To: Dr Marisa Mason Chief Executive NCEPOD 4-8 Maple Street London W1T 5HD	*Wellington House* *133 - 155 Waterloo Road* *London* *SE1 8UG* *Tel: (020) 7972 1392* *Fax: (020) 7972 4063*

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Dear Marisa,

'Adding Insult to Injury' – NCEPOD Report on Acute Kidney Injury

I am writing to you further to the above report to outline a series of actions that the Department of Health, working with a range of NHS, professional, and patients' organisations, will oversee at the national level to improve the prevention, detection and management of acute kidney injury (acute renal failure).

'Adding Insult to Injury' presented a stark picture of systematic failings, often in basic care, and made a number of helpful recommendations addressed primarily to clinical and medical directors, and to those bodies responsible for overseeing medical training. Particularly striking were the findings that 20% of post-admission cases of AKI were predictable and avoidable, and that 50% of AKI care received by the patients in the study was considered to be less than good. We were grateful to NCEPOD for bringing these serious failings to the fore and clearly highlighting the pressing need for improvements to be made.

Predictable and avoidable AKI should never occur. Whereas the NHS has made great strides since publication of the National Service Framework (NSF) for Renal Services[1] in detecting and managing chronic kidney disease – and in fact is leading the world in managing increasing numbers of patients in primary care – it is clear that much less progress has been made in relation to the NSF quality requirements to minimise the incidence, consequences and

[1] A report highlighting progress to date in implementing the NSF, including examples of good practice, was published on 14 December 2009. "Achieving Excellence in Kidney Care: Delivering the National Service Framework for Renal Services" is available from www.dh.gov.uk/publications

complications of acute kidney injury. We are disappointed that some hospitals are failing to follow the quality requirements in National Institute for Clinical Excellence (NICE) guidelines and in the NSF, and this needs to change.

It is evident from the findings presented in *'Adding Insult to Injury'* that many of the failings in relation to AKI are pervasive issues in acute patient care, rather than being matters for the renal specialty alone, and this is further evidenced both by preceding NCEPOD reports (such as the 2005-published *'An Acute Problem'*) and the recently published *Deaths in Acute Hospitals: Caring to the End?* Concerns range from poor basic care planning, and failure to recognise acute illness, to organisational deficiencies that compound these problems. Tackling AKI therefore requires that we take a broad view but also provides an opportunity to address wider issues of patient care.

Subsequent to publication of the Renal NSF, the Department of Health established action learning sets in Lancashire and South Cumbria, and in West London in 2006/07 focussed on identifying what would be needed to ensure a high quality service could be offered to patients with acute kidney injury being cared for within a District General Hospital Setting. The use of scoring systems, referral protocols and strengthening links with critical care networks were identified as key to the successful management of AKI. The outputs of the action learning sets were published and disseminated and are available online.[2]

An Acute Kidney Injury Care Initiative (AKICI) conference, convened by NHS Kidney Care, was held on 18 March 2009 with representatives from many specialist communities to work collaboratively on a range of key issues, including how to work towards a consensus definition for AKI, as lack of a uniformly accepted definition and suitably sensitive biomarkers has hindered service improvements.

Since publication of *'Adding Insult to Injury'*, we have been actively engaged with a wide range of stakeholders to identify the action that needs to be taken, by when and by whom, including through an extensive workshop held on 19 October 2009. In addition, I have presented the findings of the report to a meeting of the Strategic Health Authority Medical Directors, and have discussed the scope for local action in face-to-face meetings with several individual SHAs. Sir Bruce Keogh, the NHS Medical Director, has taken a special interest in ensuring that services improve and has written to the Care Quality Commission with a view to closer co-ordination of actions in response to this and to future NCEPOD reports.

Preliminary analysis of hospital episodes data on inpatient activity shows a significant growth in the number of bed days categorised under the heading of acute renal failure between 2007/08 and 2008/09, and although this is subject to further analysis, it may point to an increase in the awareness and

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[2] *Driving Service Improvement through Patient Focus: Report of the Phase II Renal Action Learning Sets,* www.dh.gov.uk/publications

recognition of AKI. If borne out by further analysis, this would represent a positive first step.

Going forward, we will set up a 'delivery board' comprising those organisations that have a key role to play in delivering specific actions and in driving service improvements and will bring together members of the renal specialty with those responsible for general acute care. This board will be up and running early in 2010.
The primary deliverables at the national level will be:

- tools to support routine risk assessment for AKI on all emergency admissions, and to support decision making on recognition of AKI, with the Society for Acute Medicine taking a leading role
- ensuring the integration of checks for AKI with the use of early warning scoring and response systems, including working with the Royal College of Physicians
- a drive on improvements in access to ultrasound scanning and nephrostomy through the work of the National Ultrasound Steering Group (a sub-group of the National Imaging Board)
- bringing together kidney care and critical care networks to facilitate agreement of care pathways, specialist support and transfer protocols
- surveying the capacity of specialist care to inform commissioning decisions (recognising that there has been a 54.4% increase in the number of critical care beds in England between January 2000 and July 2009)
- ensuring that AKI and relevant competencies[3] are adequately represented in the curricula for multi-professional training, including for nurses, via the responsible training boards and Royal Colleges, and through the Department of Health-funded e-learning project for junior doctors
- Piloting data collection/ audit through extension of the Vascular Society of Great Britain and Ireland's National Vascular Database, funded through NHS Kidney Care.

The above is not intended to replace the need for local action, which will be essential to achieving change. This plan of action has been devised to support the NHS in taking action itself, building on existing workstreams where possible.

Looking toward the medium term, a proposal for a clinical guideline relating to the diagnosis and management up to the point of dialysis for acute kidney injury is currently being considered through NICE's topic selection process. Assuming this topic is chosen for development as a full clinical guidelines, this is likely to address many of the issues raised in the NCEPOD report.

[3] A framework of competencies that support implementation of clinical guideline 50 (*Acutely ill patients in hospital*) was published in March 2009. *Competencies for Recognising and Responding to Acutely Ill Patients in Hospital* is available in electronic format only, from www.dh.gov.uk/publications

As well as the actions outlined above, we are keeping in close touch with a range of related initiatives, which have a bearing on dealing with AKI. These include moves internationally by professional groups to reach agreement on a definition of AKI; a variety of means to help prevent avoidable AKI or to flag the risks of it occurring in certain patient groups; and measures to improve diagnostic methods and alerts for clinicians when an adverse test result occurs.

We intend that all of the above will contribute to a rapid and marked improvement in the care of patients at risk of AKI and thereby lead to a significant difference in patient safety and outcomes. In that case I believe that *'Adding Insult to Injury'* will have played a major part in spurring the NHS to raise its performance in this area.

I am copying this letter to the NHS Chief Executive, David Nicholson, the Chief Medical Officer, Sir Liam Donaldson, the Chief Nursing Officer, Dame Christine Beasley, and to the NHS Medical Director, Sir Bruce Keogh.

Dr Donal O'Donoghue
National Clinical Director for Kidney Care