
JOINT SPECIALTY COMMITTEE FOR RENAL MEDICINE
**Minutes of a Meeting held on Tuesday 26th June 2007
at 2pm in the Linacre Room**

Present	Professor John Feehally	Chairman
	Dr John Bradley	RCP (Payment by Results Group)
	Dr Rodney Burnham	Registrar RCP
	Professor Ian Gilmore	President RCP (<i>item 07.20</i>)
	Dr Brian Junor	Scottish Colleges
	Mr Rob Lusuardi	Observer, Specialist Commissioner
	Dr Donal O'Donoghue	Observer, National Director for Kidney Care (<i>to 07.35</i>)
	Professor Steve Powis	Specialty Advisory Committee (<i>from 07.32</i>)
	Dr Paul Rylance	Society of DGH Nephrologists
	Dr Colin Short	Observer, British Transplantation Society
	Dr Paul Stevens	British Renal Society
	Dr Christopher Winearls	Renal Association, Clinical Vice President
	Catharine Perry	Committee Administrator
Apologies	Ms Alison Blezard	Patient and Carer Network
	Dr Morag Gorrie	SAS Nephrology Forum
	Dr Megan Griffith	New Consultants Committee
	Mr Gerry Lynch	Observer, Department of Health
	Professor Peter Mathieson	Renal Association, President
	Dr Rebecca Sims	Nephrology SpR Club
	Dr Mark Taylor	British Association for Paediatric Nephrology

07/20 Welcome and Apologies

The Chairman welcomed Mr Lusuardi, Specialist Commissioner, to his first meeting. Apologies were received, as listed above.

07/21 Modernising Medical Careers / MTAS

The President summarised the College's response to the Tooke Enquiry, which has been posted on the College's website. He felt that after a very difficult period the profession was uniting to find the best way forward. Clearly the selection process for specialist training posts will have to be different; any new process must be properly piloted and is unlikely to be ready for August 2008. There will be a national portal for applications but appointments will take place at the deanery level; also there should be several appointment times during the year. Despite the probability that run-through training will persist, it is important to provide flexibility for trainees. An optional third, 'buffer', year of Core Medical Training would give more time for deciding on a specialty or even to change discipline. This would also take in people on fixed term contracts and, by being limited to one year, end the current situation where SHOs remain stuck in the system for several years.

The College is calling for PMETB to become – as was intended – a ‘light touch regulator’ and also for it to be placed under the GMC. At present too many doctors are being trained for the number of available posts. Another problem is that Foundation Trusts are outwith the appointments system.

[Professor Gilmore left the meeting]

07/22 Minutes of the previous meeting

The minutes of the meeting held on 23 January 2007 were signed as a correct record.

07/23 Matters arising

(a) 07/03(e) eGFR and Life Insurance

Correspondence between Dr Tomson and Dr Kevin Somerville, who works in the insurance industry, had indicated that mere identification of a reduced eGFR should not lead to problems with life insurance. However Dr Winearls re-opened the subject by saying that some of his patients had, in fact, had premiums for life insurance trebled because eGFR was being seen of itself as a diagnostic and prognostic tool. There should be a dialogue with the insurance industry to ensure that they understand this. Dr Rylance pointed out that a similar issue in cardiology with troponin levels had been dealt with. Dr Winearls said that he would send evidence to the Chairman, who would contact Dr Somerville and ask him to come to talk with the Committee about the issue.

ACTION: Dr Winearls, Chairman

(b) 07/03(a) Independent Sector Treatment Centres

The Chairman reported that the contracts for the two ISTCs providing haemodialysis in the north of England were being finalised. Dr O’Donoghue said that they awaited final business case approval and that plans for further ISTCs were under discussion. When the restructuring of SHAs is complete, there may be more. Mr Lusuardi said that they were justified on the grounds of short capacity. Dr Winearls said that lack of capacity (the reasons for which should be investigated) could have been solved within the NHS and as the ISTCs were no quicker than NHS units to set up, so far their benefits had not been proved. Secondly, he asked what the mechanism was for expansion other than ISTCs given the lack of capital spending in the NHS. If haemodialysis is largely provided by ISTCs, that will have huge effects on the economic viability of NHS units which are precluded from competing by lack of capital investment and of sufficient income from commissioners. From the DGH perspective, Dr Rylance said that most expansion of renal services has been in DGHs, though ISTCs could change that to a structure of more satellites under the control of larger centres with consultants going out to new units. Dr Stevens said he understood that when PbR comes in there should be a mechanism to generate capital for new units.

Dr O’Donoghue said services are coming on line at the rate that the local systems wanted. In order to get capacity and capital now, commissioners and providers can opt for commercial satellites, but there is currently some delay while the functioning of PbR is clarified. Mr Lusuardi reported that in the West Midlands expansion had come from a diversity of schemes based on whether capital is required, whether patients need to be repatriated to their localities, with options for pump priming costs in the first year or two. The Chairman asked Mr Lusuardi to provide a brief account of the actions taken in the West Midlands which had

resulted in new units and could be useful in commissioning elsewhere. Dr Stevens asked whether commissioners had 5- or 10-year plans, and Mr Lusuardi said that he would find out.

ACTION: Mr Lusuardi

Dr Burnham said that the College would be concerned if ISTCs were promoted which took away resources from NHS trusts. There are also workforce planning issues related to plurality of providers in that there should be training of appropriate numbers in and for those environments.

(c) 07/03(b) Healthcare Commission National Renal Audit

The Chairman reported that the audit is now out for tender with a closing date in early July. A bid is being made by the Renal Association and the UK Renal Registry with other partners.

(d) 07/03(f) NICE - Costing of home haemodialysis

The Chairman said that nothing further had been heard from NICE following the invitation to the Renal Association to undertake some joint work on this subject.

(e) 0703(h) RCP Conferences from 2009 ***Docs 07.10A, 07.10B***

Information had been circulated on the College's new strategy for planning conferences. Members were not happy that renal conferences organised by the RCP would only take place every 2-3 years, given that in the past such conferences had attracted delegates from other specialties who might otherwise not have had exposure to renal issues. Dr Short questioned whether participants came from all parts of the country, to which Dr Burnham pointed out that College Regional Update meetings could be a way of spreading information on renal matters; regional lectures also took place, and nowadays webstreaming of conferences is possible. The Administrator was asked to find information on both regional updates and webstreaming, and the Chairman said that he would take up the issue of frequency of renal conferences with the Academic Registrar.

ACTION: Administrator

(f) 07/05 Nominations to NICE Guidelines Development Groups

This issue had arisen in relation to the CKD GDG. Nominees are sought to fulfil various functions on the Guideline Development Groups: experts are usually sought from the specialist societies, with the College often being asked to provide a physician with a more general interest in the subject. The Registrar said that the chairman of the JSC would always be consulted on nominees.

(g) 07/17 RCP Open Day, 15th September

The Chairman reported that Dr Peter Choi, of Hammersmith hospital, had agreed to coordinate the renal medicine display at the Open Day. The Administrator was asked to send a copy of the report on the previous year's open day to Dr Choi and the Chairman.

ACTION: Administrator

07/24 Committee Terms of Reference and Membership

Doc 07.11

The following changes were made to the membership of the Committee:

1. delete sentence in square brackets
2. replace with 'The Clinical Vice President or the Chair of the Clinical Service Committee of the Renal Association'

3. replace with 'The Academic Vice President of the Renal Association
6. to read: 'The JSC Chair should have the power to co-opt chairs of other Renal Association or Royal College of Physicians committees or other members of the Renal Association for ad hoc periods ...'.

It was suggested that it could be more appropriate for the British Association of Paediatric Nephrologists to become an observer and the British Transplantation Society to become a full member of the Committee. It was agreed that the Committee worked well as a forum for exchange of information between the College and the Renal Association. The Chairman said that he would try to structure the agenda so that there was a minimum of duplication with Renal Association Executive Committee meetings.

07/25 Specialty Advisory Committee Report

Doc 07.24

In Professor Powis's absence, the Chairman drew the Committee's attention to the new constitution of the Specialty Advisory Committee which, with the development of schools of medicine, will have representation from all the regions. It will focus on curriculum development and assessment. The Renal Association and the College are working together to develop a knowledge-based assessment to start in September 2008. Dr Burnham said that the question of whether people coming in through the Certificate of Eligibility of Specialist Registration will have to take exams had not yet been discussed.

Dr Stevens pointed out that when assessments identify SpRs who are performing poorly, remedying this heavily increases consultants' workloads. It was agreed that this should be communicated to Professor Powis.

07/26 Workforce Issues

Doc 07.12

The question of whether there would be sufficient consultant posts for the number of SpRs in training was raised. The Chairman said that there had in previous years been meetings with the Department of Health's Workforce Review Team, but none in 2007. It was agreed that assumptions about numbers required should be revisited and also consideration given to how renal numbers fit into the broader review of workforce. Dr Rylance pointed out that any reduction in SpR numbers would affect the viability of many units. Given the change in gender proportions in the workforce and the impact of the Working Time Directive, Dr Stevens thought that the numbers should be revised. Dr O'Donoghue confirmed that the RCP and RA workforce data were very useful and needed updating annually. Different configurations of the service would require different numbers of physicians. Dr Junor said that in Scotland workforce planning was based on 50 renal consultants to 5mn population, which was twice the numbers in England. He pointed out that Foundation Trusts advertising for 'specialists' rather than 'consultants' was a way of bringing in people from outside the EU. The Registrar reported that the College had responded to the Home Office shortage list by saying that medical specialties should not be on it. (*see also minute 07/50(b)*)

The Chairman agreed that together with Professor Mathieson he would bring together a group to examine these issues. The Registrar recommended that they liaise with Dr Alistair McIntyre, Director of the College's Medical Workforce Unit.

ACTION: Chairman

[Dr Burnham left the meeting]

07/27 RCP Peer Review Meeting, 25th April 2007

Doc 07.13

The Committee received a report from Dr Tomson on an RCP workshop held on 25th April 2007; the College's interest in peer review has been revived by the move to revalidation.. It was noted that while peer reviews have benefits, there is no actual evidence that they drive up standards. The Committee would await the outcome of the College's deliberations.

07/28 Payment by Results (ref. min. 07/07)

Dr Bradley reported that it had become clear that renal services do not mesh easily with PbR and much work would be required to fit them together, which leaves unanswered the question of how services are reimbursed now. A consultation on the future of PbR had taken place (closing date 22 June), to which the DH Renal Advisory Group had submitted information and PbR developments are on hold until this consultation reports. Whichever coding scheme is used, the important thing is to define the tariffs as accurately as possible. There is guidance in the Reference Costing Manual which recommends using the best local data while a comprehensive national classification is developed. It is open to units locally to decide how they take this forward in this interim period. Dr O'Donoghue recommended getting some pilot schemes going in the next 12 months to inform the process and to engage with the PbR team, although the pressures they face may make this a lengthy process. Mr Lusuardi said West Midlands commissioners had done some work on reference costing which showed considerable anomalies; they could work with the Department of Health on pilot projects. Dr Stevens pointed out that this delay made it even more important to address the issue of funding capital schemes.

07/29 Choose and Book (ref. min. 07/08)

Doc 07.14

Dr Rylance spoke to his report. There has been much discussion about changing the keywords. He stressed that every local hospital should check its available pathways and the Chairman recommended that renal physicians should talk with their local Choose and Book representatives.

07/30 National Service Framework (ref. min. 07/10)

Doc 07.23

Dr O'Donoghue spoke to his report. Output from the learning sets should come through after October. Acute kidney injury will need attention when the RA clinical practice guidelines come out later this year. Dr Stevens said he had noticed that there was a stakeholder forum for critical care which had no renal representation. It was agreed to be important that there should be. The Chairman said that he would follow that up for the Renal Association.

***ACTION:* Chairman**

[Dr Burnham rejoined the meeting]

07/31 18-week Pathway for Haematuria

Doc 07.15

The Chairman introduced a paper from Dr Tomson on this emerging guidance which is not consistent with the CKD Guidelines on how referrals are made to nephrologists. Dr O'Donoghue said that he and Dr Tomson would talk with this group before the guidance is signed off on 6 July.

***ACTION:* Dr O'Donoghue**

07/32 Commissioning Arrangements (ref. min. 07/18)

Tabled Paper

Mr Lusuardi circulated a paper which summarised how regional commissioning groups were developing in different ways since the Carter Review. Regrettably there was inconsistency in how the Carter recommendations were being implemented, reflecting some ambiguity in the Review recommendations. In most regions planning is collaborative, but procurement is done by PCTs, sometimes operating in networks. In some places fora have been set up to engage clinicians and users. Four out of eight respondents intend to set up comprehensive commissioning.

Dr Winearls said that pressure for improving services is coming from clinicians, not commissioners. Mr Lusuardi said that in his region they were doing needs assessments and building up service specifications for the clinical community. He said that he would complete the survey and circulate it and would also set up communication with other renal leads to provide information for the JSC.

ACTION: Mr Lusuardi

[Professor Powis joined the meeting]

07/33 Quality Outcomes Framework Revision (ref. min. 07/11)

A submission had been made and Dr Burnham reported that the College had received a positive response. Dr Tomson would be meeting Dr de Lusignan, the GP leading for renal issues in QOF negotiations.

07/34 British National Formulary and eGFR (ref. min. 06/50)

The Chairman reported that there had been discussions between the renal community (Dr MacGregor and Dr Tomson) and the BNF, which is in the process of rewriting its classification system. The issue is that BNF prescribing is based on creatinine clearance rather than GFR. Dr O'Donoghue said there was the problem of the registration of drugs according to creatinine clearance which cannot be changed so needs to be taken up on the international level.

07/35 Renal Coding (ref. min. 07/06)

The chairman reported that the group had been established to work on the renal subset of SNOMED-CT.

07/36 Renal Clinical Incidents/National Patient Safety Agency
(ref. min. 07/09)

Docs 07.16A, 16B

Dr Rylance explained the NPSA's pilot project which was designed to share learnings and suggestions for action in response serious clinical incidents and ways of avoiding them. It will also identify risk-prone situations. The pilot was supported by the College. The Renal Association has set up a similar system and the Chairman said that it should continue while the NPSA project is piloted and evaluated.

[Dr O'Donoghue left the meeting]

Previous editions of this publication had been helpful when dealing with workforce issues and for drafting job specifications. The Chairman said that he would ensure that someone was found to redraft the renal section for the 4th edition.

ACTION: Chairman

07/38 **Recertification**

The Registrar reported that the College had published six booklets on different aspects of specialist recertification and that work was continuing on a ‘basket of tools’ from which different specialties could draw the most appropriate ones for assessment. The specialist societies and the College were working together, the former providing competencies and the latter providing assessment tools. Appraisals will need to be formative for personal development, but also summative for assessment. Dr Short asked who the revalidators would be, and how they would be monitored. The Registrar responded that the structure of the scheme was still being discussed and that it could be at least five years before revalidation starts. The Chairman pointed out the difficulties of assessing individuals whose work is done in teams; however the Registrar said that the outcomes of teams would reflect the competence of the clinicians.

07/39 **NICE Consultations****Doc 07.18**

The Chairman said that no action had been taken on Febuxostat and that an appeal against the Final Appraisal Decision on osteoporosis-related treatments would have to be made by 5th July. A letter had been sent to stakeholders for the CKD Guidelines asking for evidence relating to measurement of proteinuria. Dr Stevens was that he was collecting unpublished evidence on the value and accuracy of urine protein/creatinine and albumin/creatinine ratios and asked members to pass any they were aware of to him.

ACTION: ALL

07/40 **Reports****(a) British Transplantation Society**

Dr Short said that there was nothing particular to report.

(b) British Renal Society

(1) Dr Stevens reported that information was being sought from 10,000 GPs on their practice for managing CKD. The service improvement initiative started by Dr Tomson at the annual meeting had been very successful; his vision was for service improvement to be as cost neutral as possible and to be regarded as a regular part of renal work.

(2) On workforce revision (*see also minute 07/36*) the aim was to describe the future workforce in terms of skills and competencies and on that basis see what workforce structure would improve the patient experience. Workforce needs should be addressed for all aspects of pathways for patients with renal disease including end of life care. There are examples from the DH workforce team which can be used, and it should align with their strategy. By September there should be a project plan to circulate for comment, followed by workshops on key themes. The Chairman said that this could be a joint BRS and RA enterprise.

(c) Society of DGH Nephrologists

Doc 07.25T

Dr Rylance circulated a report, commenting that many of its issues had already been covered elsewhere in the agenda. Dr Winearls said that to have sufficient nephrologists it would be necessary for them to continue to work in G(I)M in many hospitals. Dr Rylance said that it seems that the numbers of SpRs who want to dual accredit are falling. There is a general view among SpRs that renal medicine is rather onerous.

(d) New Consultants Committee

In the absence of Dr Griffiths no report was received.

(e) SAS Nephrology Forum

In the absence of Dr Gorrie, no report was received.

(f) President RCP

Doc 07.19

A report on his activities was received from the President of the RCP.

07/41 The Map of Medicine

Doc 07.26T

The Chairman said that this commercial organisation now has a contract with the NHS to develop electronically accessible clinical pathways intended to assist non-specialists in ensuring appropriate care. The early renal pathways had not been impressive and had received substantial criticisms by reviewers from the Renal Association. But it has now been agreed that renal medicine will be one of the pilot projects to test a model of the College working with specialist societies to review and revise the pathways, with financial support from the Map project. Professor Feehally felt that the widespread introduction of the Map across the NHS was now inevitable and therefore it must be a priority to ensure the pathways were 'fit for purpose'. He said he would consult with the RA President to identify a small group to lead this work. Dr Burnham said that the College was holding 'interface meetings' with the Royal College of General Practitioners to take forward a vertical integration model of care. Dr Stevens pointed out that the pathways should fit in with the NICE CKD Guidelines.

ACTION: Chairman

07/42 Date of next meeting

The Committee will next meet on Tuesday 23rd October, 2007 at 2pm.

The meeting ended at 16.25.