Acute Kidney Injury Programme Board

Meeting Minutes

4th April 2014

Time: 11.00 - 14.30

Venue: The Studio, Birmingham.

Chair: Richard Fluck (RF)

Minuted by: Teresa Wallace (TW)

Attendees:

Caroline Ashley (CA)	Ron Cullen (RC)	Kathryn Griffith (KG)	Nesta Hawker (NH)	Natasha McIntyre (NM)	Lorraine Oldridge (LO)	Joan Russell (JR)	Nick Selby (NS)
Michael Wise (MW)	Karen Thomas (KT)	Fergus Caskey (FC)	Martyn Diaper (MD)				

Attendees via teleconference:

Jonathon Hope (JHP)	Catriona Shaw (CS)	Mike Jones (MJ)	Robert Hill (RH)			

Apologies:

David Cousins (DC)	Pete Murphy (PM)	David Wheeler (DW)	Dane Wiig (DWI)	Julie Harries (JHR)	Chris Laing (CL)	David Milford (DM)
Charlie Tomson (CT)	Tom Blakeman (TB)	Carol Peden (CP)	Fiona Loud (FL)	Chas Newstead (CN)	Caroline Lecko (CL)	Nitin Kolhe (NK)
Ron Daniels (RD)						

Action points:

Action	Who	Complete
Amend PID and associated appendices	**KT**	
Update Risk Registry	**KT**	
Provide feedback to NCEPOD re confusion over their name	**JR**	
Arrange 1/4ly meetings for Chair's, Co-Chairs and Sponsors	**TW**	

Provide any suggestions on programme strapline to KT	**ALL**	
Communication strategy send any comments to KT	**ALL**	
Circulate draft Patient Involvement Policy to Board	**KT**	
Circulate revised Patient Safety Alert to Detection and Measurement Workstreams	**JR**	
Revise wording on draft Patient Safety Alert	**JR/RF**	
Amend Terms of Reference and include a case study	**KT**	
Provide comments on plain English Terms of Reference to KT	**ALL**	
Circulate Pathfinder Information to Board	**NH**	
Invite Board Members to Implementation Scoping Meetings	**KT/NH**	
Circulate information on Experienced Based Design	**KT/MD**	
Develop a patient story around the algorithm	**RH/NS**	
Connect Fast Campaign to Education Workstream	**LO**	
Invite a pharmaceutical representative to the group		

Minutes:

Agenda Item	Notes
A	**Introductions and Apologies** Apologies were noted and introductions made. New members were welcomed onto the Board.
B	**Matters Arising** The minutes were reviewed and it was agreed that they were an accurate recollection of meeting. Any outstanding actions are included in the actions above. It was agreed to defer the scope for international linkages at this point.
C	**Project Initiation Document** The document was talked through and attention was drawn to the appendices and its contents and asked for comments. It was commented that NICE is now known as the National Institute for Care Effectiveness and not clinical excellence. There were concerns regarding duplication of work. The Programme Board's key role is linkage between the workstreams and the alignment of the programme as a whole to avoid duplication of effort. There was a discussion regarding the formatting of the document which needs tidying up. In dependencies there is reference to limited funding for a third year. It was agreed that we should add this to the Acute Kidney Injury (AKI) Risk Register. The question was asked about the aims and objectives and is there a plan for delivery across primary care as well? It was stated that the whole Programme Board is across primary and secondary care. The question was asked if it is linked to the Coronary

	Artery Disease (CAD) audit? It was replied it isn't but we are trying to structure a master patient index. It was also stated that the Renal Registry is also trying to link to the CAD audit. Just because AKI is linked with the Renal Registry is doesn't mean it doesn't cover secondary care. It was queried re the questions aims and links to documents and feels that there is some variation in the main aim to delivery and implement tools or to prevent AKI. Which is the main aim and can we ensure consistency around all documents. Revisions will take place. The programme plan was discussed which after the event will be populated and subject to change and the key milestones which goes through 13/16. Interface 2.9 was also discussed which needs clarification to incorporate primary and secondary care. It should be transparent across the board. It was agreed that this was implicit in the reference to the Health and Social Care system.
D	**Risk Register** The document had been circulated but not all workstreams had completed it so this needs to be flagged as an action. The risk register was questioned and suggested that a risk matrix is put together which is easy to see and that he has templates that could be used for this and would send them to The Programme Manager. Reference was made to slide 7 which was the risk register and it was felt that this was already in the format required.
E	**Programme Budget** An overview at a glance was given showing starting points from 2013 what has been spent with a spend forecast for 2014 and going into 2015. Grant allocations that will go out in 2nd quarter and costs for launch event in 2nd quarter was explained and all expenditure is on track and if we carry on with the projections for 2014 then there will be an under spend at the end of 2014 which may mean we can go into an additional year. It was stated that the payments to patients is seen as being very important to take the strategy forward. It was mentioned that the draft patient involvement policy which is being on has been sent to our lay representatives for comment. This has been developed on the basis of the United Kingdom Renal Registry (UKRR) Patient Council documentation and policies. It was agreed to circulate the draft document to all Board members. The question was asked how do patients representatives stand with that on workstreams? It was confirmed that patients involved in workstreams will be eligible to claim payments and expenses under this policy. It was asked whether the budget includes the cost of the launch event. The reply

	stated that we are underspent for quarter 1 but is accounted for in quarter 2.
F	**Driver Diagram** It was stated that the original driver diagram focused on individual workstreams. It was felt at the last Board meeting that it was too workstream specific and did not reflect the objectives of the programme so that on feedback from the last meeting the best way to present primary drivers, secondary drivers which gives scope to the workstreams to reflect our driver diagram and that the workstreams should be conscious of what is developed and does it support the driver diagram which should be the model to take forward. It was stated that it is more clear and logical. Everyone agreed to the revised driver diagram.
G	**Update of Workstreams** **Risk** In the absence of the Chair/Co-chair for the Risk workstream the report was fed back to the Programme Board by another member. It was stated that they had met twice face to face and have a conference call in another 10 days**.** They have a developed membership and will be enhanced by another Co. Chair. Scope ready for next week, they have a Care Home representative and Nursing representation. They have a patient attending the launch and it is hoped to get that patient further involved in the workstream. A representative from community pharmacy had also been identified to join this workstream. They are asking people to identify areas of good practice. Document being pulled together for that having a smaller group. **Education** It was stated that they have held two meetings and have a plan for further meeting engaging with Public Health and Health Education England. Scope document has been shared and they are developing a campaign applying the learning from the Fast (stroke campaign) and getting across the message of modifying the risk. Creating a repository and developing a system which either endorses or gives a standard badge for tools and products to say that they meet the standard of the national AKI Programme. Workstream is suggesting that we develop an AKI leadership programme working with the academy? A member of the workstream confirmed that she had connections if needed with the Academy. It was asked about the fast campaign and mentioned the lead of the fast campaign it was agreed that introductions would be made. It was asked how the campaign is going recruiting patient representation and was advised that the worksteam has a patient representative. **Detection** It was stated that this workstream have had two face to face meetings plus a conference call. The first meeting focused on group structure i.e. Laboratory

	Information Management System (LIMS), bio chemists, structure for the workstream including a core and several sub groups which have all been recruited to. The workstream has a patient representative. Four sub groups have been devised– algorithm, software implementation group and it was stated that the software implementation group is to focus on laboratories which should be trouble shooting putting the algorithm into hospitals. The Expert Reference Group, who have practical experience for e-alerts, has been established to get specific people into the work and provide an opportunity to share their practice at a scientific day on the 19th June. It was also stated that the challenge is to define the focus of that meeting on the algorithm. The fourth group is a best practice group for e-alerts and how to do this in real life what is the message and focus on standardisation as much as possible. A second meeting took place to develop the scope document and bring the core group together. Algorithm on National Health Service (NHS) website. Link with measurement worksteam is becoming important and members from other worksteams will be invited to join. Focusing of e-alert to ensure they are aligned and sustained. Planned phase approach in scope It was queried the timescale to being able to deal with LIMS supplier and getting algorithm embedded which is a key step in the programme. It was stated that LIMS will have something that would be confirmed by July 2014 to develop software which will be ready to install by two major suppliers – this will cover 80% of laboratories. It was agreed that it would be pertinent to have a date when this should be mandated for Trusts. The resistance and challenge re words such as algorithm was questioned. Language needs to be simplified and a patient's story could help to do this in relation to blood tests. It was stated that patients will have right to access blood results which gives an important tool to patients and carers. Experienced Based Design was mentioned regarding the co-design with patients and (EBD) – steps with pathway which needs to be patient facing. It was agreed but questioned area re chronic disease. A member of the workstream agreed to provide links to this work and the Programme Manager will circulate. It was also suggested that it is part of the education workstream if it could be developed – what patients should ask for not just a blood test but other elements It was stated that creating a result that a patient has AKI against it supporting clinical teams and it needs to be a tool which can be used. It was asked if there ever will be an aim for creatinine to be online so that patients can access on line. There were questions around the baseline and how it is created. It was stated that it's trying to join everything up and that it is important to deal with the technical aspects of the algorithm and the results and then address the educational aspects. It will be important to wrap the support and education around the mechanics of the

	test results It was stated that an element of the worksteam scope is also which patients get tested and at what time It's about educating patients. Discussion around should there be a base line with, access to results wherever the tests are done. It was asked what are our steps along the road to get to our aim? It was also asked what information is through the laboratory test on line which patients can have their blood tests explained. It was stated it is a difficult line to tread between patients and General Practitioners (GP) to meet an understanding. **Intervention** The workstream have met by conference call and have agreed the scope and are now looking at this work by considering the following :- What do you do around recovery? What do you do when diagnosed? What do you do if you have a patient with AKI? Some interventions that have a small impact in primary care develop some sort of tool that patients can be easily identified i.e. drugs they take etc. Information re drug holidays etc. Tool for those admitted to hospital re a scoring system. Care bundle on how to look after AKI patients. Advice re AKI network – directing pathways. AKI recovering care plan which is related to GP's a communications pathway and care plan. **Implementation** Looked at base line data from Bristol and Derby. Agreed to draft a Commissioning for Quality and Innovation (CQUIN) and develop a risk assessment tool. Met with the Advancing Quality Alliance (AQUA) which has developed a care bundle and tools – they are going to be part of the pathfinder group and hope to have indicators of AKI in their bundle by the autumn. Scope completed. Pathfinder - three interfaces, primary, secondary, tertiary. A member of the workstream designed an AKI recovery. Two meetings with commissioners 19th May and 11th June. Details of these meetings to be sent to all Board members. Can this target the NHS Bettercare Fund process. 3 levels from the Clinical Commissioning Group (CCG) and AKI is graded as a level 1 and possibly apportioned a grant. Negotiations where the thresholds lie. Important to remember that the difference between the intervention and the implementation workstreams is that the intervention workstream thinks of the what and the implementation workstream thinks of the how. Powerpoint presentation to be circulated to all Board members. **Measurement**

	Met with patient and carer representatives on group – email correspondence with detection workstream re algorithm. We would like to measure the benchmark. Prepared application for National Information Governance Board which gives permission to collect data without patient consent re AKI and primary and secondary care. Have set up a mail box to receive files from LIMS etc. when AKI patients are flagged.
H	**AKI Launch Event** The launch event was discussed in that the design of the event had been configured around the workstreams. A wide range of stakeholders are attending to deal with the interface issues talked about today.
I	**Terms of Reference – plain English** It was stated that at the last board meeting it was recommended that the Terms of Reference for the Programme Board were turned into a plain English document. It was asked if everyone had viewed the document? If not can board members and in particular our lay representatives read this document and give feedback to the Programme Manager. It was mentioned that an injury applied generally brings up trauma bit it seems that we need to specify that injury in that it is not associated to trauma and actually trying to put that in plain English would be a benefit to us. This was discussed amongst the Board and it was said that to say it's not traumatic and an injury in the clinical sense it is. It was stated that we need to take these comments and form a heading paragraph and put it into context so if anyone has some words we could use please give feedback to the Programme Manager. It was asked if we should include a case study like we have used at the beginning of Richard's welcome in the joining instructions for the launch event. It was replied that we can design something for consultation to fit in where? If anyone has any specific comments on the document and if so please forward them to the Programme Manager. It was asked if the national confidential enquiry is actually confidential or out to the public? It was discussed loading the plain English Terms of Reference onto the website when it is ready and it was agreed to feedback comments to National Confidential Enquiry into Patient Outcome and Death (NCPOD) re the confusion around their title.
J	**E-Alert paper/Algorithm Update** It was stated that they were asked to produce a paper for the AKI Programme Board and not the general public/lay people to use. It was asked that even if you haven't read it please try to use it as an anchor. It was stated that it is much clearer and more understandable than previous documents.

	Draft Patient Safety Alert It was explained the alerting system and what they are. There are three stages – 1) a warning letting NHS know that there is an incident. Be aware this could happen, 2) provision of resources that are available and what can help advising NHS how to use and change practice and 3) mandated. Alerts sent out by the Consumer Advisory Board (CABS) managed by NHS England – so if an alert sent out a reply to say that the action if completed. Can be monitored by trust regulators to see if users have replied or not. Adopting a systematic and single source of providing AKI results is important to trusts, patients and a board as going forward. A single definition. Alerts – need to be simple. Algorithm should be a stage 3 alert for the NHS to put it in the system. It was asked how do we get this fundamental element in place? Should we use the words or phrase e-alerts. We are asking for something in the pathology system for managing. We are asking them to implement a test rather than an e-alert. It was stated that what is not specified is that e-alerts – results that are fed into general practice. We need the right to have a phase in transmission results. Laboratory level for work in practice – baseline definition – what is the normal for an individual. Alerting laboratories to AKI – and we should be able to pull off this information to see who has AKI. **Algorithm – data** Actions: algorithm to be imbedded into LIMS systems and organisations to send information in a particular format to a particular place. It was asked is it possible to put on top of document on the left a clear message what the ask is as in paragraph 3? It was replied that the format and layout is descriptive. It was stated this is purely about alerts in the LIMS systems so some trusts have alerts in place already so do we get them to change or to use the algorithm in another system. It was asked what impact would there be on an organisation if we asked them to use the LIMS. It was stated we have to be careful not to introduce risk into organisations that are using a system at the moment but to use the algorithm running in the background so that we can still pull off the information. It was asked so the trust should carry on with the systems they have but install the LIMS algorithm which may lead to redundancy. The reply was yes we are asking them to conform to a national standard so we can compare apples to apples. It's dependent of their transitions pathway. Alerting is the way the result is managed but we need consistency in the measurement of an AKI individual in a care setting. It was questioned how organisations are going to react? Need to work on words re standardisation. It was stated that we would not drag organisations back but they do need to use the algorithm at some point.

	Discussion of crossover of messages re the part of the implementation workstream as opposed to the education workstream. Stage 1 what are the interventions for that and how do you educate to avoid that. The document was seen as part of a process by a member of a workstream but she was interested to know how many hospitals offer systems to offer e-alerts. It was stated circa 15 centres but it is not the majority. It was mentioned that organisations not doing it at all but we need to 1) standardise and 2) quality improvement. It was asked how quickly will the e-alert go out? It was replied that this should be the beginning of May or send it out giving a date when it is achievable. It was stated that there are many trusts who can run the algorithm within their system. It doesn't matter which system as long as you comply with the algorithm. Or we ask that they comply with LIMS and discontinue with any other. Will we be causing risk asking for the change and cause the laboratories too much grief in implementing the change. It was stated that we do need to stress that this is about standardisation but we need to advise the questions that may be received on how they deal with this new system. It should be confirmed that this happens at pathology level within an information system. A member of the Board is to look at this – a help sheet behind this could be helpful. It was asked what it costs in terms of money. It was replied that there will be a cost but maybe pressure needs to be put on LIMS but it is a ball park figure of ½ million.
K	**Proposed quarterly review meetings for Sponsors and Chairs.** The question was asked should we have a regular ¼ly meeting between workstream chairs and would this be considered valuable? This was agreed that it would be helpful. These are to be set up.
K	**Communications Strategy** It was asked what should we call ourselves for people to bond with us, what can we use as a strapline. One suggestion offered was Keeping kidneys happy. It was agreed that any suggestions should be sent through to the Programme Manager. Also issue of workstream chairs are they happy with their title. Any comments should be fedback to the Programme Manager. The communication strategy was mentioned, comments were asked for. It was also confirmed that we are currently working on the specification for the stand alone website. At the moment we have a page on the NHS England website. A suggestion was made regarding have a discussion forum as part of the website.
L	**Any Other Business** It was decided that we would do two versions of the minutes. One detailed version for reference for the Board and one concise version to be made publically available.