NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report

Indicator area: Acute kidney injury

Consultation period: 8 February – 8 March 2017

Date of Indicator Advisory Committee meeting: 6 June 2017

Contents

Summary of indicators included in the consultation 2
GP1: Register 3
GP2: Return of renal function 5
GP3: Medication review – people that have had an episode of AKI 6
GP4: Information and subsequent prevention 8
Appendix A: Consultation comments 10
Appendix B: Equality impact assessment 27

Summary of indicators included in the consultation

ID	Indicator	Evidence source
GP1	The practice establishes and maintains a register of all people aged 18 years and over with an episode of AKI in the preceding 12 months.	Acute kidney injury (2014) NICE QS76.
GP2	The percentage of people with an episode of AKI in the preceding 12 months who have had a serum creatinine, eGFR and either an ACR or PCR recorded within 3 months of the record of diagnosis.	Measurement at 3 months is supported by recommendations in the Kidney disease: improving global outcomes (KDIGO) Clinical practice guideline for acute kidney injury (2012) recommendation 2.3.4. Acute kidney injury: prevention, detection and management (2013) NICE guideline CG169 recommendations 1.3.1, 1.3.2, 1.4.1 and 1.4.2.
GP3	The percentage of people aged 18 years and over with an episode of AKI in the preceding 12 months who have had a medication review within 1 month of the record of diagnosis	Acute kidney injury (2014) NICE QS76 statement 1
GP4	The percentage of people with an episode of AKI in the preceding 12 months who have been given written information about AKI within 1 month of the record of diagnosis.	Acute kidney injury: prevention, detection and management (2013) NICE guideline CG169 recommendations, 1.6.2 and 1.6.3

GP1: Register

The practice establishes and maintains a register of all people aged 18 years and over with an episode of AKI in the preceding 12 months.

Rationale

Acute kidney injury is increasingly being seen in primary care in people without any acute illness. People with previous episodes of AKI are at higher risk of experiencing it again. Having a register of people with previous episodes of AKI will allow healthcare professionals to more easily monitor and treat people.

Summary of consultation comments

Stakeholders supported the inclusion of this indicator, but also reported barriers to achieving it. A number of stakeholders referenced issues with hospitals not providing accurate and timely information on episodes of AKI to general practice. A lack of algorithms specific to primary care and IT limitations preventing the use of automated alert systems for identifying people who have had AKI were also identified.

Stakeholders felt that there is confusion over the appropriate clinical codes for AKI, acute renal failure and AKI stage. Issues around awareness of the condition and inconsistent coding within general practice was flagged as something that would need to be considered if the register was to be implemented. The existence of a register for both AKI and CKD was also identified as potentially causing some confusion. There were comments that indicators for CKD surveillance are needed and AKI should be considered within those instead.

Stakeholders raised concerns over potential resource issues for GPs if they were required to start coding all cases of AKI and carrying out the related follow up. Possible consequences for patients, such as anxiety caused by insufficient information being provided on diagnosis and potential issues a diagnosis could have with travel insurance and financial services were also flagged. There were comments on whether this indicator gives a patient-centred outcome and is supported by an evidence base.

Specific question/s included at consultation

- Is aged 18 years and over a suitable population group?

Stakeholder comments on the population were mixed, with some thinking the population is suitable, and a stakeholder suggesting that equations to

calculate eGFR are only valid for this age group. Other suggestions were including all ages, and that the register should focus on older people who are more at risk.

Considerations for the advisory committee

The committee is asked to consider:

- if it is feasible to identify a set of clinical codes for general practice to use to develop and maintain a practice register
- the reliance on timely and accurate discharge information from hospitals on the feasibility of an AKI register
- whether the establishment of a register would have a significant impact on GP workload
- if the register should focus on a specific age group.

GP2: Return of renal function

The percentage of people with an episode of AKI in the preceding 12 months who have had a serum creatinine, eGFR and either an ACR or PCR recorded within 3 months of the record of diagnosis

Rationale

Reviewing renal function 3 months after a diagnosis of AKI can determine disease resolution, new episodes of AKI or worsening of pre-existing CKD. Where the disease is not resolved appropriate care can then be provided.

Summary of consultation comments

A number of stakeholder flagged the same issues as noted for GP1 in relation to information sharing and inconsistent coding. Stakeholders suggested implementing reminders on primary care IT systems that flag the need for these follow up tests.

Comments were raised about the potential resource implications for GPs having to recall a large number of patients for testing and also the increase in laboratory costs. Some stakeholders felt that in some cases these follow up tests should be done in secondary care rather than primary care if someone has had a long stay in hospital. The evidence base for this indicator was also questioned.

Specific question/s included at consultation

Is the time frame of 3 months feasible for this population?

- Some stakeholders felt that it is feasible, whilst others felt more frequent monitoring is needed for later stage AKI to check for deterioration. A one month timeframe was suggested to align with the other indicators.

Considerations for the advisory committee

The committee is asked to consider:

- if the 3 month timeframe is suitable
- if this is likely to have significant resource implications for laboratories and GP practices to provide and record this information
- whether this should be a secondary care indicator rather than general practice.

GP3: Medication review – people that have had an episode of AKI

The percentage of people aged 18 years and over with an episode of AKI in the preceding 12 months who have had a medication review within 1 month of the record of diagnosis

Rationale

Medication review in primary care is especially important if the episode of AKI occurs in secondary care. It can ensure that post discharge, any necessary medications have been restarted or discontinued as indicated and the patient knows how to minimise the risks of a future episode. Patients can be advised on the use and potential risks associated with over the counter NSAIDs.

Summary of consultation comments

Stakeholders felt that this is an important indicator, but barriers to achieving it were raised. Workload of general practice was highlighted as a potential barrier, as were delays by hospitals in sharing discharge information with primary care.

Some stakeholders felt that this is not a primary care indicator as the medication review should happen at the time of diagnosis, with information about any changes to medication being communicated to the general practice. It was also queried whether this indicator gives a patient-centred outcome and is supported by an evidence base.

One stakeholder asked that references to ACE inhibitors and ARBs as 'potentially nephrotoxic' are removed from supplementary documentation for this indicator.

Specific question/s included at consultation

Is the time frame of 1 month feasible in this population?

Some stakeholders felt that the timeframe is feasible, whereas others stated that 1 month is too soon and further review should happen after blood tests are carried out, therefore after 3 months.

Considerations for the advisory committee

The committee is asked to consider:

- if the 1 month timeframe is suitable

- if delayed provision of discharge information by hospitals will prevent achievement
- if this is likely to have significant resource implications for GP practices to carry out the medication reviews
- whether this should be a secondary care indicator rather than general practice.

GP4: Information and subsequent prevention

The percentage of people with an episode of AKI in the preceding 12 months who have been given written information about AKI within 1 month of the record of diagnosis.

Rationale

Some episodes of AKI may be preventable through patient education, via written patient information about the causes of AKI, how people can self-manage their condition to reduce the risk of a future episode e.g. maintaining hydration, and when to seek help.

Summary of consultation comments

Stakeholders raised barriers to implementing this indicator, including issues communicating discharge information between secondary and primary care, so GPs aren't always aware of the diagnosis, and possible resource issues for GPs recalling patients to provide them with information. A number of stakeholders felt that this should be a CCG indicator as information about the condition should be given by the clinician who made the diagnosis. As most cases are diagnosed and managed in secondary care, the provision of information should happen then rather than when someone is discharged.

Stakeholders made suggestions on the written information, saying it needs to be standardised, easy to understand and available in different languages, but that this might be difficult.

Specific question/s included at consultation

- Is the time frame of 1 month feasible in this population?

  Stakeholders felt that information should be provided at the time of diagnosis and that this will primarily happen in secondary care. In this situation it would be feasible to achieve this indicator. Potential issues with the timely receipt of discharge letters in primary care was raised as a barrier to implementing this in time.

Considerations for the advisory committee

The committee is asked to consider:

- if the 1 month timeframe is suitable
- if delayed provision of discharge information by hospitals will prevent achievement
- if this is likely to have significant resource implications on GP practices to call patients in and provide them with information
- whether this should be a secondary care indicator rather than general practice.

Appendix A: Consultation comments

ID	Proforma question no.	Stakeholder organisation	Comment
Question 1.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP1	1.1	British Medical Association	We do not believe that the information contained in discharge letters from hospitals regarding whether the patient has had a clinically significant episode of AKI is always accurate, In particular chronic age-related changes can be interpreted as acute events.
GP1	1.1	Individual comment	No
GP1	1.1	NHS Medway Clinical Commissioning Group	Requires practices to code AKI Read. Code for acute kidney injury is a synonym for Acute Renal Failure K04 which is not clinically the same. Unless codes for stage of AKI are used will potentially cause confusion K04C, K04D, K04E
GP1	1.1	The Royal College of General Practitioners	• A wide range of acceptable codes should be available • Good hospital communication regarding diagnosis of acute kidney injury is required • GPs need to receive timely discharge information • It will require the functionality to define baseline renal function and appropriate software to define a 50% fall • There is a lack of algorithms that have been derived from and used within primary care populations (not secondary care populations which have different predictive values to primary care populations) showing patient benefit
GP1	1.1	Royal College of Nursing	Practices may not be aware of all episodes of AKI (such as those occurring whilst in secondary care). There might also be confusion about coding for different stages of AKI.

GP1	1.1	Royal College of Pathologists	Alert systems are still very primitive in many places and limitations in IT inhibit any automated system to be ideally put in place. There has also been resistance in many areas by renal clinical teams given the significant undertaking at having to police the identification of AKI by the laboratory services.
GP1	1.1	West Midlands Renal Network	Yes – in discussion with GPs this would be a significant administrative burden to manually enter all AKIs, at a time when they are under very considerable pressure.
Question 1.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP1	1.2	British Medical Association	If diagnoses are inaccurate, patients can be affected in non-medical ways. In the older age group often affected travel insurance is a particular problem, if denied it can adversely affect quality of life in retirement and maintaining of family relationships. In younger people access to normal financial services could be affected.
GP1	1.2	Individual comment - doctor	No
GP1	1.2	The Royal College of General Practitioners	• Usually the diagnosis is made during a hospital admission and appears on the discharge summary. The secondary care provider does not usually inform the GP practice what information the patient has received about their diagnosis • Many patients now have access to their electronic letter and if this diagnosis appears on their record with no explanation it is likely to cause anxiety and extra phone calls to the GP practice. Part of the diagnostic pathway should include the provision of information to the patient at the time of diagnosis to minimise these issues • The current resource and manpower status of general practice may not be in a position to take on the development and maintenance of new indicator registers

GP1	1.2	Royal College of Nursing	There might be potential confusion with establishment of both an AKI and CKD Register. It is likely that Practices will still maintain a CKD Register (following recent QOF indicators).
GP1	1.2	Royal College of Pathologists	Increased testing for biochemistry labs as more focus is placed on these patients. While clinically beneficial to the patients, this may lead to budgetary issues for laboratories at a time when they are being scrutinised and penalised for spend.
GP1	1.2	West Midlands Renal Network	No
Question 1.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP1	1.3	Individual comment - doctor	No
GP1	1.3	The Royal College of General Practitioners	No
GP1	1.3	Royal College of Nursing	None Specific.
GP1	1.3	Royal College of Pathologists	Nothing specific but the usual bias and differentials that exist for these patient sub-groups are likely to persist for these conditions.
GP1	1.3	West Midlands Renal Network	No
Question 1.4: Do you have any general comments on this indicator?			

GP1	1.4	British Kidney Patient Association	We think that GP1, GP2 and GP3 are all positive proposals, which will assist kidney patients. The removal of some Chronic Kidney Disease QoF points previously may make it more difficult to recognise and advise people with a confirmed CKD diagnosis who are at risk of AKI. Only a CKD register is now required rather than a record of ACR, ACR treatment and blood pressure, which we regret. The recent CKD audit by HQIP demonstrated that ACR checks for people at risk are not being carried out to many patients at risk http://www.hqip.org.uk/resources/national-chronic-kidney-disease-audit-national-report-part-1/ Under the indicator rationale you state "A medication review should be also completed after each episode of AKI to determine the optimal management of any pre-existing conditions such as hypotension." This is just as likely to be 'hypertension'.
GP1	1.4	Individual comment - doctor	In order to ensure focus on high risk groups eg elderly and co-morbidity would a different age range be considered?
GP1	1.4	NHS Medway Clinical Commissioning Group	AKI mostly hospital diagnosed

GP1	1.4	The Royal College of General Practitioners	• This is an important patient safety indicator as the coded diagnosis will lead to appropriate prescribing alerts for drugs such as NSAIDs • In cases where AKI occurs in people who already have impaired renal function, it seems misleading to treat it as a separate entity. The worry is that by concentrating on the acute (AKI) aspects will distract people from good surveillance of the longer term and more important chronic condition. If one were to consider it as 'acute on chronic renal impairment', then the important indicators would relate to the surveillance of the underlying CKD • There does not appear to be a consensus that there will be a significant benefit to patients by keeping this register and there doesn't seem to be an evidence base supporting it • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to implementation
GP1	1.4	Royal College of Nursing	Whilst this indicator is welcomed, the lack of an indicator for CKD could potentially be detrimental to identifying people with progressive CKD, especially if there is no indicator for ACR measurement.
GP1	1.4	West Midlands Renal Network	It is a worthwhile indicator. NICE / NHS England should have discussions with providers of primary care IT systems about automated registration of AKI episodes taken from AKI alerts / HL7 messages sent to GP practices.
Question 1.5: Is aged 18 years and over a suitable population group?			
GP1	1.5	Individual comment - doctor	Yes
GP1	1.5	The Royal College of General Practitioners	The indicator should include all age groups
GP1	1.5	Royal College of Nursing	Yes

GP1	1.5	Royal College of Pathologists	Identification of AKI is based around calculation of eGFR to which the equations are only valid and reported for this age group. Clearly AKI can occur in patients less than 18yrs but they will be excluded from these calculations and subsequent register/monitoring.
GP1	1.5	West Midlands Renal Network	Yes
Question 2.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP2	2.1	British Kidney Patient Association	People who have had an episode of AKI may be left with CKD, so would need to be recorded on both registers. Please can you clarify this as it may cause confusion.
GP2	2.1	Individual comment - doctor	No
GP2	2.1	NHS Medway Clinical Commissioning Group	Letters from hospital still delayed Why don't hospital organise tests on discharge and FU Less risk of patient not being coded in primary care
GP2	2.1	Royal College of Nursing	None Specific.
GP2	2.1	Royal College of Pathologists	This may lead to increased use of these tests within the pathology services. At a time when pathology labs are being heavily scrutinised on cost, this will be seen as a detrimental impact on pathology services even though there may be clear benefit to the patient.

GP2	2.1	The Royal College of General Practitioners	• This indicator may just involve an admin 'chase up' of test results carried out elsewhere - accurate and timely information flows from secondary care providers are required • The tests are likely to have been done in a secondary care environment – and may have even been followed up in secondary care • Patients should be advised that a follow up will be needed and either be given a blood form by the hospital or advised that they need a blood test • Requires patient consent to have bloods taken every 3 months • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to implementation
GP2	2.1	West Midlands Renal Network	Yes – this requires recall of sick elderly patients to GP surgeries after the AKI episode. In discussion with GP colleagues they have limited resources for recalling/chasing patients and phlebotomy. The situation for the ACR/PCR indicator will be even more challenging. This is at a time when GPs are under very considerable pressure
Question 2.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP2	2.2	British Kidney Patient Association	Please see above.
GP2	2.2	Individual comment - doctor	No
GP2	2.2	Royal College of Nursing	No
GP2	2.2	Royal College of Pathologists	Yes – increased, unfunded use of pathology resource.

GP2	2.2	The Royal College of General Practitioners	• It may result in extra administrative work with no change to the outcome • This should be a secondary care indicator rather than a primary care indicator • If patients aren't fully informed about the diagnosis, it may cause unnecessary anxiety • There are concerns about the impact on insurance application • There are current workload issues in relation to resources in primary care and the need to prioritise the frail elderly and their associated multi-morbidity • More elderly people identified with chronic kidney disease with greater prescribing of ACEI and other antihypertensive medication with the potential for increased falls in the elderly due to postural hypotension and AKI during an inter-current acute illness
GP2	2.2	West Midlands Renal Network	No
Question 2.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP2	2.3	Individual comment - doctor	No
GP2	2.3	Royal College of Nursing	No
GP2	2.3	Royal College of Pathologists	Nothing specific but the usual bias and differentials that exist for these patient sub-groups are likely to persist for these conditions.
GP2	2.3	The Royal College of General Practitioners	The ability of the GP practice to achieve this indicator may be affected by how it is dealt with by the local hospital
GP2	2.3	West Midlands Renal Network	No
Question 2.4: Do you have any general comments on this indicator?			

GP2	2.4	British Kidney Patient Association	We would like to see people who at risk for AKI being given information on keeping their kidneys safe; this will be more than those people on the CKD register. We have information prepared by the BKPA, RCGP and Think Kidneys for this purpose which can be provided in a black and white easy download format also. http://www.britishkidney-pa.co.uk/images/downloads/patient_information_leaflets/AKI_Leaflet-_How_to_keep_your_Kidneys_Safe.pdf
GP2	2.4	British Medical Association	It is vital that the clinician identifying the episode of AKI is responsible for informing the patient of this event and ensuring that the patient or their carers understand the arrangements for follow up. This is clearly set out in the standard NHS contract based on recommendations in Standards for the communication of patient diagnostic test results on discharge from hospital. This is therefore not solely a general practice responsibility.
GP2	2.4	Diabetes UK	The serum creatinine used to be an indicator in the diabetes section to assess the development of kidney disease/impaired renal function. This indicator has been removed in QOF diabetes section. Consequently, the number of people with diabetes recorded as getting this test of renal function has fallen. This decrease in people not receiving this test could be a symptom of decreasing standards of care. In addition this is an evidence based indicator of good diabetes care, which is included in NICE guidelines. If people with diabetes are not getting it, despite being at a greater risk of kidney complications than those without diabetes, it seems prudent to measure in people with diabetes as well as people with kidney disease.
GP2	2.4	Individual comment - doctor	Will need flagging as reminder on Primary Care IT systems once diagnosis is entered once diagnosis is entered
GP2	2.4	Royal College of Nursing	Not at this stage

GP2	2.4	Royal College of Pathologists	3 months is a long period of time. If a patient is identified with AKI 2 or AKI3 then they should be monitored very closely.
GP2	2.4	The Royal College of General Practitioners	There are potentially significant resource implications for primary care
GP2	2.4	West Midlands Renal Network	Compliance rates with the indicator are likely to be low.
Question 2.5: Is the time frame of 3 months feasible for this population?			
GP2	2.5	Royal College of Nursing	It seems odd that this indicator is for 3 months post AKI episode, yet the other indicators are 1 month post-AKI episode. It would be better to give each of the indicators the same time period, so everything can be done at one appointment.
GP2	2.5	Royal College of Pathologists	Its feasible but many patients may suffer harm or worsening of condition/recurrence if not monitored more frequently
GP2	2.5	The Royal College of General Practitioners	• The timeframe of 3 months is feasible provided that the GP surgery is informed in a timely manner by the secondary care providers otherwise this is a very tight framework • It may be more useful to think of longer term management once care has been properly handed back to the GP
GP2	2.5	West Midlands Renal Network	Yes
Question 3.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP3	3.1	Individual - GP	The main one is lack of time/clinicians to attend to the to do this with subsequent difficulty of access to appointments
GP3	3.1	Individual comment - doctor	No
GP3	3.1	NHS Medway Clinical Commissioning Group	Delay in letters from hospital. Shouldn't physician diagnosing AKI do a medication review at the time. Further review would depend on subsequent results as bloods not being repeated for 3 months one month from diagnosis doesn't fit timeframe. Suggest doing after bloods

GP3	3.1	Royal College of Nursing	None Specific.
GP3	3.1	The Royal College of General Practitioners	• The 'code' for medication review has traditionally only been needed by QOF once a year, so GPs will need to remember to add it • Practice based pharmacists would be important • The timeframe of 1 month may well mean that many patients are either still undergoing in-patient treatment, have just been discharged from secondary care or are recovering from that care. Trying to get a good cohort of these individuals to attend a general practice for a medication review within this timeframe will be challenging • Frequently, discharge letters are not received in time to complete a medication review within a month of diagnosis. In addition at this stage patients may not be recovered enough to attend the surgery for a medication review • Current workload issues in relation to resources in primary care and the need to prioritise the frail elderly and their associated multi-morbidity • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to implementation
GP3	3.1	West Midlands Renal Network	No
Question 3.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP3	3.2	British Kidney Patient Association	The risk of a patient not restarting a treatment is high without appropriate advice to the patient, so the timely medication review is essential to avoid further harm.

GP3	3.2	British Society for Heart Failure	The British Society for Heart Failure (BSH) feels very strongly that drugs such as ACE inhibitors and ARBs should not be referred to as "potentially nephrotoxic" (see 'indicator rationale'). These drugs are life-prolonging for patients with heart failure and reduced left ventricular systolic function. Indeed, they are one of the few interventions that have been shown to reduce progression to end stage renal disease, for patients with chronic kidney disease. 'Think kidneys' also agree that these drugs should not be referred to as 'nephrotoxic'. There is a huge danger that this gives the wrong message to healthcare professionals with potential detrimental consequences to the care of many patients, and particularly those with heart failure.
GP3	3.2	Individual comment - doctor	No
GP3	3.2	Royal College of Nursing	No
GP3	3.2	The Royal College of General Practitioners	Time and resource implications for primary care appointments if these reviews are to be undertaken face to face. Primary care systems are already overwhelmed by demand
GP3	3.2	West Midlands Renal Network	No
Question 3.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP3	3.3	Individual comment - doctor	No
GP3	3.3	Royal College of Nursing	No
GP3	3.3	The Royal College of General Practitioners	No
GP3	3.3	West Midlands Renal Network	No
Question 3.4: Do you have any general comments on this indicator?			
GP3	3.4	British Medical Association	This is not appropriate as a primary care indicator as the medication review should be done at the time the AKI is identified and is the responsibility of the clinician identifying the condition. The changes to the patient's medication must be clearly communicated to the general practice.

GP3	3.4	British Society for Heart Failure	The BSH feel strongly that this indicator should highlight the following: - ACE inhibitors and ARBs are disease modifying drugs that improve the prognosis for patients with heart failure - A reduction in renal function is common after initiating these drugs and should in general not preclude their appropriate use - If a patient has had an episode of AKI, it is important to ensure that patients with heart failure have a review of their drugs within a month of the record of the diagnosis, and to ensure that evidence based therapies are (re-) optimized.
GP3	3.4	Individual comment - doctor	No
GP3	3.4	Royal College of Nursing	No
GP3	3.4	The Royal College of General Practitioners	• This is potentially a useful indicator for remembering which drugs to stop, or which to restart following AKI recovery • It will clash with other guidelines when medication is stopped • If AKI is diagnosed in hospital, it should be acceptable to record that the hospital has undertaken a medication review (provided that the GP practice has reconciled the medication)
GP3	3.4	West Midlands Renal Network	It would be useful.
Question 3.5: Is the time frame of 1 month feasible in this population?			
GP3	3.5	British Medical Association	This is not appropriate as the medication review should be done at the time the AKI is identified
GP3	3.5	Individual comment - doctor	Would ideally be one month but three months may be more achievable and link to repeat eGFR and ACR/PCR
GP3	3.5	NHS Medway Clinical Commissioning Group	See 3.1
GP3	3.5	Royal College of Nursing	Yes
GP3	3.5	The Royal College of General Practitioners	The timeframe would not universally be feasible and 3 months would be better
GP3	3.5	West Midlands Renal Network	Yes

Question 4.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP4	4.1	British Kidney Patient Association	Awareness of the existence of good patient information, and described below.
GP4	4.1	Crossfell Health Centre - GP	This should be a CCG indicator - the people to do this are the team who make the diagnosis. This is usually in hospital which is where the discussions should take place.
GP4	4.1	Individual comment - doctor	Needs to be delivered at time of diagnosis in that care setting
GP4	4.1	NHS Medway Clinical Commissioning Group	Shouldn't this be the responsibility of the physician diagnosing AKI so often secondary care.
GP4	4.1	Royal College of Nursing	The written information needs to be standardised as there are numerous information leaflets available (some are not user friendly).
GP4	4.1	The Royal College of General Practitioners	• This is predominantly secondary care diagnosis so perhaps this should be a secondary care indicator • There must be accurate transfer of information from secondary care to GP practices • The GP surgery is not always aware of the diagnosis through discharge letters to enable them to provide written information within this time frame. In addition, it is preferable for a patient to be provided with written information about AKI at the time of diagnosis, and by the team making the diagnosis, rather than the provision of information to fall upon the GP • Current workload issues in relation to resources in primary care and the need to prioritise the frail elderly and their associated multi-morbidity • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to implementation

GP4	4.1	West Midlands Renal Network	No
Question 4.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP4	4.2	British Kidney Patient Association	No, we support it.
GP4	4.2	Individual comment - doctor	No
GP4	4.2	Royal College of Nursing	No
GP4	4.2	The Royal College of General Practitioners	• If GPs are measured on this indicator it could become a frustrating admin exercise to find out what information the hospital gave to the patient. • It may result in resources being directed away from an area with greater need
GP4	4.2	West Midlands Renal Network	No
Question 4.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP4	4.3	Individual comment - doctor	No
GP4	4.3	Royal College of Nursing	Some of the information is difficult to understand and not user friendly for people who do not have English as their first language.
GP4	4.3	The Royal College of General Practitioners	No
GP4	4.3	West Midlands Renal Network	Yes – it would be very difficult to provide leaflets for patients who do not speak English (many ethnic minority patients). There are two reasons for this: a. Most patients who do not speak English have poor literacy skills in their own dialect. b. The range of languages needed for any leaflet would be very large and impractical.
Question 4.4: Do you have any general comments on this indicator?			

GP4	4.4	British Kidney Patient Association	The BKPA, with the Royal College of GPs and the Think Kidneys programme, have developed information for people who have had AKI which we recommend is offered to patients and can make available as a black and white information prescription http://www.britishkidney-pa.co.uk/images/downloads/patient_information_leaflets/AKI_leaflet.pdf
GP4	4.4	British Medical Association	This is not appropriate general practice indicator as the information should be provided at the time the AKI is identified and is the responsibility of the clinician identifying the condition.
GP4	4.4	Individual comment - doctor	No
GP4	4.4	Royal College of Nursing	Not at this stage
GP4	4.4	The Royal College of General Practitioners	• The vast majority of these patients will have been diagnosed in hospital and should have that information provided to them in hospital. • It would be most appropriate that this indicator should relate to the managing clinician at the time of the diagnosis of AKI. It is not clear why this would therefore become a primary care indicator if the episode is diagnosed and managed in a secondary care setting
GP4	4.4	West Midlands Renal Network	This is appropriate for community acquired AKI; however, the acute Trusts manage about 90% of episodes, so this should be an indicator for the acute Trusts/CCGs.
Question 4.5: Is the time frame of 1 month feasible in this population?			
GP4	4.5	British Medical Association	This is not appropriate as the information should be provided at the time the AKI is identified
GP4	4.5	Individual comment - doctor	Yes
GP4	4.5	Royal College of Nursing	Yes

GP4	4.5	The Royal College of General Practitioners	• Written information should be provided to the patient at the time of diagnosis, so the timeframe of 1 month is feasible where the diagnosis is made in primary care however 3 months would be preferable. • Where the diagnosis is made in secondary care, however, timely receipt of discharge letters will create a barrier
GP4	4.5	West Midlands Renal Network	Yes

Appendix B: Equality impact assessment

Protected characteristics		
• Age • Disability • Gender reassignment	• Pregnancy and maternity • Race • Religion or belief	• Sex • Sexual orientation
Note: 1) The characteristic of marriage and civil partnership is protected only from unlawful discrimination. There is no legal requirement to consider the need to advance equality and foster good relations. 2) The definition of direct discrimination includes less favourable treatment of someone associated with a person with a protected characteristic, such as the carer of a disabled person.		
Socioeconomic factors		
The relevance and nature of socioeconomic factors will vary according to the quality standard topic. They may include deprivation and disadvantage associated with particular geographical areas, or other geographical distinctions (for example, urban versus rural).		
Other definable characteristics		
Certain groups in the population experience poor health because of circumstances distinct from – though often affected by – sharing a protected characteristic or socioeconomic factors. The defining characteristics of groups of this sort will emerge from the evidence (although a quality standard topic will sometimes explicitly cover such a group). Examples of groups identified are: • looked-after children • people who are homeless • prisoners and young offenders.		

Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Acute kidney injury

1.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
Stakeholders commented that there might be issues with the provision of information for ethnic minority patients where English is not their first language. Stakeholders also mentioned that there is high incidence of AKI in care homes.

1.2 Have any population groups, treatments or settings been excluded from coverage by the indicators at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?
No population groups, treatments or settings have been excluded from coverage at this stage.

1.3 Do any of the indicators make it more difficult in practice for a specific group to access services compared with another group? If so, what are the barriers to, or the difficulties with, access for the specific group?
No – comments from consultation do not suggest that the indicator will make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention.

1.4 Is there potential for the indicators to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No – comments from consultation do not suggest that the indicator will have an adverse impact on people with disabilities.

Completed by lead technical analyst: Stacy Wilkinson

Date 30/03/2017

Approved by NICE quality assurance lead: Brian Bennett

Date 06/04/2017