THE RENAL ASSOCIATION founded 1950

The Renal Association

Executive Meeting

Meeting minutes produced 10/10/10

Location: Crowne Plaza Hotel, Birmingham

Date 29th September 2010

Present - Lorraine Harper (LH), Charlie Tomson- chair (CT), Stuart Rodger (SR), Peter Mathieson (PM) in part, Kevin Harris (KH), Mary Mcgraw (MM), Martin Raftery (MR), Paul Harden (PH) in part, , Donal O'Donoghue (DO), Damian Fogarty (DF)Simon Davies (SD), Neil Turner (NT), Robert Mactier (RM) in part, Andrew Lewington (AL), Bruce Hendry (BH), Fiona Loud (FL) Kidney Alliance, Rob Lewis (RL), John Reynolds (JR). Sue Carr (SC), Magdi Yaqoob (MY) in part, Liz Lightstone (LL), Peter Choi (PC), Jonathan Barratt (JB), Andrew Fry (AF) SpR club, Jonathan Fox (JF), Graham Lipkin (GL), , Abraham Abraham (AA), Fiona Karet (FK).

1. Apologies –Mark Macgregor, Billy Nelson, Jane MacDonald, Albert Ong, Caroline Savage, Colin Baigent

2. Minutes of the previous meeting –
    a. Bruce Hendry and Fiona Loud were not present
    b. Accurate representation of meeting with amendment

3. Matters arising – none

4. President's report – attached in paper's submitted
    a. A number of the trustees are demitting from post, Kevin Harris – clinical vice president, Caroline Savage- academic vice president, Stuart Rodger honorary treasurer. CT thanked all for their hard work on behalf of the RA
    b. CT welcomed on behalf of the RA Peter Choi, Jonathan Barratt and Abraham Abraham as newly elected members of the executive.
    c. CT noted there was a review of the ACCEA system and that comments were needed for a response to the consultation document.
    d. Report accepted without major discussion

5. Treasurer's report –

a. RA income reduced due to reduced corporate income and loss of corporate partners, approximately £50K loss in income. This needs to be considered in future planning. Overall finances are healthy. The quarterly account is running to expected budget.

b. The final reconciliation of the joint BRS/RA meeting has not been received. Expect modest profit of £23K which will be split equally with BRS. The meeting cost the RA more than usual due to the 60th anniversary celebrations. SR wished to minute his wishes of success to JF in planning and agreeing 2011 budget.

c. CT asked what suggestions SR might have and others as to what should be done to bring costs down in line with corporate loss. SR responded that the RA had made £100K profit in 2009/10. BH noted that it was important not to let reserves get too large. SR responded that to maintain accounts in line with charity rules RA needed at moment to run modest surplus.

6. Clinical vice president report – Kevin Harris

a. KH will be succeeded by MR after this meeting

b. Clinical Guidelines Committee – report given in absence of Rob Mactier who was sitting on appeal panel for Renal Registry HR issue.

i. Rob was congratulated for gaining approval for the RA guidelines by NHS Evidence, having met all domain criteria.

ii. NICE will publish revised criteria for treatment of anaemia in CKD, this will differ from the RA guideline. MR noted there were too many guidelines. DD noted that NICE had to go through same process as RA to get NHS Evidence accreditation. Differences in guidelines reflect the poor quality of evidence available. RL noted that RA needs to be involved with NICE guidelines

iii. Quality standards document needs to be responded to by RA. Response needs to be positive and reflect how quality standards are useful.

iv. Working with KDIGO aiming to harmonise guidelines on AKI. Definitions for AKI needs to be operationalised this is being supported by DoH.

c. Meeting held on cheaper kidney care, important as finances tighten. Need to ensure no post-code commissioning of kidney services. CT noted that several clever ideas to reduce costs and improve care were discussed but will be challenging to implement. The government spending review is likely to make renal unit budgets more difficult. Essential that lead clinicians do not reduce quality. Quality standards likely to be become ever more important.

d. Renal Registry report – Damian Fogarty

i. Afzal Chaudhry is the new secretary of the RR committee. Committee needs to be invigorated Afzal will seek views on what the aims of the committee are and how to improve its working.

ii. DF stated that the new health secretary, Andrew Lansley, is more interested in outcomes in health rather than process. The RR needs to be cognizant of how it needs to change to develop this approach. Outcome data are more difficult to collect as demonstrated by the vascular audit where much less

data have been collected than expected. The annual report also needs to evolve. Feedback from nephrologists is required. SR asked who survey should go to. CT suggested that initially should be sent to CDs and committee, if sent to all nephrologists likely to get lower response rate.

iii. PM attended appeal hearing relating to the director of the RR. Dr Ansell was disputing terms of contract and appealing decision to terminate contract. PM reported appeal panel's decision was outstanding.

iv. Registry working was currently challenging. The RRMB were keen to resolve issues as it was damaging the RR. PM congratulated and thanked DF for all his efforts in the current difficulties.

e. CD Forum – Martin Raftery reported that the last CD forum was successful and next meeting March 2011.

7. BAPN report – Mary McGraw- the BAPN were finding the current financial situation to be a major challenge in finding funds to support ongoing work. They had been successful in acquiring some monies from KRUK. Networks were less well established than adult networks but had received some support to develop these with commissioner engagement. Less successful in finding funds to support audit.

8. NSF report Donal O'Donoghue report submitted – the new government is articulating a vision of the NHS with lots of changes and therefore opportunities to improve service.

   a. Outcomes framework – is a logical extension of the Darzi report. The CKD quality standard is important. Nephrologists need to think about how to make this work. Need to ensure a pragmatic rather than perfectionist approach is taken with quality indicators that map back onto details eg HD – vascular access, transport. No response from RA received on NHS White Paper consultation . The Kidney Alliance has formulated response. MR unsure of usefulness of response, decisions already made. PM feels response should be submitted accord from DO'D and BH. CT noted that there are lots of opportunities in white paper to focus on outcomes but this would be challenging to implement. Need constructive response. MR happy to pull response together but not keen to write. Timeline short, response needed by 6/10. FL felt might be better to submit a single response from the renal community. RL supportive of joint response. Alliance groups have better success rates in changing opinions. DF commented that it would be useful to move information collected to a patient centred approach but this had potential for increased bureaucracy. Success of nephrology is dependent on good information. CT concluded that a RA response was needed - comments to MR. DO'D stated that DoH are looking for clinician engagement but needs to be positive highlighting things achieved.

   b. A repeat of the patient transport survey will be performed

   c. Payment by results is moving ahead; 9 trusts are piloting the exercise. Mandatory tariff – for adult HD £166/episode, for CAPD £48/day this had not changed. Best practice tariff incentive for HD by fistula. If >85% access by fistula/graft funding will remain at above level but penalized if below this. Currently out for sense check. Home HD being left off tariff at moment, although cheaper than hospital HD current costings do not take account of set up costs. Further information is needed.

   d. Shared decision making and patient choice should aid progress on palliative care and pre-emptive transplant programmes. To move this forward need to collect good

quality data including outcome and patient experience. The RR puts the renal community in a good place to drive forward the agenda but needs to engage in discussions positively.

9. Vascular access – a minute's silence was held to note the death of Ali Bakran. Mr Bakran transplant and vascular surgeon died unexpectedly while on holiday, was a friend to the renal community.

10. Green Nephrology – CT noted that a very successful day was held at the green nephrology summit. A lot of work had been done by Andy Connor identifying money saving as well as green ideas. DO'D was praised for ambition in setting up the fellowship. Campaign for greener healthcare wish to appoint to a 6 month fellowship but lack £4K The executive was asked whether they would top up funding. It was suggested that this could be used to support development of Webex meetings for RA. SC pointed out that Leicester recently held very successful web conference using Webex. KH noted these can work well but need high quality kit to be successful. SR suggested piloting this on trustee teleconferences first. This was supported by BH. NT also agreed Webex use should be piloted as he felt current systems were not adequate to run a meeting as large as the executive using current systems. BH also noted that it was impossible for CT to champion green nephrology alone a further champion was required**. CT asked the executive whether they would support 1) £4K top up for campaign for greener healthcare to fund 6 month fellowship 2) pilot Webex meetings, 3) support need for additional green champion.** PM asked what could be achieved in a 6 month fellowship? CT noted that Andy Connor achieved a lot in 12 months, a paper is in press with Quarterly Journal of Medicine. The 6 month fellowship would allow a case to be built for funding from the Health Care Foundation to continue. DO'D commented that Andy Connor should be the RA champion given his success. He has left a huge legacy for on-going development. General support to co-opt Andy Connor onto executive as Green Champion. Executive felt that green issues needed to be made more mainstream. Concern from executive about funding the £4K top up. Unclear about the usefulness of such a short period of funding and lack of a formal proposal. MM was concerned that it set a precedent for topping up funds which may put RA at risk in times of austerity. **Action – CT to bring formal proposal to next meeting.**

11. No representatives from devolved nations and no submitted reports

12. Academic Vice President report – Bruce Hendry

    a. BH taken over from Caroline Savage as academic vice president. BH thanked Caroline for all her hard work developing the UK research agenda, supporting initiation and development with NT of UKKRC and chairing the renal specialty group for the CLRN. BH takes over from NT as chair of UKKRC. FK takes over from BH as chair of research committee. JR is chair of the scientist's working group.

    b. BH wishes to review working of the research and clinical trials committee due to the changing environment of research. In collaboration with chairs of the committees a report will be submitted to next executive committee. FK agreed and commented that a review was needed as what constituted research had expanded and how the RA responded to the research agenda of clinical and laboratory science was important. The renal community needs to exploit funding from NIHR, which dictates need to have benefit within 3-5 years for patients but laboratory research also needs to continue to be supported and also funding for blue sky projects is required.

c. Education and training committee - report submitted Sue Carr. BH noted that SC had achieved an enormous amount. SC noted that funding for the elearning project had been withdrawn. A resubmission with pared down request for funding had been sent back to DoH. Funding for IT to support elearning not cheap. SC asked executive whether there was a desire to support elearning. LL suggested that this was the sort of thing that pharma gave unrestricted educational grants for. She asked whether the RA would be comfortable approaching pharma for this sort of funding. NT felt issue not funding but content. AF suggested if password protected site would increase membership within SpR group. NT not keen on password protecting but suggested that a CPD certificate, only available to members, may increase use and membership. Suggested that ANC could be videotaped SC responded this had a large associated cost. FK suggested that this initiative should be driven by trainees but AF noted that it required support from supervisors and training committees. **Action SC to bring back proposal**

13. Appeal panel entered meeting – CT thanked all as independent elected members of the executive for their efforts on this difficult matter. MY responded by telling the executive it was his last meeting and he had greatly enjoyed his time with the executive and hoped his services could be of use in the future.

14. SAC – Simon Davies SAC met 28/9/10 unable to produce report in time for meeting

    a. National recruitment was successful. However nephrology has become the least competitive specialty with low numbers applying for jobs.

    b. 2010 curriculum is in place with eportfolio. Need to help trainers engage

    c. Quality management – SAC used to send teams to assess programmes, which was abandoned with introduction of PMetB. Now re-introduced assessment of programmes by SAC, which will have major role in driving quality of training programmes. CT asked if peer review of renal units could be piggy-backed onto this. SD thought it would be unlikely to be approved.

    d. Workforce planning – Since last meeting there has been more engagement from the postgraduate dean. Phil Mason has put in a lot of work to provide high quality workforce planning data to the centre for workforce intelligence. Nephrology has the worst trainee: consultant ratio with too few consultants. Need to reduce 11 training numbers across the country, 9 from London 2 from West Midlands. This may intrinsically disadvantage London. Previously numbers had been given to new trainees when others had OOPE instead of having LATS. NT thinks this is wrong as will discourage STCs from allowing trainees to have OOPE. SD noted that other deaneries will also have to reduce numbers. SD noted that if trainees undertake OOPE the number cannot be passed to another trainee but OOPE will still be encouraged. CT asked if the RA could do anything to promote the attractiveness of the specialty to trainees. Discussion centred around the need to understand why junior doctors are not interested in renal as a specialty: is it a lack of exposure, lack of private practice and/or excess anti-social hours. MM noted there was a similar issue in paediatrics and many factors were important. Increasing placements to increase exposure, increasing profile at careers fair and feeding into career websites all help to increase recruitment. MR felt it was important to have local champions who sold the specialty. The executive also felt it was important not to give out a message accepting current level of consultants as this number was still under-represented compared to other countries. 50% of trusts do not have a nephrologist.

Need to build stronger links with other specialties such as acute medicine to increase profile. AL noted that need to get renal curriculum into wider medical student course. NCEPOD report needs to be included in the undergraduate curriculum. The Medical Schools Council currently reviewing this issue. NT concerned that the ST1/2 experience is putting individuals off renal training. JB who is lead for CMT training in Leicester suggested that trainees were put off by registrar and consultant experience. DO'D suggested that this will change in next 5 years as move to consultant delivered service. **ACTION JB with representatives from SpR club to develop proposal to help increase recruitment to nephrology**

15. International Committee

    a. Albert Ong wished to work with the ISN to develop a joint fellowship. Would cost RA £8K/annum for 5 years. BH supportive. The RA needs to continue to support training in under developed countries. The UK even in this time of austerity was a wealthy country. FK noted that KRUK support ISN fellowships but all go to Sheffield. Need wider dissemination. MR asked what the funding would pay for as only have observer status. KH noted that there were difficulties getting GMC registration which limits usefulness of fellowship and may explain why all ISN fellows go to Sheffield where they have solved registration issue. The Royal College can support registration. PM noted that there are many ISN fellowships but few come to UK due to difficulties with registration. JB noted that someone needs to lead dealing with GMC on registration. **Action AO to develop formal proposal to take forward, include how to address GMC issues**

    b. Albert Ong suggested that an overseas membership category be developed charged at trainee rate. Approved by all. **Action – Albert to draft wording of membership category**

    c. Survey in September issue eNews of all overseas trainees.

16. Meetings

    a. Joint meeting with BRS –Birmingham 6-11th June programme committee moving forward with scientific programme. Hope to have complete end of October

    b. RA stand alone meeting with representation from Mayo clinic. Mayo clinic will bring 6-9 speakers RA cover hotel and registration costs only. Held at SAGE centre Newcastle 11-14th June

    c. Joint meeting with BTS 2013 13-15th March Bournemouth

    d. Cardio-renal forum with Dutch. Held at Royal College Physicians 15th October. 100 registrants target number was 200.

    e. Joint meeting with French society 10-12 Feb Paris. Advertised eNews programme complete. No response to request for sponsorship from RA corporate as yet.

    f. Joint meeting with dermatologists – no financial risk held Royal College Physicians 24/3/11.

    g. Proposed meeting joint with Diabetes group ABCD February 2012. Need to pull together planning committee

    h. Amgen approached to provide bursaries for annual RA meeting, awaiting response.

i. Principles of joint meetings with BRS – draft document only circulated to trustees not executive in error. CT defined principles as stated in draft document to the executive. LL noted that the meetings with the BRS were of lower scientific content and very expensive compared to other meetings. RL disagreed stating that an expanded programme delivered something for everyone and that the principle of a joint meeting was a good one. PM noted that attendance at joint meetings was excellent. There was a philosophical argument about whether to have joint or stand alone meetings. LH noted that last year's September executive meeting robust discussion had supported the principle of joint meetings with BRS. CT commented that all sessions at the 2010 meeting were well attended. PM did feel that the RA should not sign up to 10% inflation costs but was in favour of joint meetings. JF stated the budget for 2011 meeting would be same as 2010. MR felt that inflation should not be built into agreement on finances and only inflation costs of RPI should be accepted. Meetings with BRS should be every 3 years and after 2011 need tighter rein on finances. All agreed with principle.

17. SpR club – Andrew Fry –funding is a problem having lost major sponsor. It was felt that being affiliated with RA would be beneficial in attracting future funding. Recent meeting well received, attended by CT. STCs needed to encourage attendance at the SpR club. Website address to change soon.

18. Rare disease committee proposal – proposal submitted to executive to support formation of new rare disease committee. MM supports the formation of such a committee but wishes to see stronger wording around governance of disease specific working groups so that projects are of high quality and properly and realistically costed. The committee would report to the executive as other RA committees. KRUK and British Kidney Patients Association are committed to providing £500K to develop the initiative. No written confirmation of this yet. NT had convinced other partners of the opportunity to improve outcomes for patients through these groups. Majority of money needs to go into development of infrastructure. A chair needs to be appointed with approval through normal processes of RA. Expressions of interest call will be placed in eNews. Most work will be done virtually with one face to face meeting at annual meeting.

19. EuroPD meeting – not discussed extensively as SD had to leave. Need to know success of previous meetings before taking on any financial risk **Action CT to discuss with SD**

20. Proposal for women in nephrology committee – proposal submitted in papers. General support for proposal but wish to change to one face to face and one virtual meeting. RA executive approved £1K for meeting/annum for 2 years and it was not necessary to specify what this would be spent on. Support will be reviewed after 2 years. Concern that the name may put people off, PH suggested change to equal opportunities in nephrology – advertise support less than full time working. Expression of interest call in eNews.

21. NPSA – Paul Rylance previously alerted nephrology community on NPSA issues. This is a single point of failure if Paul can't do it and need to ensure continuity . Patient safety issues much wider than just device issues as previously reported by Paul. This service should come under remit of clinical services committee. **Action Graham Lipkin to take forward NPSA issues as chair of clinical services committee.**

22. Renal scientist working party report will be submitted to next meeting

23. Vote of thanks – CT gave vote of thanks to PM who did not step down as President until the extraordinary general meeting in June when CT's election was formally ratified. CT also thanked all demitting trustees for their hard work for the RA.

24. Next meeting 14th January