

JOINT SPECIALTY COMMITTEE FOR RENAL MEDICINE**Minutes of a Meeting held on
Tuesday 23rd January 2007 at 10.30am**

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| Present | Dr Charlie Tomson | Nephrologist without Portfolio, Chairman <i>(from item 07.08)</i> |
| | Professor John Feehally | Renal Association <i>(in the chair to 07.07)</i> |
| | Dr John Bradley | RCP (Payment by Results Group) |
| | Dr Morag Gorrie | SAS Nephrology Forum |
| | Dr Brian Junor | Scottish Colleges |
| | Ms Donna Macarthur | Specialist Commissioner (Observer) |
| | Dr Donal O'Donoghue | DH Renal Advisory Group |
| | Professor Steve Powis | Specialty Advisory Committee |
| | Dr Paul Rylance | Society of DGH Nephrologists |
| | Dr Paul Stevens | British Renal Society |
| | Dr Christopher Winearls | Renal Association |
| | Professor Ian Gilmore | President RCP |
| | Catharine Perry | Committee Administrator |
| Apologies | Ms Alison Blezard | Patient and Carer Network |
| | Dr Rodney Burnham | Registrar RCP |
| | Dr Megan Griffith | New Consultants Committee |
| | Dr Colin Short | British Transplantation Society |
| | Dr Rebecca Sims | Nephrology SpR Club |
| | Dr Mark Taylor | British Association for Paediatric Nephrology |

07/01 Welcome

The Chairman welcomed Ms Macarthur, Specialist Commissioner, to her first meeting.

07/02 Minutes of the meeting held on 24 October 2006

The heading to minute 06/41 was changed to read: "Minutes of the meeting held on 20 June 2006". With this amendment the Chairman signed the minutes as a correct record.

07/03 Matters arising from the minutes**(a) 06/42(b) Independent Sector Treatment Centres**

It was reported that in the first wave of ISTCs, contracts had been signed for Cheshire and Merseyside, and South Yorkshire and Humberside. Local clinicians are satisfied with the governance and financial arrangements. This items relates to Payment by Results. *(see 07.07 below)*

(b) 06/42(e) Healthcare Commission National Renal Audit Scoping Project Report
The Commission has approved the recommendations from the renal community to include in the audit transport, vascular access, and early CKD. However there is currently no funding available for the project, although there may be for 2007-08. Dr Stevens reported that Kidney Research UK and St George's Hospital have received funding from the Health Foundation to carry out research on ways of managing kidney disease at the primary care level, including some aspects of audit. This will involve the Renal Registry. It is important that the audit elements should be picked up.

(c) 06/42(h) Working Party on the Changing Face of Renal Medicine
The report from this Working Party will be launched on 8th March, World Kidney Day. The President would be glad to receive concrete examples of issues raised by current moves to plurality of provision and 'care closer to home'.

(d) 06/42(g) IPEM Special Interest Groups
An article had been written for the Renal Association e-news.

(e) 06/43 eGFR, CKD and the implications for life insurance (taken later)
The Chairman reported that he had spoken with a representative of the insurance industry, who had assured him that insurers were aware of this issue and were not inappropriately penalising people who had developed early kidney disease.

(f) 06/47 NICE press release: home vs hospital dialysis
Professor Feehally reported that he had corresponded with the Chief Executive of NICE about concerns over the NICE position on the proportion of dialysis patients who would be expected to do home haemodialysis, but a change in the stated NICE position would not be forthcoming in the short term. The Renal Association has however accepted an invitation from NICE to collaborate in looking again at the costing of home dialysis.

(g) 06/48 UK CKD Guidelines, April 2006
It was reported that Steve Blades and Richard Burden had developed a patient information leaflet (available on the RA website) and printed by the Association of Renal Industries, and that this was available for widespread distribution.

(h) 06/49 RCP Conferences and Lectures
No topics or lecturers had been suggested for 2008. This item will be on the next agenda for suggestions for 2009.

(i) 06/52 Youthhealthtalk.org
The Chairman had written to Dr Mark Taylor to ask directors of Paediatric Renal Units to suggest names.

(j) 06/53 Clinical Excellence Awards, 2007
Professor Feehally reported that names had been forward to the College from the Renal Association for submission for clinical excellence awards in 2007.

(k) 06/54(a)(iii) NICE Consultation on lipids modification in secondary prevention
Dr Graham Warwick has been asked to prepare a response for this consultation.

(l) 06/56(b) Patient and Carer Network leaflets
The Chairman reported that he had given the PCN feedback on their patient information leaflets.

07/04 Committee Membership

It was noted that Dr Mark Taylor had replaced Professor Maurice Savage as a representative from the British Association of Paediatric Nephrology, and that Ms Donna Macarthur had replaced Mr Martin Flowers as a Specialist Commissioner Observer. A new member is being sought from the Patient and Carer Network to replace Mr Price.

(cf. min. 07.10) With Dr O'Donoghue's appointment as National Director for Kidney Services members thought it important that he remain on the Committee as an observer, but not to replace Mr Lynch, whose contribution is also very helpful. The Administrator was asked to find out how this could be accomplished.

***ACTION:* Administrator**

07/05 CKD Guidelines Development Group

The College had put forward the names of Dr Maarten Taal and Dr Hugh Gallagher for this GDG, but they had not been appointed to the Group (Dr Taal had prepared comments on the scoping exercise). This raised questions about the status of 'College representatives' on NICE Guidelines Development Groups. The Administrator was asked to clarify the College's involvement in Guidelines development.

***ACTION:* Administrator**

It was agreed that it was better for the College and the Renal Association to submit separate responses but that some coordination was desirable, lest the renal community appear to be providing conflicting opinions.

07/06 Renal Coding Meeting

Docs 07.01, 07.02

A report had been circulated on the meeting held on 12 January to bring together interested parties in order to harmonise the various clinical coding schemes now in use. Professor Feehally reported that it seems almost certain that SNOMED-CT will be approved by the DH as the coding language to be used. SNOMED-CT has wide usage in the western world and is developing beyond its pathology background. It was agreed at the meeting that the various groups will work together to develop a renal subset for SNOMED-CT. Dr O'Donoghue asked whether the College had a view on SNOMED-CT, and Professor Gilmore undertook to report back on this.

***ACTION:* President**

07.07 Payment by Results

Doc 07.03

Dr Bradley introduced his paper which summarised recent documentation. He felt that the guidance made clear that comprehensive coverage of renal services through PbR including transport, new building costs, depreciation. Erythropoietin treatment is listed amongst high cost drugs that may in the future be unbundled and costed separately. Overall there was considerable anxiety about how PbR will effect renal untis when the mandatory tariff is introduced.

The final HRG version 4 will be released in 2007, so the aim should be to influence the next version in two main ways:

- (a) by getting the right level of specificity, and

(b) by ensuring that the tariff is set appropriately.

Tariffs are based upon reference costs from all Trusts' mandatory returns, but they report costs in very different ways. Thus the first objective should be to make clear to Trusts what they should be reporting and including in the tariff. The DH is preparing a letter to Clinical Directors and Financial Directors telling them what is to be included in mandatory reporting.

Unbundling: Dr Stevens pointed out that RRT tariffs needs to include counselling, social work, occupational therapy and conservative management and that when it is provided by the independent sector these other elements must either be included, or be unbundled and provided separately. At present these are included by implication as there is no other way of getting the package of care paid for. Ms Macarthur pointed out a danger of unbundling, that it will allow commissioners to take out certain costs. The Tariff Group should look at how to define sessions for conservative management. Finance directors need to know this so that when they are costing they include all of it in their returns.

Specific points

(1) the DH recommends local arrangements for non-tariff services but conservative care does not have any local arrangements. This point should be made to the DH End of Life Group (chaired by Mike Richards), as for them it is a generic issue.

(2) There is guidance relating to telephone advice if it is given to the patient, not the GP, which should be brought to people's attention.

[*post-meeting note: From Payment by Results Guidance, 2007-08, Version 1, December 2006:*
3.i What is covered by the tariff?

25. DSCN 32.2004 mandates non-face-to-face outpatient activity, e.g. telephone consultations, to be collected and transmitted. The data was collected for the first time as part of the 2005/06 reference cost collection. As the tariff is based on 2004/05 reference costs, non-face to face activity continues to be treated as an overhead on the attendance tariffs and is not separately reimbursed.]

(3) A tariff is needed to cover the year of care before RRT starts, which can be expensive.

(4) PbR may not be appropriate for long term renal care. Perhaps there should be separate dialysis and care tariffs.

(5) Commissioners are benchmarking across specialties, and will only commission when benchmarks are hit.

(6) For a complex case with several conditions, the highest tariff is usually taken.

(6) The administrative costs are going to be high, which is an argument for keeping tariffs broad and simple. Private hospitals assign costs to the smallest items.

[Professor Powis joined the meeting]

The President stated that the Department's aim was clearly to drive costs down and make efficiency savings by having a better understanding of the activities that go on; however there could come a point where this is counterproductive. Professor Powis pointed out that hospitals

will shape their services on the basis of the tariffs so tariff changes will affect income from what had been their core business. The Institute for Innovation and Improvement of the DH is examining hospitals where they are apportioning costs correctly and providing a high quality service, with a view to sharing it as best practice elsewhere - tariffs would be based on these centres of excellence rather than reference costs from all hospitals. It might be possible for renal medicine to be a part of this work

[Dr Tomson joined the meeting]

Dr Bradley will draft an email for the Chairman to send to Mike Tapp to convey the anxieties of the renal community and to get issues around renal medicine on the Tariff Working Group's agenda. This has been effective for other specialties such as parenteral nutrition.

ACTION: Dr Bradley, Chairman

07/08 Choose and Book

Doc 07.04

A discussion of the update paper provided by Dr Rylance revealed several major problems for renal medicine in the Choose and Book system.

- Hypertension has been moved to general medicine to cardiology, against advice from renal clinicians. Thus a nephrologist running a hypertension clinic would have to call him/herself a hypertension doctor to get referrals. The general nephrology clinic code was intended to keep the system simple.
- Booking is being done by clerks who do not have GPs' local knowledge. The idea of the system was that the GP and the patient should decide which clinic to book together in front of the screen. However using the programme takes a long time and it is not user friendly.
- Referrals are being made to distant clinics rather than ones actually close to the patient. The valid principle of patient choice is conflicting with the move to providing care closer to home. This a solution to a problem which does not exist in nephrology, as GPs know where the most appropriate clinics are.
- This 'shopping around' distorts planning: a patient can go to another, more distant, clinic for diagnosis (where they displace local people) but when the condition becomes chronic they change to the nearest clinic and so displace existing patients.
- It takes away from clinicians control of the rate of seeing patients.
- There is no mechanism for quality control of appropriateness of referrals.
- The IT system does not always work, so many hospitals are still using a paper system.

It was thought that the most serious issue was the risk of planning being destabilised by people turning up from other clinics. It might be possible to collect data to prove this point, but the response is likely to be that these are local arrangements which should be fixed locally.

For individual clinicians the best course of action is to familiarise themselves with the pathways and check what GPs are seeing on their systems. If things are going wrong the should talk with Choose and Book personnel in their hospitals.

Dr Rylance said that he is representing the RA and BRS on the National Specialty Reference Group which includes clinicians and will soon be having its first meeting, although how it relates to the DH is not clear. The Group is asking for feedback on local experiences and he will pass these problems and difficulties on to them.

ACTION: Dr Rylance

The College is running a Roadshow in Leicester on 22 March for consultants to debate current health reform with ministers at which the Secretary of State will be present. Professor Feehally will attend this in order to raise our concerns.

ACTION: Professor Feehally

The Committee heard that nephrologists in Liverpool have succeeded in making Choose and Book work. Dr Rylance will ask them to share their experience via the RA Clinical Affairs Board.

ACTION: Dr Rylance

[Professor Gilmore left the meeting]

07/09 Renal Clinical Incidents / National Patient Safety Agency

Doc 07.05

Dr Rylance reported that details of incidents can be reported to the NPSA using an online e-form. He had met with representatives of the NPSA who were interested in the possibility of using renal medicine as a pilot scheme for collecting in-depth information about incidents. This however would not achieve the sharing of learning from detailed accounts of avoidable incidents and near-misses.

After discussion it was agreed that the Clinical Affairs Board of the Renal Association should be encouraged to set up a web-based means of sharing anonymised information. The legal aspects of this need to be investigated, to prevent ambulance-chasers from forcing disclosure of information. It was pointed out that disclosure to the patient usually lessens the risk of legal action.

ACTION: Dr Winearls

The Committee also wished to encourage people to use the formal NPSA reporting process. Dr Rylance will follow up the willingness of the NPSA to do a sample search on, for example, haemodialysis to see if it produces useful information. The strand of their work named 'Deterioration not recognised or acted upon', which is developing an early warning scoring system, is very relevant to renal medicine. Dr Rylance will report back on anything of relevance.

ACTION: Dr Rylance

07/10 National Service Framework (ref. min. 06/46)

Dr O'Donoghue reported that he has been appointed by the DH as National Director for Kidney Care. He further reported that:

- Information from critical care leads shows that in a number of areas it was difficult to place people with acute renal failure in renal units, so they were kept in inappropriate places. Guidelines are awaited from the Renal Association and the Intensive Care Society to help promote joint working between the specialties. There are two action learning sets looking at this problem.
- The Transport Learning Set report has been published.
- The MRSA toolkit has been published. There will be a meeting to launch it on 8th March.
- Pilot projects on the renal mandatory enhanced staphylococcal surveillance system for MRSA bacteraemia in dialysis patients had ended and had worked well. From 1 April all MRSA reporting will have the renal element included in their mandatory returns. Dr O'Donoghue expressed the hope that the Renal Registry will be able to continue collation of these data once funding for the Health Protection Agency scheme runs out in 2008.
- The DH Renal Chemical Pathology Group reports increased uptake of IDMS traceable 4vMDRD reporting of eGFR and a reduction in inter-laboratory variance in creatinine assays. The Group is now considering the issues relating to reporting of urine protein/albumin.
- Work has been done with the National Institute for Innovation and Improvement on a 'web 2.0' website, to be launched as a pilot on 8 March. The NIII will support it for a period (6 or 12 months). This links with the idea of a virtual collaborative.
- Two workshops are planned: one on haemodialysis capacity, in order to get tariff right and respond to concerns about ISCTs, and the other on the patient experience in order to provide tools to measure experience and make sure that lessons are fed into local systems.

07/11 Quality and Outcomes Framework(ref. min 06/46)

Doc 07.09

In the current QOF (which is a UK-wide scheme) the kidney disease markers are different from those submitted by the JSC, but it is only possible to suggest minor changes for 2007. The NHS Employers Confederation is calling for comments on current clinical areas or suggestions for new ones by 28 February.

The process is that suggestions are measured against criteria relating to the commonness of the condition, whether the GP practice has main responsibility for managing it, there is good evidence of quality research, and whether making realistic changes to the way GP practices work will improve patient care. Groups putting in successful ideas would then be invited for an interview in March. The NHS Employers Confederation negotiates with the BMA Professional Committee on this to feed into the QOF.

It was agreed that the Chairman should write to Dr Maarten Taal, Dr Mark McGregor (Scotland) and Dr Lawrence Goldberg to ask them to consult widely and prepare a submission; this should be seen by Dr Tomson and Dr Winearls before being sent off. Dr Stevens will inform the CKD Forum about this so that they can submit independently; it would be good if those preparing the two submissions liaised so that they are not giving conflicting ideas.

***ACTION:* Chairman, Dr Stevens**

07/12 End of life care for patients with established renal failure (ref. min 04/46)

There are currently two related issues:

1 Concern that offering intensive outpatient-based collaborative care to every person with severe kidney disease not having dialysis (for whatever reason) is not funded at the moment. There should be an HRG or other payment mechanism for the non-dialytic care of very sick patients dying with kidney failure in the community.

2 As a separate piece of work, the Registry and other bodies need to be able to record what happens to people with severe kidney failure, using the distinctions outlined in the previous minute.

The advisability of having two separate terminologies was questioned as the renal community would benefit from having one shared terminology which can be used as a basis for coding.

For the first problem, Dr Burns and Dr Farrington have provided a list of definitions for Residual Renal Care (their term for supportive renal care, or conservative care at stage 4 or 5) to the DH End of Life Group chaired by Professor Mike Richards. Supportive care for non-dialysis stage 5 is one of the few stages which have a definite starting point. It was felt that the proposed terminology was too complicated and Drs Burns and Farrington should be asked to consult other renal clinicians and come up with something simpler which would be suitable for HRG 5.

Dr O'Donoghue agreed to feed back the Committee's concerns to Dr Burns and Dr Farrington and ask them to share a revised version with Dr Hugh Cairns (HRG Group) and Dr Bradley, who is due to talk to Clinical Directors and can include this topic in his talk. Dr Burns and Dr Farrington should be invited to the RA Clinical Directors Forum.

ACTION: Dr O'Donoghue, Dr Bradley

07/13 Specialty Advisory Committee Report

Professor Powis reported that the new structure for the SAC was due to be agreed in March, including transitional arrangements. The new curriculum was about to be printed. The SAC is currently working on mapping when trainees have gained competencies, and how to assess them. A national person specification is being developed for 'Modernising Medical Careers' and national interviews will be held in the spring for appointments. There is a slow expansion in the SpR grade which is happening at the local level, with deaneries communicating directly with PMETB. The SAC will be involved through the Regional Specialty Advisers, whose functions are being split into Training and Service. They are likely to be heads of schools of medicine, each nominated by several deaneries. The SAC will also include representatives from the Renal Association.

The new SAC structure, made up largely of regional specialty advisers, was discussed, in particular the fact that there is no way to guarantee any representation from District General Hospitals, which provide an important part of trainees' experience. Dr Rylance said that despite being able to provide training, DGH nephrologists feel disadvantaged at every stage; he would welcome more opportunities for getting trainees into their hospitals.

Although it is quite possible that of the eight regional members of the SAC at least one will come from a DGH, the Committee was perturbed by the lack of provision for this

representation. Professor Powis, while pointing out that the main purpose of the SAC will be curriculum development and assessment, said that he would take the Committee's concerns back.

ACTION: Professor Powis

07/14 Workforce Issues

The College census for 2005 was published in December and a census of non-medical staff being carried out by the RA, BRS and the Registry will be completed by 14 February, the date of a DH Workforce Review Team meeting which Dr O'Donoghue will attend. Given the current pressure to reduce the numbers of consultants in hospitals, the fact that few renal consultant posts are being advertised and appointments are made by local negotiation, there is a danger that post-CCT trainees may not be able to find a post. Some posts are being advertised for 'specialists' rather than 'consultants'.

The position seems to be that there is a national commitment to train specialist nephrologists to a single level of competency as consultants, but the current rate of adverts for new jobs is lower, and appointments are made by local negotiation. People are trained to the same standard but being paid less. This situation needs to be monitored, and Professor Feehally will take this issue to the Renal Association Education and Training Committee.

ACTION: Professor Feehally

Lastly, Dr O'Donoghue reported that post-CCT accreditation is being developed and could be used to give people additional competencies, thus enabling them to move into the specialty at short notice.

[Dr Gorrie left the meeting]

07/15 NICE Consultations

- (a) Guideline for the Management of Type 2 diabetes: Three names have been suggested for the Guideline Development Group
- (b) Febuxostat for the management of hyperuricaemia in patients with gout: Dr Paramit Chowdhury has been nominated to attend the scoping workshop, 16 February
- (c) Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women: Review postponed to 7 February
- (d) Cinacalcet hydrochloride for the treatment of secondary hyperparathyroidism in patients with end-stage renal disease on maintenance dialysis therapy: FAD published on 3 November; issue expected in January. *(see also 07.03(k))*

07/16 Regular Reports

(a) Patient and Carer Network

There were no particular issues to raise from the Network.

(b) British Association of Paediatric Nephrology

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

(c) British Renal Society

Doc 07.07

A report was received from Dr Stevens.

(d) British Transplantation Society

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

(e) Society of District General Hospital Nephrologists

Dr Rylance said that SDGH issues had already been covered. He was encouraged by the prominence given to their needs in the report on *The Changing Face of Renal Medicine*.

(f) New Consultants Committee

In the absence of Dr Griffith no report was received.

(g) SAS Nephrology Forum

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

(h) President RCP report, September 06 – January 07

Doc 07.06

The report from the President was noted.

07/17 RCP Open Day, 15 September 2007

The Open Day is a good opportunity to promote the specialty to potential medical trainees and to inform the public. Ideas for a display, to be put together by the specialist societies, will be discussed by the Renal Association.

07/18 Carter Review of Commissioning Arrangements

Doc 07.09T

The Chairman raised the issue of variations in specialist commissioning across the country following implementation of the Carter Review's recommendations. Ms Macarthur said that new strategic commissioning groups were being formed in the new Strategic Health Authorities, with more flexibility in what they can commission. Commissioning of services might be delegated to PCTs working collaboratively. A meeting of specialist commissioners will be held at the end of February.

Concerns were expressed that the Carter recommendations are not mandatory and that there will be marked regional differences in interpretation. The outcomes of the first period of the new systems should be monitored. Dr Winearls said that there were some good local arrangements, for example in Merseyside, but these were not disseminated around the country.

Ms Macarthur was asked to report on how the arrangements are working at the next meeting.

ACTION: Ms Macarthur

07/19 Date of next meeting

The Committee will next meet on Wednesday 27 June 2007 at 2pm.

The meeting ended at 13.30.