The changing face of renal medicine in the UK

John P Monson, on behalf of the Working Party of the Royal College of Physicians and the Renal Association

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A Working Party charged with the examination of the future of renal medicine provision, and particularly delivery of patient care, medical staffing and commissioning of renal services, was established as a joint initiative between the Royal College of Physicians and the Renal Association in 2005 and has recently reported its findings and recommendations.[1] Membership of the Working Party included clinical and academic nephrologists, from both traditional teaching centres and district general hospitals (DGHs), lay representation and a non-renal physician as chair. A number of developments, including the National Service Frameworks for Renal Services in England and Wales, the expansion of multiprofessional team working and the development of relationships between nephrology and primary care and other specialist teams highlighted the need for a Working Party. All of these factors provide an opportunity to enhance the provision of high quality patient-centred renal services. Against this backdrop there are pressing concerns in relation to specialist manpower, which derive from several factors impacting simultaneously on recruitment and staffing levels.

Manpower considerations

The traditional perception of nephrology is of an acute, hospital-based, interventional discipline with high esteem, academic credentials and a motivated consultant staff working long hours in a high intensity culture. More recently, evidence has been emerging to suggest that this traditional culture may be a disincentive to recruitment and, in particular, that it may be counterproductive for those trainees who require flexible training needs. Whereas the percentage of renal medicine registrars who are training flexibly is similar to other specialties, the overall numbers are very low (<3%) and are unlikely to reflect the underlying need for flexibility. An expansion in opportunities for flexible training is therefore recommended by the Working Party. Simultaneously, reduction in working hours for trainees poses a serious threat to experiential learning and will increase the requirement for investment in competency-based learning techniques that have not been completely validated. In recognition of this the Working Party recommended that, after completion of core training, there should be opportunities for accredited subspecialty expertise in dialysis medicine, critical care nephrology, interventional nephrology and transplant medicine.

In relation to academic nephrology, the Working Party recognised the importance of research opportunities for trainees, while highlighting that only a minority currently undertake a period of dedicated research. Furthermore, priority should be given to the establishment of a UK clinical research network for renal disease in order to ensure that opportunities for advances in patient care are maximised.

Renal units in district general hospitals

Recent growth in renal services has occurred predominantly in DGHs and the expansion has been absorbed by hard-pressed physicians who usually carry additional responsibilities for acute general medicine. In light of the prohibitively high number of trainees required to provide a specialist on-call rota, the Working Party concluded that expansion of consultant numbers in DGH renal units was essential. While recognising that dual accreditation in renal medicine and general (internal) medicine would remain the norm, the Working Party recommended that a commitment to acute general medicine should not be expected throughout a consultant's career.

In the provision of patient-centred care, the report supports the continuing expansion of extended competency-based roles for all health professionals in the renal multiprofessional team. The increasing emphasis on early detection of chronic kidney disease and the provision of conservative treatment for some patients with advanced renal disease will necessitate robust links with primary care and other secondary care services. The provision of high quality diagnostic

services across all renal units, including those based in traditional DGHs will be of paramount importance.

Commissioning of renal services

The Working Party recognised the existence of geographical inequalities in the provision of renal services in the UK and recommended increased effectiveness of specialised commissioning by means of locality networks, needs assessment and prioritised investment. The development of tariffs for renal services, which will inevitably be highly complex, will require full clinical engagement.

The members of the Working Party are grateful to the large number of individuals who provided evidence to inform its deliberations and hope that the recommendations will provide a useful basis for the planning of renal medicine provision over the coming years.

Members of the Working Party

John Monson (Chair), Emeritus Professor of Clinical Endocrinology and Consultant Physician, St Bartholomew's and the Royal London Hospitals; **Lindsey Barker**, Consultant Nephrologist, Royal Berkshire Hospital; **Gordon Bell**, Consultant Nephrologist and Clinical Director of Renal Medicine, Royal Liverpool University Hospital; **John Feehally**, Consultant Nephrologist, University Hospitals of Leicester; Honorary Professor of Renal Medicine, University of Leicester; President, Renal Association; **Tim Goodship**, Professor of Renal Medicine, University of Newcastle upon Tyne; **Bob Price**, Patient and Carer Network Representative, Royal College of Physicians; **Paul Rylance**, Consultant Nephrologist, Royal Wolverhampton Hospitals; Chair, Society for DGH Nephrologists

Reference

1 Royal College of Physicians and the Renal Association. *The changing face of renal medicine in the UK: the future of the specialty*. Report of a Working Party. London: Royal College of Physicians and the Renal Association, 2007.