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

Friday 14th March 2014

Cedar Court Hotel, Denby Dale Rd, Calder Grove, Wakefield, WF4 3QZ

Feedback Report

1. Background

April 1st 2013 saw the beginning of the new Y&H Strategic Clinical Networks (SCN) & Senate, bringing together the former Cardiac, Stroke and Renal Networks across Yorkshire and the Humber into one cardiovascular disease (CVD) area, also encompassing Diabetes. The pre-existing network area for the Renal Network has been carried forward into the new CVD Strategic Clinical Network structure.

The SCN Core team hosted a series of disease specific "Stakeholder" events. The purpose of these events was to support existing Networks, to engage with new stakeholders and to allow priority areas to be discussed and agreed. The CVD (Renal) Stakeholder event was held on 30th September 2013.

Priorities, previously identified through consultation, are aligned with the nationally agreed priorities

The agreed priority areas for Renal across Yorkshire and the Humber are:

i. Acute Kidney Injury (AKI)
ii. Transplantation
iii. Variation (primary and secondary care)
iv. Previous work areas that required continuation (local determination) and cross-cutting issues

2. Introduction

There was agreement at the CVD (Renal) Stakeholder event that AKI is not purely an issue for nephrology and therefore requires a collaborative approach across primary and secondary care. It was generally felt appropriate that the SCN should coordinate work on AKI. A number of actions were identified, these are categorised as:

1. Baseline Data
2. Share Best Practice
3. Education
4. Engaging CCGs & Primary Care
5. Pathway
6. E-Alerts
7. Medicine Management & Pharmacy
8. Communication

It was proposed that implementation should be through sub/ working groups within the SCN and supported by a Y&H AKI Forum. Work on AKI should involve all key

stakeholders, including CCGs, DGHs, Nephrologists, Critical Care, Primary Care & Community, Care Homes, ambulance services.

A list of the key actions is attached in **Appendix A.**

3. Feedback from AKIPCI Event

The programme for the event is attached as **Appendix B.**

3.1 Welcome and Introduction

Dr John Stoves, Y&H Renal SCN Clinical Lead & Consultant Nephrologist, Bradford Teaching Hospitals FT, opened the meeting and gave an overview of the profile for Nephrology within a regional CVD Network:

- Promote current and future regional priorities
- Strengthen links with primary care, Clinical Commissioning Groups (CCGs) and sub-regional Collaborative Commissioning Groups – SYCOM, NEYCOM, 10CC
- Liaise with renal units, National Clinical Director, other SCN renal leads, specialty leads (cardiac, diabetes, stroke), Clinical Reference Group (CRG) leads
- Involve patients and patient representatives
- Summarise care quality indicators – Public Health England, Quality Outcome Framework, Renal Registry/HES, Service Specifications (best practice, current initiatives, barriers to change)
- Structure - Renal Strategy Group, Renal Clinical Expert Group, Local Implementation Groups, CVD Strategy Groups, MDT regional forums (AKI, transplant, home therapies and shared care, conservative care)
- Support from the Clinical Senate and Allied Health Sciences Network (AHSN) – implementing NICE guidance in primary care

He re-iterated that AKI is a key renal priority for Yorkshire & the Humber and detailed numerous other areas included on the work programme but highlighted four specifics in relation to AKI:

- Primary Care capacity, quality and expertise
- E-consultation
- Education (undergraduate, postgraduate, multidisciplinary)
- Sharing of patient electronic medical records between primary and secondary care

<u>3.2 The Regional Position - Updates and Summary of Regional Position</u>

There followed presentations from 12 of the 14 providers across Yorkshire and the Humber region giving an update on AKI successes, challenges and barriers, and vision and next steps.

1. **Airedale** - *Rachel Binks, Nurse Consultant, Airedale NHS Trust*
2. **Barnsley** – *Dr Subhash Rana, Consultant in Acute Medicine, Barnsley NHS FT*
3. **Bradford** – *Dr Russell Roberts, Clinical Lead & Consultant Nephrologist, Bradford Teaching Hospitals NHS FT*
4. **Calderdale & Huddersfield** – *Anita Hill, Pharmacist, Calderdale & Huddersfield NHS FT*
5. **Chesterfield** – *Dr Tarek Sobka, Consultant Nephrologist, Chesterfield NHS FT*
6. **Doncaster & Bassetlaw** – *Dr Ian Stott, Clinical Lead & Consultant Nephrologist, Doncaster & Bassetlaw Hospitals NHS FT*
7. **Harrogate & District** - *Dr David Border, Clinical Lead & Consultant Nephrologist, York Teaching Hospital NHS FT*

8. **Hull & East Yorkshire –** *Dr Muhammad Imran, Consultant Nephrologist, Hull & E Yorkshire NHS FT*
9. **Leeds –** *Dr Andy Lewington, Consultant Nephrologist, Leeds Teaching Hospitals*
10. **Mid Yorkshire –** *Dr Paul Clarke, Consultant Nephrologist, Mid Yorks NHS Trust*
11. **Sheffield** – *Dr Bisher Kawar, Consultant Nephrologist, Sheffield Teaching Hospitals NHS FT*
12. **York** – *Dr David Border, Clinical Lead & Consultant Nephrologist, York Teaching Hospital NHS FT*

No presentations were available from Rotherham and North Lincolnshire & Goole.

Dr Andy Lewington, Consultant Nephrologist, LTHT, gave a summary of these presentations, identifying a number of common themes.

- Accurate and full coding of admissions
- AKI care bundle
- AKI relevant clerking proformas
- Audits, local and national
- E-alerts
- Education
- Engaging with CCGs on AKI in the community
- Identifying champions
- IT
- Management pathway/referral guide
- Recognition of AKI
- Raising the profile of AKI
- 7-day working / staffing and recruitment

Some providers consider these are successes where other providers consider that there are challenges and barriers in these areas. Some providers listed some of these areas as part of their vision and next steps for AKI. It is apparent that there is great variation across providers within Yorkshire & the Humber in the implementation of a formal AKI pathway which, in itself, provides an opportunity for shared learning.

3.3 AKI in primary care – challenges and possible solutions

Dr Sarah Harding, Leeds GP, gave a presentation which focussed on the need to engage more of primary care and what GPs have to do to help the AKI pathway. She proposed that, looking at the top 2% of vulnerable patients (104 patients in an average GP practice of 5200), and using a risk stratification tool, risk factors (hypertension, diabetes, heart failure, CKD and age) could be identified. Data were presented detailing the number of risk factors identified for those vulnerable patients.

Dr Harding summarised that:

- kidneys are a marker of health
- vulnerability is a marker of renal risk
- GPs need to be able to quickly identify AKI risk
- good discharge information is required

and that the challenge was for GPs to learn is what to do when they identify risk of AKI.

Dr John Connolly, Bradford GP, gave a presentation on ‘Sick Day Advice to prevent AKI’ and a Sick Day Algorithm for acute or chronic kidney disease. He demonstrated a draft protocol in SystmOne to remind GPs to suspend medication to prevent acute-on-chronic kidney disease. The protocol aims to help clinicians intervene early when patients likely to be at risk of acute or chronic kidney disease present with acute illness.

The presentation generated a lot of discussion around the use of this tool, with some useful feedback for suggested improvements.

3.4 Electronic Alerts and the National AKI Algorithm: how should these be implemented?

Dr Mike Bosomworth, Clinical Sciences Lead for Blood Sciences & Specialist Labs Medicine, LTHT, gave a presentation on Electronic Alerts and the National AKI Algorithm.

The algorithm for generating E-Alerts for Acute Kidney injury is based on serum creatinine changes with time. The potential AKI stage can be transmitted electronically to a clinical system but that in itself is probably not an e-alert. There are issues with clinical systems within both primary and secondary care with regard to the way in which the e-alert is generated, where the e-alerts should be sent and when (in hours / out of hours / weekends / Bank Holidays). There are different questions and different answers with different secondary care trusts and CCGs. Additionally, the AKI stage should mean the same thing across the UK.

The NHS England Clinical Director for Renal Medicine, Dr Richard Fluck, has agreed that the AKI detection algorithm should become the NHS England official AKI detection algorithm. However, there have been some communication and technical issues about getting it onto the NHS England website.

3.5 Implementation of e-NEWS: impact on hospital mortality and potential for reducing morbidity associated with AKI

Dr Donald Richardson, Consultant Nephrologist, York, was unable to attend the meeting but Dr David Border, also a Consultant Nephrologist in York, gave Dr Richardson’s presentation.

The presentation looked at:

- Risk assessment and prevention of AKI using track and trigger systems (early warning scores) for routine monitoring and scoring
- Mortality review, observations, electronic entry of observations, deteriorating patient escalation policy
- Education and training of nurses
- In-hospital summary of hospital level mortality indicators and outcomes and the intervention and prevention of the deteriorating patient.
- Length of stay
- Crash calls
- Specialty specific workload, including AKI and renal
- Attendances, admissions and discharges

The track and trigger system gives the opportunity to:

- Reduce mortality
- Reduce LOS
- Reduce crash calls
- Increase (appropriate) workload for medical specialties and outreach and ICU

3.6 Discussion: Y&H AKI Toolkit – 5 Impact Actions

Round table discussions took place to identify 5 Impact Actions for AKI. Each group was asked to feedback one Impact Action identified during discussion.

These were identified as follows:

1. As a group, record numbers and patient details and use for audit and outcome measures (as an audit or research tool).
2. Integrated regional primary and secondary care interface, to be devolved to CCGs for roll-out.
3. CQUiN or Serious Untoward Incident as a mechanism to test out the pathway or algorithm.
4. Education as a priority – share what we're doing, not re-invent. Education of patients (multi-lingual) - work together as a group, or set up a small working group, to develop patient education.
5. Importance of AKI recording on discharge letters – the person discharging the patient is not always the person who treated AKI.

There were other useful comments and suggestions made including:

- use of correct coding,
- a standard regional paragraph to be included to alert to risk,
- development of a CQUiN (as per Heart Failure or COPD), and
- the opportunity, as a Group, to influence the Clinical Reference Group.

Several groups submitted their discussion notes and flipchart paper at the end of the event. These can be found in **Appendix C**.

Information was shared about the website www.aki.org.uk where there are links to organisations, guidance, recommendations, pathways, e-learning modules on various sites.

3.7 Next Steps

Dr Stoves gave details of the planned AKI Forum to be held on Monday 16th June at the Park Plaza Hotel, Leeds and outlined the programme. There will be invited speakers, update and progress reports from across the region for primary and secondary care and breakout sessions with discussions and workshops.

It is proposed that working groups are set up for agreed working areas.

A summary report of this meeting will be circulated.

4. Evaluation

The Evaluation forms have been analysed and a brief summary produced. This can be found in **Appendix D**.

APPENDIX A

LIST OF KEY ACTIONS / AKI AREAS TO EXPLORE
from Group Discussions at the Renal Stakeholder Event on 30.09.13

1. **Baseline Data**
   - Review existing data for Y&H
   - Audit
   - Referrals
   - Coding
   - Current work underway in all Trusts

2. **Share best practice**
   - Derby work
   - London AKI pathway
   - West Yorkshire & Leeds work
   - Protocols & Guidelines
   - Develop a regional AKI Forum
   - Link to audit – 'name & shame' and learn from the best

3. **Education**
   - Create a clear message re AKI – simple definition; headlines
   - Raise awareness – posters, leaflets, marketing – 12,000 lives saved
   - Develop programme of education – primary care & general practice
   - Support development of in-house rolling programme of education for providers – rotate around relevant departments
   - Patient Education & information – information sheets
   - Link to regional AKI Forum & sharing best practice

4. **Engaging CCGs & Primary Care**
   - Develop levers and incentives for CCGs
   - Present the case to CCGs in terms of quality, patient safety, productivity
   - Develop a clear message for primary care
   - Develop GP Champions for the region
   - Develop advice & guidance
   - Address AKI in the Community – this hasn't been done to date

5. **Pathway**
   - To have a gold standard pathway across AKI pathway, such as WY Pathway.
   - All Trusts to sign up to an AKI Network Pathway
   - Develop at a sub-regional level
   - Review NCEPOD Pathway of Care
   - Involve YAS in pathway work

6. **E-Alerts**
   - Trusts to commence measurement, ahead of national template
   - Alerts to be mandated

- Liaise on development of lab algorithm
- Link alerts to primary care (creatinine levels - triggers)

7. Medicine Management & Pharmacy

- Further develop guidance on which medication increases risk of AKI
- Links within the community and primary care - Communication from secondary care to GP on drug management to be improved.

8. Communication

- Develop dashboard
- Links with ODN (critical care)
- Post AKI episode: medical report – indicate to primary care
- CCG Engagement & Communication - encourage CCGs to raise profile of AKI in the Trusts who don’t have renal services; Highlight Quality & Productivity agenda
- Present to CCG GP Forums
- Access to timely specialist advice – liaison with specialist nurses
- Website development
- Intranet services – information available

9. Networks

- Develop Y&H AKI Forum
- Create Sub-group / working group with SCN
- Include CCGs, DGH, Nephrologists, Critical Care, Primary Care & Community, Care Homes, YAS

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

Friday 14th March 2014 1330-1700 (*lunch available from 1pm*)

Cedar Court Hotel, Denby Dale Rd, Calder Grove, Wakefield, WF4 3QZ

A G E N D A

1330 Welcome & Introductions
Dr John Stoves, Y&H Renal SCN Clinical Lead & Consultant Nephrologist, BTHFT

1400 The Regional Position - Updates
Five minute (1-slide) presentations from each Provider covering:
- Successes
- Challenges & Barriers
- Vision & Next Steps

13. **Airedale** - *Rachel Binks*
14. **Barnsley** – *tbn*
15. **Bradford** – *Dr Russell Roberts*
16. **Calderdale & Huddersfield** – *Anita Hill*
17. **Chesterfield** – *Dr Tarek Sobka*
18. **Doncaster & Bassetlaw** – *Dr Ian Stott*
19. **Harrogate & District** - *Dr David Border*
20. **Hull & East Yorkshire –** *Dr Muhammad Imran*
21. **Leeds –** *Dr Andy Lewington*
22. **Mid Yorkshire –** *Dr Paul Clarke*
23. **North Lincolnshire & Goole** - *tbn*
24. **Rotherham** - *tbn*
25. **Sheffield** – *Dr Bisher Kawar*
26. **York** – *Dr David Border*

1500 Summary of Regional Position
Dr Andy Lewington, Consultant Nephrologist, LTHT

1515 AKI in primary care – challenges and possible solutions
Dr John Connolly, GP Bradford, & Dr Sarah Harding, GP Leeds

1530 Electronic Alerts and the National AKI Algorithm: how should these be implemented?
Mike Bosomworth, Clinical Sciences Lead for Blood Sciences & Specialist Labs Medicine, LTHT

1545 Implementation of e-NEWS: impact on hospital mortality and potential for reducing morbidity associated with AKI
Dr Donald Richardson, Consultant Nephrologist, York

1600 Discussion: Y&H AKI Toolkit – 5 Impact Actions

1645 Next Steps
Dr John Stoves, Y&H Renal SCN Clinical Lead & Consultant Nephrologist, BTHFT

1700 Close of meeting

AKI PCI Working Group – Notes from table discussions

Table 1

1. AKI Alert
    - Primary care bundle
    - Work aware systems

2. Hospital Alert
    - audit feedback

3. Concurrent Rx
    - EPx
    - Primary care follow-up
    - Primary + secondary care
        - medicine management
        - pharmacy alert

4. Follow-up criteria

5. AKI in deteriorating patient
    - AKI
    - Critical care
    - Education package regionally

6. Patient Sick Day Advice

Table 2

1. Need integrated primary and secondary care
    - Regional approach
    - Actively engage all CCGs across the region

2. Education tool
    - Standard approach to teaching & training
    - Mandatory training across the whole region in secondary care

3. Commissioners to look at protected learning time for all allied staff

4. IT
    - Encourage each trust to have a statutory IT plan of action for e-alert
    - NEWS – clinical response

5. Clear commissioned pathway to specialist renal care/ beds with specified timeframes for transfer

Summary Flipchart (JS)

1. Communication with primary care especially longitudinal metrics post discharge from secondary care from e-alert reports

2. Primary / Secondary Collaboration re interfacing work / CVD forum

3. Quality Assurance of AKI Patient Pathway (transfer to renal centre)

4. Education
    - Undergraduate / post graduate
    - Mandatory training
    - Linked to e-prompts
    - Website collection
    - Patient-facing

Yorkshire & the Humber Acute Kidney Injury Patient Care Initiative: 14.03.14
Cedar Court Hotel, Wakefield – EVALUATION

RESPONSES (11 OUT OF 31 ATTENDEES)

1. How would you rate the content of the sessions?

Session Title	Excellent	Good	Average	Fair	Poor	No Response
Welcome & Introduction – Dr John Stoves	1	8	1			1
The Regional Position - Updates – Provider representatives		8	2			1
Summary of the Regional Position – Dr Andy Lewington	2	8	1			
AKI in Primary Care – challenges and possible solutions – Dr Sarah Harding & Dr John Connolly	4	7				
Electronic Alerts and the National AKI Algorithm: how should these be implemented? – Mike Bosomworth	2	8	1			
Implementation of E-News: impact on hospital mortality and potential for reducing morbidity associated with AKI – Dr Dave Border (for Dr Donald Richardson)	4	5				2
Discussion: Y&H AKI Toolkit – 5 Impact Actions	3	5	1			2
Next Steps –Dr John Stoves	1	2	1			7

Please comment:

- Great opportunity to find out what other Trusts are doing which impacts on patient safety and AKI.
- Regional Position updates too long.

2. Overall how would you rate the methods used?

Tick as applicable	Excellent	Good	Average	Fair	Poor	No Response
Presentations	1	10				
Opportunity for Questions & Answers	3	7				1
Networking Opportunities	3	6	1	1		

Please comment:

- Workshops and discussion helps with sharing and building.

	Excellent	Good	Average	Fair	Poor	No Response
3. How would you rate the overall organisation of the Forum?	3	7				1

4. How would you rate the venue and facilities?

Tick as applicable	Excellent	Good	Average	Fair	Poor	Not Applicable	No Response
Venue	2	7	1				1
Catering	1	6	3				1
Access	5	5					1
Car parking	6	4					1

5. Would you attend another Forum?	Definitely	Probably	Unsure	Probably Not	Definitely Not	No Response
	8	2				1

Please comment:

- Interested in sharing good practice.
- Need to network and keep updated.
- As part of my portfolio of work for CCGs.

6. Do you have any suggestions for the content and format of the next Forum?

- Follow-up of impact actions.
- Discussion/presentation on NICE guidelines and recommendations – how each Trust is implementing.

7. Would you be interested in supporting organisation of a future forum meeting?	No Response	No	Yes	Email Address:
	1	2	8	*Contact details provided*

8. About you

Role:	Admin	Carer	Doctor	Nurse	Patient	Other	No Response
	1		4	1		3	2

Organisation:	CCG	CSU	Hospital	NHS England	Patient	Other	No Response
	2		4	1		3	1

Area:			
	Airedale	Doncaster	North Yorks & Humber
	Calderdale	NHS England	Wakefield
	Chesterfield	North Kirklees	York
	(No response -2)		

9. Any other comments:
No other comments received.