the accounts are healthy. The VAT position of the RR is safe but needs to be future proofed particularly with future inclusion of RPV, as RPV could be viewed as a service.

#### 7. Clinical Affairs Board

- 7.1. Payment by results discussions are on-going. The DH has deferred the introduction of a mandatory tariff for 09 due to the realisation that the data is of poor quality. A sheet helping managers complete data returns should improve quality of data and a mandatory tariff will be introduced for 2010/11
- 7.2. Joint guidelines produced by RA & British Association of Urological Surgeons have been published and the new terminology - visible and non-visible haematuria - has been incorporated into the NICE guidelines on CKD. A haemodialysis working party is being set up by Mark MacGregor and Edwina Brown is developing a PD working party.
- 7.3. NICE CKD guidelines have been published and can be downloaded from their website.
- 7.4. The NICE Home Haemodialysis costing template has finished consultation. This does not make any recommendations of the percentage of patients who should be undertaking this modality. It has been accepted that there needs to be recognition of start up costs for Home HD.
- 7.5. Acute Kidney Injury – A working party which included the RA, Intensive Care Society, Association of Clinical Biochemists, and Association of Surgeons has issued guidance on the use of IV fluids for surgical patients; this will be posted on the RA website. Formal thanks were given to Andy Lewington who led for the RA on this large piece of work. Two AKI

audits are ongoing NCEPOD in England and the Scottish audit of surgical mortality. These will give information about AKI and risk factors. However the information collected is at a very high level. If more detail is to be obtained from future audits the RA needs to continue engagement with NCEPOD and SASM, and it was suggested Andy Lewington was the most obvious person to do this. Andy agreed.

- 7.6. Guideline Committee – chaired by Rob MacTier. These are up to date for the 4<sup>th</sup> edition. Rob note that the guidelines section of the RA website needed to be improved. Rob has discussed with Mark MacGregor how best to do this; at the least need to see current guidelines, the position of draft guidelines including plans for chapters and timetable for response and harmonisation of current and past editions. A transplantation guideline will be updated to coincide with that from KDOQI and a draft of guidelines on blood borne viruses has been started. A summary of the RA/BAUS guidelines on haematuria has been submitted to the BMJ - decision awaited. It was noted that guideline visibility is an important issue. Is it possible to link this in some way to Google to increase ‘penetration’? Recent publications from those outside RA continued to quote previous editions of the RA Standards documents, perhaps because of difficulties in referencing web-based guidelines. It should be noted that the NICE CKD guidelines now supersede the joint specialty guidelines and a link from the RA website to the NICE CKD guidelines should be made. Martin Raftery noted that the RA is an effective stakeholder in influencing guidelines developed by NICE, although RA members voice a multiplicity of views and therefore were difficult to represent. The formal response document from the RA was taken on board by NICE in 6 of the 9 areas highlighted, including a useful warning on the use of eGFR>60 and highlighting the importance of discussion between professionals prior to referral. **ACTION Mark MacGregor to update links on website for CKD guidelines and to investigate ways of increasing penetration of guidelines possibly through Google**
- 7.7. SSRND consultation document. This document suggests that renal services should be taken out of the specialised services and commissioning should be left to PCTs. This should be strongly resisted. The renal desk in the DH is not supportive of this move even though they wish to increase the number of dialysis centres. Martin Raftery wishes to email all members of the RA to lobby against this move. Approved by the Executive **ACTION Martin Raftery to email all members regarding the SSRND consultation document.**
8. Renal Registry report - Charlie Tomson
  - 8.1. The RR is progressing well: more analyses are being performed and they are of better quality. Data validation and correction of errors remains a major part of the Registry’s work: quarterly returns on completeness and in incident and prevalent numbers are now being sent to Clinical Directors. The RR is behind the USRDS in terms of reporting on clinical data (e.g. admissions) but better with lab data. Charlie Tomson noted that the clinical data will be improved if agreement to link to NHS such as the Hospital Episode Statistics database will allow reporting of clinical admissions, average lengths of stay etc. If linked at individual patient level this could produce very good quality data.
  - 8.2. Charlie Tomson raised the issue of whether new analyses should be published first in the Annual Report as preliminary findings, or first as articles in peer-reviewed journals. This was a particular issue now that the Annual Report would also be appearing as a web-only supplement to Nephron Clinical Practice, which might prejudice a later full publication. Salaries for Registry Registrars, who perform most of these new analyses, ultimately come from capitation fees, so it would be possible to argue that all new analyses should first be shared with Clinical Directors whose centres pay these fees. However, there was also the possibility that preliminary publication of analyses would be misleading. The consensus view was that it would be acceptable for such new analyses to be subjected to full peer review by submission to a journal; if the analysis was of sufficient interest to merit it, it could be repeated for subsequent Annual Reports. An authorship policy would be written and discussed at the next Registry Committee meeting
  - 8.3. Charlie Tomson has agreed to stay on as chair until 2010 at least. Succession planning will need to allow for at least one year of overlap.
  - 8.4. Agreement has been made to supply data to NHS choices: this will be similar to that seen by Clinical Directors and will be performance indicators but not survival data.
9. Renal patient view
  - 9.1. RPV is now run by RA. It will sit within the RR and costs will be covered by a capitation fee of £2.50. This will be used to staff and develop RPV. Capitation governance and oversight of RPV should be included in the RRMB. Neil Turner as chair of RPV should sit in the Executive Committee and report through the Clinical Affairs Board as any other working

committee. Martin Raftery has circulated the proposed capitation fee to all Clinical Director's with request that any feedback should go straight to John Feehally. He has so far not received any feedback and this is taken as agreement by Clinical Directors to the capitation fee. RPV will be discussed at next Clinical Director's forum. Funding in devolved nations may differ and be problematic. At present returns to RPV in Scotland are via a grant from the Scottish office, which cannot be guaranteed. RPV should be UK wide and be funded by per capitation through out the UK. Wales is funded on a per capitation basis. Northern Ireland should be by per capitation but Billy Nelson noted there were bureaucratic issues. Kevin Harris noted that RPV should be included in payment by results as there is a budget line in the tariff for informatics. **ACTION Kevin Harris to raise RPV at next PBR meeting.**

10. NSF update no paper received Donal O'Donoghue not present
  - 10.1. Peter Mathieson noted that Juliette Kingcombe is moving on from her portfolio in the DH. He wished to formally thank her for her efforts on behalf of the RA.
  - 10.2. John Feehally noted the intention to supplement the recently published DH End of Life strategy with a document on conservative kidney care will be launched at the BRS meeting. Ken Farrington is leading this work.
  - 10.3. The paediatric to adult services transition initiative by the Colleges of Physicians & Child Health will produce a generic guideline on how to manage this step. The renal community is developing a speciality specific document: RA representation is by John Feehally and Paul Harden and David Milford from the BAPN. The DH wishes to invest in this area. and there may be the opportunity to pump prime posts if a clear care pathway is produced. Jane Tizard from the BAPN has received an email about transition of care for those children who have had a transplant. It is important there is not duplication of effort so Jane will forward email to John Feehally **ACTION Jane Tizard**

Kidney Care Support Team has resources to support proposals from renal units for projects which show potential for early improvement in patient outcomes. This resource is presently being underused, and the Tsar welcome approaches from RA would welcome approaches from the RA. This is being communicated by word of mouth and also written to Clinical Directors and lead nurses.

11. Academic affairs board report- enclosed
  - 11.1. Clinical Trials Subcommittee – Colin Baigent sends his apologies. Kirsty Reith, a clinical fellow, has developed a spreadsheet to document renal trial activity within the UK. This has been cascaded through renal research consortium leads. Astral results have been published. At Glasgow Colin Baigent discussed REN-1 and the trials committee are polling members via email on their use of B-Blockers in dialysis patients. A trial of plasma exchange in patients with ANCA-associated vasculitis has been funded by the MRC and aims to recruit 500 patients.
  - 11.2. The International subcommittee – Jo Adu sends apologies – has established relations with many renal units in developing countries. The IS wishes the RA to approve funding of a UK speaker to the African Advanced Nephrology Course. Travel costs would be approximately £1000 – Agreed by Executive
  - 11.3. Education and Training subcommittee – Sue Carr has replaced Edwina Brown as chair of this committee. Guidelines for endorsement of outside meetings have been drafted and will be distributed. The committee has agreed to organise 3 sessions at the Liverpool meeting and Sue will chase these up. A suggestion for the inclusion of a radiological session organised by Liverpool physicians was not included in this year's programme for the annual meeting but will be considered for future meetings. Sue will push forward on-line education. The agreement with Doctors.net to develop an on-line academy has not been as fruitful as expected. Sue is discussing with John Firth. KBA see under president's report. Engagement with the ANC continues and remains a very highly regarded meeting. **Action points – Sue Carr to pull together the 3 sessions for the Liverpool meeting and to encourage on-line education.**
  - 11.4. Research Subcommittee – Bruce Hendry (Chair) is developing a UK renal genetics meeting to take a strategic overview of renal genetics research in the UK. This will include what research is currently on-going, what banking offers and how to tie in the UK Renal Research consortium. An invitation to stakeholders has been issued. Attendees are not being offered expenses. There should be representation from the devolved nations including Patrick Maxwell from Northern Ireland. Charlie Tomson suggested CME should be applied for to allow attendees to claim expenses from trusts. A session at the Liverpool meeting has been organised on commercialisation and biotechnology.

12. Specialty Advisory Committee – Steve Powis

- 12.1. SAC membership – Steve Powis noted there was no lay member on the committee and there did not seem to be any mechanism within the RA to identify a lay member. Peter Mathieson noted he knew someone who would be effective in this role and would forward to Steve Powis **ACTION PETER MATHIESON** . SP will step down next year as chair. Selection of new chair was a College issue. Peter Mathieson formally thanked Steve Powis for all his hard work. Sue Carr would chair the SAC curriculum sub-group. PMETB wished only minor changes to the curriculum. A rewrite based mainly around delivery and assessment was expected in 2010. This gives the opportunity to include minor changes in the curriculum content.
- 12.2. Recruitment at ST2 level was done nationally and applicants were on the whole good. The DH wish a person specification for recruitment for 2009 but at the moment it is unclear if this will be a national or local process. Concerns about workforce planning have been fed back to Deaneries.
- 12.3. Article 14A – Currently 50% of applications have been turned down explained in part by an increase in overseas applicants. There continues to be a high level of misunderstanding of requirements to be included in the specialist registry via the article 14 route. Most applicants are failing because of a lack of transplantation experience, although this is explicit in the advice given on the website. Article 14 experience needs to be assessed against benchmark of trainees coming out of the current curriculum. Transplantation is already assessed generously. Delays in turnabout for applications are mainly due to PMETB acquiring documentation. A strict timeline is in place for assessors decisions. Concern has been raised about excluding good applicants who have specialist expertise in dialysis medicine, but do not fulfil all criteria [most commonly lack of transplant experience]. Steve Powis noted that there is a route for inclusion if the specialty is recognised in other countries but not in the UK (Article 14B). However to be included via this route applicants needed to have spent >6months training overseas where the specialty is recognised. This would not help a good number of UK dialysis specialists presently in the staff or associate specialist grades. The curriculum could be changed to allow a dialysis medicine speciality to develop, but so far this idea had not received majority support from trainees or consultants.
- 12.4. UK Kidney Research Consortium – Caroline Savage noted that the chair of UKRRC is due to rotate to KRUK. REN-1 is progressing and REN II is being developed by Paul Roderick to look at biomarkers in kidney disease. Peter Mathieson noted there is a framework 7 call for large multi-national consortium for CKD. Caroline Savage would alert Paul Roderick to this. **ACTION Caroline Savage**

### 13. Meetings 2008-2010

- 13.1. Liverpool joint meeting with BTS April 20-24<sup>th</sup> 2009 –
  - 13.1.1. The Liverpool programme committee have almost finalised the programme for the meeting. Sessions to be confirmed are the three organised by the Education and Training committee. Sue Carr will help chase these sessions. Invitations have been issued with an excellent response. Website is due to be launched soon with links from the RA and BTS home pages. The meeting has a timeline established and close of abstract submission will be Mon 12<sup>th</sup> Jan 09. Registration costs are an outstanding issue with the BTS. The conference venue is fit for purpose and was visited by Lorraine Harper with MCI and the BTS secretariat. Logistics are progressing well and the secretariats are working well together. Sessions for sponsorship remain an issue. The RA corporate breakfast session will go ahead on the Tuesday. It is important that we have corporate feedback as happened in Glasgow.
  - 13.1.2. Registration fees and sponsorship – The BTS remain anxious about sponsorship and registrations fees. Peter Mathieson discussed with Peter Friend, President of the BTS, who was concerned that people would not attend breakfast symposia despite the information supplied regarding attendance at the Glasgow breakfast symposia. He wished to have 2 corporate sessions at 1pm and 7pm on the Wednesday and 1 session on Thursday at 1pm. It was noted that this would clash with the poster sessions and that the Corporates did not universally like lunch symposia. They were liked by the big companies who could provide these but the smaller companies felt it meant people did not visit the exhibition. Peter Friend also suggested that there should be only one moderated poster session. Discussion by all felt that the poster sessions should be unopposed in the programme and that there should be a poster session each day to showcase young researchers. David Goldsmith noted that the ERA has lunch symposia at the same time as posters and that attendance at the posters is very poor. Symposia at lunchtime were felt to be a bad thing. The breakfast symposia should happen on the Tuesday for the RA stand alone day. The Wednesday symposia should happen at the

end of the day and the programme moved forwards an hour. Stuart Rodger noted that the BTS wished to reduce registration fees and were prepared to take a loss of £20K. SR will meet with the BTS in November to finalise registration costs. **ACTION Peter Mathieson to report back to Peter Friend. Stuart Rodger/Lorraine Harper to meet with BTS to firm up registration fees**

- 13.1.3. The breakfast AGM at Glasgow worked well with provision of breakfast and pre-registration. This should be done again probably the Wednesday morning of the meeting. The executive meetings will happen on Monday 19<sup>th</sup> April.
- 13.1.4. The social programme will be separate except for a joint reception between the BTS and RA and will not be included in the conference costs.
- 13.2. The ESPN meeting is occurring in Birmingham on 2-5<sup>th</sup> September 09 and is overlapping with the BAPN. The website is up and running. A link will be made from the RA website to the ESPN and it will be highlighted in eNews.
- 13.3. Manchester 2010 is the 60<sup>th</sup> anniversary of the RA. The annual meeting will be held with the BRS. There will be a separate day for RA birthday celebrations. The planning for this needs to be started. Phil Kalra, Alastair Hutchinson and Jane McDonald have offered to be local coordinators. Jane will be president of the BRS at this point. Peter Mathieson has already viewed the Manchester venue. John Feehally, as RA archivist, will take leading role in the historical aspects of the meeting.
- 13.4. RCP meetings
  - 13.4.1. 24<sup>th</sup> Feb 09 Chronic kidney disease (RCP & RA)
  - 13.4.2. 21<sup>st</sup> Sept 09 Cardio-renal Interface (RCP, RA & British cardiovascular society)
  - 13.4.3. 9<sup>th</sup> Nov 09 Vasculitis (RCP, RA and British Society for Rheumatology)
14. Honorary Secretary – Lorraine Harper is now in post
15. Logo and electronic voting
  - 15.1. The electronic vote for the logo proceeded well. Turnout was impressive and higher than previous votes including the last president's vote. Anomalies were attended to rapidly by the Electoral Reform Society. Future votes should be electronic but the next vote which will be for the new President should have an option to return a paper vote.
  - 15.2. The new logo was agreed by an overwhelming majority of the membership by 7:1. The costs to implement are about £1500. The new logo is easier to work with than previous and there were few complaints relating to the change raised by the membership.
16. AOB
  - 16.1. Rob Lewis asked what position the RA took on the sub-consultant grade. Two views had been strongly articulated; one suggested by Phil Mason chair of work force planning that this should be accepted and dealt with as it will happen; the other that it should be strongly resisted. The RA needed to have an extensive debate about this as there is going to be an excess of renal CCT holders without consultancy positions. Bruce Hendry noted that there had also been a proliferation in academic training posts but no thought to their future. Martin Rafferty noted that Phil Mason's briefing document had been sent to all Clinical Directors but could be resent to generate debate. He would organise to have it debated at the next Clinical Director's forum **ACTION Martin Rafferty**. It was suggested that this document should be sent to all RA members and feedback should go directly to Phil Mason. It was noted that implementation of this grade would be permanent and would have an impact on lower grades straight back to medical students, which had not been thought through. Caroline Savage noted that it was essential that any planning for these posts also included training issues and long-term career paths. Shabbir Mochala noted that the SpR has debated these issues. They have concluded that it is difficult to take a view as to acceptance or rejection until it is clear exactly what sub-consultant means. They wish to engage with the process and influence positively. Although they all want consultant posts they are realistic that the future will require a change in career structure. Martin Rafferty noted that the sub-consultant grade was already happening in surgery although stalemate had occurred in cardio-thoracic surgery as no agreement had been reached as to what to do. The BRS are currently undertaking a workforce planning review. There is dissociation between the number of trainees and likely consultant posts and this is a large problem. The trainees may be mopped up by polyclinics
  - 16.2. The issue of polyclinics raised a very important point commented on more fully by Martin Rafferty. An Independent sector treatment centre contract has been issued to the tune of £2.4million to a private company that has no track record in the provision of dialysis. The dialysis provided will operate under EIB governance but this needs to be monitored and publicised through the Clinical Affairs Board.

17. Date and time of next meetings

Jan 15<sup>th</sup> 09 Guy's Hospital London

April 20<sup>th</sup> Jury's Inn, Albert Dock, Liverpool

Sept 8<sup>th</sup> – venue to be arranged

Prepared by Lorraine Harper