Yorkshire & the Humber
Acute Kidney Injury Patient Care Initiative (AKIPCI)

9 October 2015, 1400-1700

Hatfeild Hall, Normanton Golf Club, Aberford Road, Wakefield, WF3 4JP

Notes

1. Welcome, Introductions, Overview & Discussion

Dr John Stoves, Y&H Renal SCN Clinical Lead & Consultant Nephrologist, BTHFT

Dr Stoves welcomed everyone to the meeting and gave an especial welcome to the team from Barnsley who are new attendees at the forum. Dr Stoves also welcomed the speakers and conducted introductions.

The group were notified that all presentations from the forum are available on the Yorkshire and the Humber SCN website accessible here:
http://www.yhscn.nhs.uk/cardiovascular/Renal/renal-documents-and-links.php

2. AKI Alerting to Primary Care - Planning the Roll Out

Dr Ian Stott, Consultant Nephrologist, Doncaster and Bassetlaw NHS Foundation Trust

Dr Stott advised that he was attending the forum today to talk about AKI in Primary Care. Dr Stott advised that sadly none of his GP colleagues were able to attend, as they faced significant pressures in practice.

Please see the presentation slides for further information.

Comments, Questions and Actions:

Question: Do GPs see different guidance to the guidance within the Trust?
Answer: Yes. We have two sets of advice. A mobile app for junior doctors in hospital and different advice tailored for GPs.

Question: The warning colours on the ICE system are they just for GPs?
Answer: No they are also in place in the hospital, which allows clinicians to pull up a ward of patients and see at a glance how many patients have AKI.

Question: Is the system colouring bespoke to your ICE system?
Answer: No, it has been used in Luton and Dunstable and it appears to be a function within ICE so is not bespoke. Doncaster are using the colours for AKI but other people can also use the colours to highlight other clinical issues.

Question: We have had issues with the company that maintain ICE in our Trust, as they do not keep to their KPIs. Did you have to pay extra to have the colour function turned on?
Answer: We haven't experienced any issues with this and as far as I am aware we did not have to pay extra to have the colour function. However, I will double check this with our IT lead Pete Taylor.

Question: What is your population size?
Answer: 400,000

Question: Are GPs seeing this information now and what is the impact?
Answer: GPs are seeing the information now and in terms of impact we have not yet received any feedback. This system will now provide us with a cohort of patients where we can look into their AKI in Primary Care. Numbers are not going to be enormous for Primary Care but for patients it will be really important, as potentially preventable cases will be highlighted and will save lives. We have not yet seen any massive changes in referral patterns but we suspect there will be an incremental change.

Comment: Dr Lewington stated that the risk work stream in NHS England is monitoring impact on GPs and ensuring information and education is targeting appropriately, as there are concerns about overwhelming GPs who are already busy in practice.

Question: With regards to the discharge summary from the AKI CQUIN our Trust received a letter from a GP stating that GMC guidance states those who request the tests should follow them up and not pass the tests to general practice. How will you approach this with GPs in Doncaster and Bassetlaw?
Answer: We have not encountered this issue as yet but we do need to look at AKI discharges to primary care to ensure no additional burden is being placed on GP colleagues.

Question: For patients with hyperkalaemia do you get that reported more than AKI?
Answer: In Doncaster and Bassetlaw the GP Out of Hours service is based in A&E so we can test for hyperkalaemia. We get issues with potassium, which would not concern me in a chronic patient but would in an AKI patient. Problem patients are usually known to us when it comes to hyperkalaemia.

Comment: Regarding follow on blood tests, especially for heart failure patients, there are often many blood tests and follow up bone scans required, which can be challenging. The GP systems have many recalls and alerts and GPs can often get recall fatigue.

Comment: Regarding the AKI alerts in Calderdale, the system picks up quite a few patients whose baseline creatinine is wrong.
Reply: We also experience issues, the baselining is flawed. The national algorithm is one of the better ones to use but they all create problems. It is very difficult and one of our labs is looking at a different algorithm. However, you can't escape from the fact that you can't teach a computer to do everything, all results still need to be reviewed by a clinician.

Comment: We also have issues with the algorithm as it reflects issues with 12 monthly patients and we would recommend changing this to 14 monthly, which would improve things for the labs.
Reply: I agree the algorithm needs reviewing and, as with the first iteration, it will require further clinical input.

3. Prescribing and Acute Kidney Injury – Experiences in Primary Care

Su Wood, Independent Prescriber, Prescribing Support Services & University of Leeds

Su Wood provided the forum with an overview of her work on AKI risk and prescribing for older adults.

Please see the presentation slides for more information.

Comments, Questions and Answers:

Comment: Your work highlights the gaps in knowledge around drugs. There is knowledge around nephrotoxic drugs but education is required around other drugs. This is a great piece of work and once published will help to raise awareness.

Question: The term nephrotoxic do you have any views on it?
Answer: I think that sometimes the word makes people think they are the only drugs that affect kidneys but there are so many other drugs that impact on kidneys also. Clearer

messages need to be developed to identify all drugs that affect kidneys to avoid confusion over the word nephrotoxic.

Question: Regarding the C&G and MDRD definitions, we use MDRD because it is easier to collect and view than C&G. How do you think we could make collection of MDRD easier?
Answer: It can be collected because the data is in the various systems. But the focus should just be on our very elderly patients and we are looking at how we can make this easier to view. The PHD panel for this piece of work felt that from a medicines safety point of view a strategy needs to be developed to encourage people to use the C&G for elderly patients. Electronic records will facilitate this but the definition relies on a body weight measurement and so we need to ensure this is captured within systems before we can progress further.

Question: MDRD generally underestimates eGFR in the elderly but is it better that CKD-EPI?
Answer: CKD-EPI produces higher GFR and lower CKD estimates, particularly among 18–59 year age groups with MDRD estimated GFRs of 45–59 mL/min/1.73m2 (Stage 3A). However, at ages >70 years there is very little difference between the equations, and among the very elderly, CKD-EPI may actually increase CKD prevalence estimates. (Ref: Carter et al Q J Med doi:10.1093/qjmed/hcr077). Also CKD-EPI is now recommended in NICE CG 182 (CKD guidelines).

4. Identification and Management of Acute Kidney Injury in the Community

Dr Alastair Bradley, GP, Tramways Medical Centre and Academic Training Fellow, University of Sheffield

Dr Bradley advised the forum that his presentation would provide a practical look at work undertaken on AKI in Primary Care and how this ties in to the work undertaken in Secondary Care.

Please see the presentation slides for more information.

Comments, Questions and Actions:

Comment: It is great to see GPs talking about AKI. We are seeing quicker referrals to Secondary Care for patients with AKI and this is really good work.

Question: With regards to QS1 from NICE: educating patients how do you think this will be integrated into Primary Care?
Answer: In general practice we have a care programme approach and give patients a half hour appointment to go through medications and educational work with patients. It doesn't work for everyone but we could also look at patient education groups for those with CKD and we also need to target those who have been admitted and discharged with an AKI. We do need to work on patient education and care programming is a good approach.

Question: What education would you provide for practice nurses on AKI?
Reply: We would suggest they look at the guidance to check how often they should monitor patients and when they should escalate to a GP. Nurse practitioners could also help to identify risks by looking at kidney function and checking against drugs. Nurses need to link in and work on monitoring and drug checks.

Question: What do GPs think about the AKI CQUIN? Will it make a difference?
Reply: For GPs we need to learn from AKI follow ups where we could have made a difference in primary care and from these we can learn how to prevent cases in future.

Question: Is AKI covered in GP mandatory learning?
Answer: It is not in our mandatory training but education is important. We need the CCG to apply the appropriate pressure to include AKI on educational sessions and protected learning time. In our practice we have our own learning initiatives and would include AKI in this.

5. Tackling Acute Kidney Injury - Health Foundation Multi-Centre Quality Improvement Project

Natalie Jackson, Health Informatics Senior Project Manager, Academic Health Science Network

Natalie Jackson provided an overview of the Health Foundation Multi-Centre Quality Improvement Project: Tackling AKI.

Please see the presentation slides for more information.

Comments, Questions and Actions:

Question: If a patient has gone home but has been alerted how do they get followed up?
Answer: The bundle is about instant feedback on the wards. So should be followed up straight away.

Question: We have a care bundle with 10 elements and people find it hard to do all 10 and have said 6 would be better. Is the project indicating an optimum number of care actions?
Answer: For the project in Bradford we are using 8 elements but there is feedback to indicate that fewer actions would be preferable.

Comment: Dr Stoves stated that not all elements of the care bundle can be completed at a single time point. The purpose of the bundle is to ensure that people understand care is ongoing rather than one-off completion of the bundle. It is about education and instilling deeper knowledge.

Comment: Dr Lewington stated that it would be great to have a standard care bundle for junior doctors across the region and recommended that members of the forum check out the Think Kidneys website for further information: https://www.thinkkidneys.nhs.uk/

6. Development of a Y&H Nurse Acute Kidney Injury Forum

Andrea Fox, Lecturer, University of Sheffield and Louise Wild, AKI Nurse Educator, Sheffield Teaching Hospitals NHS Foundation Trust

Andrea Fox and Louise Wild provided the forum with an update on the Nurse AKI forum and work being undertaken to involve nursing staff in education and awareness of AKI. Andrea Fox advised that a webpage is being established to include information on AKI and Chronic Kidney Disease (CKD).

Andrea Fox and Louise Wild advised the forum that the intention is to provide an annual face to face AKI event for nurses and online updates in between. To help progress this a region wide steering group needs to be established to organise the agenda and engage regional stakeholders. Andrea Fox and Louise Wild enquired if anyone on the forum would be interested in joining the steering group or could provide contacts for interested parties.

Dr Lewington stated that he would support regional meetings for nurses and suggested working with Nicky Lamb, Renal Nurse Educator from Leeds.

ACTION: Please contact Andrea Fox (andrea.fox@sheffield.ac.uk) or Louise Wild (Louise.Wild@sth.nhs.uk) for more information/to take part in the AKI Nurses Steering Group.

Please see the Powtoon video for more information.

Comments, Questions and Answers:

Comment: Dr Lewington stated that the work being undertaken in Sheffield is reaching many people and is receiving excellent feedback.

Question: Can the video Powtoon work be shared?

Answer: Yes. It will be shared in the slides or contact Andrea Fox for more information.

7. **Acute Kidney Injury and Renal Developments at Calderdale and Huddersfield NHS Foundation Trust: Including the Challenges of Implementing the AKI CQUIN**

Dr Mansoor Ali, Consultant Renal Physician, Calderdale and Huddersfield NHS Foundation Trust

Dr Ali provided the forum with an overview of developments in renal services at Calderdale and Huddersfield NHS Foundation Trust and the challenges they have faced implementing the AKI CQUIN.

Please see the presentation slides for more details.

Comments, Questions and Answers:

Question: Interestingly the CQUIN data from CHFT is almost exactly the same as the Barnsley CQUIN data; this is reassuring to see. Have you changed your discharge summary?
Answer: No, we are experiencing lots of resistance to changing the discharge summary and are discussing this further with senior clinicians at the Trust.

8. **Summary and Next Steps**

Dr John Stoves, Y&H Renal SCN Clinical Lead & Consultant Nephrologist, BTHFT and Dr Andy Lewington, Consultant Nephrologist, LTHT.

Dr Stoves and Dr Lewington thanked all the speakers for their excellent presentations.

Dr Lewington advised the forum that as part of the national work around AKI a new risk study was being developed. The risk study will focus on developing a risk calculator for primary and secondary care. The initial study will start with data collection on acute units and analysis will follow to see if risk scores can be worked out. Dr Lewington will be contacting Trusts across the region to invite participation in this study.

Dr Stoves advised the forum that Dr Lobaz, Wayne Robson and colleagues from Barnsley Hospital had produced a series of guidelines and fluid balance charts. Wayne Robson provided the forum with a brief overview of work to date in Barnsley and stated that documentation would be shared with the forum.

Dr Stoves and Dr Lewington discussed the development of a Yorkshire and the Humber patient pathway and transfer criteria. The patient pathway and transfer criteria have been agreed by all Trusts in West Yorkshire but there is the potential to improve patient experience and safety if a pathway was agreed across the region. Trainee doctors rotate from Trust to Trust and having a single pathway and transfer criteria would provide a robust process for junior doctors to follow.

ACTION: Sarah Boul to resend the patient pathway and transfer criteria for comment and discussion.

Dr Stoves enquired of the forum if there were any particular topics that could feature on the next forum. The following suggestions were made: an update from Calderdale and Huddersfield on the development of their renal services; an update from Dr Lewington on NHS England tools such as patient leaflets and risk calculator and an AKI metrics update from Fergus Caskey at the Renal Registry.

Dr Stoves and Dr Lewington stated that the next meeting will be held in Spring 2016 and a specific date will be confirmed in due course.

Any further comments should be given to Rebecca Campbell, Quality Improvement Manager, Yorkshire & the Humber Strategic Clinical Network on 0113 8253448 or rebecca.campbell6@nhs.net

Copies of the presentations are available on the Yorkshire and the Humber SCN website: http://www.yhscn.nhs.uk/cardiovascular/Renal/renal-documents-and-links.php

If you have any difficulties accessing the presentations please contact Sarah Boul: sarah.boul@nhs.net.