

Executive Meeting

Location: Copthorne Hotel, Birmingham

Date 11th September 2009

Agenda

No. Item

Present – Peter Mathieson (PM) John Feehally (JF) Lorraine Harper Stuart Rodger (SR) Kevin Harris (KH) Charlie Tomson (CT) Rob Mactier (RM), Magdi Yaqoob (MY), Andrew Lewington (AL), Laurie Solomon (LS), Bisher Kawar (BK), Albert Ong (AO), Bruce Hendry (BH), Stephen Morgan (SM), Martin Raftery (MR) Neil Turner (NT) William Nelson (BN), John Williams (JW), Rob Lewis (RL), Paul Harden (PH), John Reynolds (JR) Mick Kumwenda (KM)

1. Apologies – Caroline Savage Donal O’Donoghue Mary McGraw Jane McDonald Mark MacGregor Sue Carr Colin Baigent Gordon Bell Fiona Loud
2. New members of the Executive – Welcome to Steve Morgan, DGH rep, Paul Harden and John Reynolds, new elected members, Albert Ong, Chair International Committee, Mary McGraw, BAPN rep. PM apologised for not inviting Jane MacDonald, President of the BRS. Carolyn Johnson and Stella Goodson from MCI were introduced.
3. Announcements – JF has been elected as ISN president. Paul Harden has taken over the Chair of the ISN Sister Programme. Both should be congratulated
4. Previous minutes – accepted as written
5. Matters arising –
 - a. Meeting has now become paperless. There were no comments from the Executive about the need for a CD with all papers for the meeting. Future meetings will not accept late documents.
 - b. Joint guidelines had been developed with the gastroenterologists, GI surgeons and GI radiologists regarding bowel prep. Draft guidelines are available on the BSG website. Comments from renal physicians with an interest in fluid balance physiology would be welcomed. Guidelines should help Trusts respond to patient safety report.
 - c. KH noted that NCEPOD report on Acute Kidney Injury had been published; guidelines have implications for workload but the recommendations are not binding
 - d. 13.b Saeed Ahmed has been appointed as assistant webmaster
6. President’s report – attached
 - a. There has been a proliferation of requests to have joint meetings with the RA. The joint meeting with the BTS in Liverpool was a success and they wish to do again in 2013. Joint conferences are perceived as being useful but important that flexibility in

partners and ability to have stand alone meetings maintained. The RA will have a joint meeting with BRS in 2010, should this be repeated in 2011? The RA has agreed to meet with the French in February 2011, other meetings in 2011 include the WCN in April, Vancouver. The BRS have already booked 1st week in June at the ICC in Birmingham for 2011. If the RA were to have a standalone conference the calendar would be very congested. BH noted that joint meetings were successful. PM commented that he agreed but finances with the BRS were complicated because they had to cover their annual running costs making the meeting expensive. Attendance at the Glasgow joint BRS/RA meeting was 1350, the BTS/RA meeting was 1100, the last stand alone meeting 600. Most but not all industry partners like joint meetings. The joint meetings need to be multi-disciplinary. CT worried about ensuring that sufficient items of interest for laboratory scientists to make meeting attractive. MR noted that flexibility needed to be maintained and he would not be keen to move to joint meetings with the BRS every year. He suggested that BRS/RA joint meetings should occur every 2-3 years. Despite concerns about cost of joint BRS/RA meeting all agreed to go with another joint meeting with BRS in 2011 due to meeting congestion. JR asked about costs for 2010. PM stated that the costs of the meeting will be similar to Glasgow with a substantial saving for non-clinical scientists. There will however, because of the nature of finance situation with the BRS, oscillations in costs year on year. JF wished to explore a 3 way meeting with BRS/BTS and RA. He was concerned that RA independence may be threatened by joint meetings but acknowledged joint meetings were successful. NT favoured joint meetings. RL noted that there were economies of scale with joint meetings. BN noted that the EDTA had previously run joint meetings but meetings were now stand alone. Were there lessons to be learned from their experience? Nobody commented. JW noted flexibility was very important he suggested every 3 years with BRS, every 3 years with BTS, and every 3 years with another partner.

Conclusion of discussion – have joint meeting with BRS in 2011 but this should not lead to the expectation of meeting with them every year. Need to maintain some flexibility.

- b. BAPN wish to join with the RA. Further discussion around the details is needed. It is envisaged that the BAPN would become a division of the RA with no independent membership. There would be joint meetings. The BAPN president would become a Trustee of the RA and the BAPN Hon Sec would be represented on the executive committee – **Approved without comment**
- c. Positions vacant 2010 –The Honorary Treasurer, Clinical and Academic Vice-Presidents are all due to demit in 2010. The call for the Honorary Treasure will be in November with close in December. A job description will be written. Executive members should think about whether they may wish to apply for any of the posts. All posts have Trustee status and a significant workload. Discussions should be had with PM and current post holders
- d. Trainee membership is a concern. Only 50% of trainees are members but almost 95% of consultants. Unclear what drivers are present that increase membership at consultant level. This issue needs to be taken to the SpR club. Need to ensure the RA

is relevant to the needs of trainees. PM will discuss when he attends SpR club meeting. CT noted that the RA needs to give value for money to all members

7. Treasurer's report – see attached
 - a. General account healthy. £250K surplus from Liverpool meeting and membership fees. Holding £1.4million for Kidney Care in a ring-fenced account. This is likely to be given back in this financial year. Liverpool joint profit £150K but outstanding debts. Expected £50K profit for RA. Auditors happy with financial status.
 - b. Budget agreed for 2010 meeting with BRS. Registration very good value for money for non-clinical scientists. Registration fee includes the option of the 60th Anniversary dinner or the Gala dinner. Costs for breakfast at AGM - £450. Increases attendance, liked by members, overall represents value for money. **Treasurer's report approved without comment**
8. Clinical Vice-president report
 - a. PD working party report will be signed off in November
 - b. HHD working party needs re-invigoration. The Dept of Health is keen to see home therapy use increase. A clear vision on what is needed is necessary.
 - c. Acute Kidney Injury (AKI) – recent launch of NCEPOD report. Standards for AKI need to improve, this is a neglected part of the NSF report. AL is taking a working party forward to define operational definitions of AKI to prompt action, will be linked to NICE guidance 50. NICE are keen to develop guidance for AKI. Workshop on AKI organised for October. AL has met with NICE. A group has been assembled to work up core competencies. Local initiatives to develop action on AKI are needed. RL asked what sanctions are present to ensure that Trusts take notice of the report. KH replied- at present none. Once NICE issue guidance with targets, Trusts are then legally obliged to take notice. KH noted that the long game had to be taken to improve AKI care. MY noted that 20% of patients develop AKI and the NCEPOD report has major implications for nephrology workload. Pilots to ensure proper infrastructure development are required. MR noted that there was a large list of topics waiting to be assessed by NICE. NICE topics priorities were decided by ministers therefore it will be very difficult to get AKI on agenda. CT agreed and noted that the NKF need to be engaged to drive AKI agenda with NICE. JW commented that in Wales each Trust has been mandated to respond to the NCEPOD report using the self-assessment tool provided in the report. It has been easier in Wales as Ministers have delegated responsibility for quality to the Medical Director. SM noted that there is a problem with DGHs as often no renal input. NT noted there needs to improved training of junior doctors in general medicine to improve care of patients at risk of AKI. This could be done by on-line training. BN noted that information was needed on the current situation and what resources required to improve AKI care. MR suggested that resources were probably appropriate but improved management was needed. Also need to involve radiologists as high risk patients often having imaging. RL to make contact with a radiology rep for the working group.
 - d. Swine flu – lot of work done to get dosing of Tamiflu correct. RA Working group have advised national flu line. Self identified patients with CKD will be advised to get Relenza because of concern about Tamiflu.
9. Renal registry report –

- a. New Chair of the RR has been appointed – Damian Fogarty (DF). Formal congratulations noted. DF will start shadowing CT and will take over at the AGM in May.
 - b. Annual report on track for publication
 - c. Maps on website very useful, includes centre specific reports and trends over time using quarterly data
 - d. Data completeness – A problem has been identified in data returns. Some units defaulting missing values to “cause unknown” to ensure data complete
 - e. MRC funding to develop Rare Disease registry. Will use web-based data entry, requiring individual patient consent. A pilot will be running soon on paediatric FSGS and MCGN; if successful, data collection on other rare diseases could follow
 - f. National renal dataset - The response to the NRD frequently asked questions document has been submitted to the Information Centre and Department of Health.
 - g. New EDTA primary renal diagnosis codes are now signed off. They will not be implemented immediately. The new codes map to old codes and will allow retrospective analysis without recoding.
 - h. Linkage of RR with HES will happen soon and will allow description of hospital stays but will not provide any information on beds or costs at present.
 - i. UKT database and RR have cross-talk with data sharing. Research papers are in preparation.
10. Reports from devolved nations
- a. JW Wales – Trusts and PCTs are to merge. Renal will merge in to 1 network with commissioning function. Will be operation 1/4/10. All renal services are regional, centrally managed and will allow national contract negotiations.
 - b. BN Northern Ireland – there have been 15 episodes of dialysis associated haemolysis. Many episodes have been mild. Episodes often difficult to detect. Think that episodes are line related, currently under investigation. BN discussed a link with the Irish nephrologists, general support. Irish Renal Association president will contact PM. There have been changes in the Northern Ireland Health Service and resource issues are present in transplant and access surgery.
 - c. Scotland – no formal report SR stated that in Scotland there is national tendering of renal services but savings are not fed back into the renal clinical service. Clinicians are very involved in the process. Tendering is not just driven by costs but includes a quality element
11. Guidelines committee – the group meets annually at the RA conference. It is noted that the RA guidelines group is well respected amongst other guideline groups. RM to be congratulated
- a. 14 modules have been completed and in final format on website. All use the modified grade system. Limited patient involvement which needs to improve to be viewed as a NHS guidelines partner. SR suggested contacting KRUK or KPA to get formal patient involvement in the guidelines group. RM wished to link with RR to look at implementation of guidelines.
 - b. New guidelines – Blood borne virus, PD access, Haemodialysis and RRT almost complete; cardiovascular guidelines being developed by Charlie Ferro, David Wheeler, and David Goldsmith; AKI – AL going to KDIGO feedback session and will

provide commentary on guidance for the RA. No guideline on glomerulonephritis or vasculitis from the RA. KDIGO is due to look at this. A commentary will be provided by the RA

12. Clinical Affairs Board report –
 - a. All Strategic Health Authorities were represented at last meeting
 - b. Swine flu – no letter was sent in August and awaiting update on vaccine, which is currently under safety testing. Vaccine will probably be released in early October. Single dose vaccine. GPs will probably take over administration. HD nurses must be a priority to receive the vaccine. Concern about patients getting confused between swine flu and seasonal flu and therefore not taking up seasonal flu vaccine.
 - c. Next CD forum will be 6th or 13th March
13. Green Nephrology – Paper attached
 - a. Green targets for RA – RL felt that these did not reflect green activity. Need to push industry to be greener and to increase re-cycling. A policy on re-cycling is required. CT responded that a sustainability policy is being developed. Need to get the RA house in order before preaching to industry. RL felt the current policy devised contained a lot of tokenism. MY asked how printing of paper compared with the electricity required to run laptops rated in terms of a carbon footprint as RA have moved to paperless meetings. CT promised to calculate green footprint. He commented that Baxter and Fresenius already have a good sustainability policy. RL requested that meetings should not have bottled water. CT said this was difficult to mandate.
 - b. A research fellow has been employed who will address green issues in renal units. Units will be visited and best practice collated. MR noted that there can be centralised dialysate delivery which not only improves green health care as decreases number of deliveries but also reduces cost.
 - c. Virtual meetings not possible at moment as webcasts not of sufficient quality.
14. Academic report
 - a. Education and training Committee, Clinical trials Committee and International Committee reports attached
 - b. Research Committee – BH noted the research committee had met in April at the RA Conference. A biotech symposium had taken place during the conference. Thanks to Tim Johnson and Julie Williams for organising. The main lessons from the session were
 - i. It's difficult to take laboratory science into the clinic
 - ii. Need heroic efforts to gain funding
 - iii. Tensions between biotech industry, who wish non-disclosure and laboratory scientist, who tend to disclose research to allow development
 - iv. Repeat session in 2010 to increase awareness of funding sources. Could use MRC technology and the Health Innovation Council as partners

Genetics workshop organised in January which was very successful. This has moved forward with a renal monogenic clinical study group developing led by Robert Kleta. Important to keep JF and Moin Saleem in touch with activities centred on rare diseases. No development on the polygenic genetic diseases. PM noted that the MRC DNA bank

for glomerulonephritis grant was a huge resource and is now providing important results moving understanding of polygenic diseases forward. Important to support active projects.

Current climate for biomedical research is good. Clinical trials are being supported. Funding for biomedical research guaranteed in the next comprehensive spending review.

- c. SAC – no report. Unknown if Steve Powis has been replaced as Chair of SAC
- d. International Committee – new Chair appointed Albert Ong
- e. UKKRC – NT reported that UKKRC are facilitating good clinical research. Clinical study groups have been formed REN-1 has mutated into BOND and needs to be pushed through with support from the CLRNs. There is a question about the role of the RA clinical trial committee with changes in the current clinical research arena. PM is keen to retain but needs to be kept under review. NT noted the situation was confusing CLRN are all about delivery of research rather than development. CLRN specialty leads overlap with UKKRC leads. UKKRC is about development of research

15. Meetings

- a. Joint with Dutch in 2010 – Dutch keen to have a joint meeting in September 2010. If focussed on proteinuria and vascular damage could get cardio-renal group to organise – David Wheeler and Phil Kalra. JF was unsure about repeating the cardiorenal meeting in 2010. PM noted that good research collaborations may arise from a joint meeting. The Dutch have a very strong research community with expertise in rare disease and epidemiology
- b. French meeting 2011 in Paris – Robert Unwin leading. Needs scientific committee. LH to be involved. Date set for 10-12th February 2011.
- c. Manchester 2010 – progressing well scientific programme complete. All speakers confirmed for 60th anniversary. The RA anniversary dinner will not be black tie

16. Advanced Nephrology Course – continues to be successful. Changes will take place in January; the ANC will become a residential course over 3 days, 40% of sessions will be interactive and the duration of lectures will be reduced to 35 mins each. The course will cover the NSCE curriculum but will not be a curriculum course. International educators on dialysis will attend. Limited consultant attendance. A transplant update is being organised in Oxford in 2 weeks consultant only good attendance. ANC organisers do not wish to have a consultant only course as mix has advantages to both groups, but aware need to increase consultant training. Tensions between delivery of service and study leave for consultants. Trainees attending course more junior because of training. Two supported places are available for overseas trainees.

17. Terms of President Tenure – It was announced at the AGM for consideration that the President's tenure should change from 3 to 2 years. This will have a knock on effect on the Past-President's tenure which will revert back to 2 years to coincide with President's tenure. PM noted that the RA was previously a small organisation and there were not enough candidates to change President every 2 years. The RA has enlarged and now has 1000 members. PM asked for agreement that President's term of office should be 2 years – **Agreed by Exec.** CT requested that the change in term of office should apply to his presidency.

18. Executive elections – New members Paul Harden, Liz Lightstone and John Reynolds. Elections organised by Electoral Reform Society very successful. All future elections should be electronic.
19. Communications
 - a. Website - Website needs to be professionalised. Agreed budget for MCI to undertake work to update website. MCI, Neil Turner and Mark MacGregor met in Edinburgh to clarify roles and issues as relates to website. NT formally thanked for his continued input to the website
20. AOB
 - a. Revalidation – RCP working to move this forward. Peter Drew leading on this. Re-licensing and recertification will conform to standards and be based on appraisal process. It needs to be a positive process. Specialty specific standards are needed, relates to 5 specialty questions needed by the 30/9/09. Laurie Solomon attended RCP meeting on RA's behalf and will continue to assist Peter drew with this piece of work, including an urgent survey of Exec members. JF noted that it was difficult to monitor all that consultants do.
 - b. RPV doing well NT will provide a report for next meeting
 - c. Need ideas to celebrate World Kidney Day
21. Next Meeting 14th January Birmingham Venue TBA