NHS
London Clinical Senate

NHS
South East Clinical Senate
Kent Surrey and Sussex

London and South East Clinical Senates' - Improving Health Together: Advice on proposals for consolidating acute renal services within South West London, Surrey Heartlands and Frimley ICSs Report

May 2021

Contact details of the key personnel coordinating the review process

Ali Parsons
South East Clinical Senates (Kent Surrey Sussex)
Email: aliparsons@nhs.net
england.clinicalsenatesec@nhs.net
Web: www.secsenate.nhs.uk

Emily Webster
London Clinical Senate
Email: Emilywebster@nhs.net
Web: www.Londonsenate.nhs.uk

Table of contents

Addendum: Independent Clinical Review of additional reconfiguration options for acute renal services - Advice on proposals for consolidating acute renal services within South West London, Surrey Heartlands and Frimley ICSs.

1. Introduction and Context of the renal service reconfiguration proposals in Surrey and South West London

The Improving Healthcare Together 2020 to 2030 programme (IHT) was set up by the predecessor bodies to NHS Surrey Heartlands and NHS South West London CCGs in January 2018 to find the best solutions for the long-standing issues facing Epsom and St Helier hospitals.

NHS Surrey Heartlands and NHS South West London CCGs asked the Clinical Senates of London and the South East (Kent Surrey and Sussex), to provide independent advice on their proposals to improve the future of acute services in the combined geographies of Sutton, Merton and Surrey Downs CCGs. These services are provided by Epsom and St Helier University Hospitals NHS Trust.

The Clinical Senates have previously provided their advice in two stages:

- **Stage 1: September 2018: Review of the issues paper and supporting technical annex (case for change for acute service reconfiguration, clinical model and solutions development)** to *'Improving Healthcare Together 2020-2030'*
    - A desktop review of the emerging content in parallel with public engagement to inform further development for the pre-consultation business case (PCBC).
- **Stage 2: March 2019 Formal review of Draft PCBC**
    - The Senates reviewed the draft PCBC limited to shortlisted service configuration solutions inclusive of the clinical models for: A&E Urgent and Acute Care (inclusive of critical care, renal, acute medicine etc.), Planned Care, Maternity, Paediatrics.

As part of the acute service reconfiguration plans it was proposed that renal inpatient services provided by Epsom and St Helier would move from St Helier to Sutton, alongside other acute hospital inpatient services. This proposal formed part of the decision-making business case presented to and agreed by South West London CCG and Surrey Heartlands CCG at a Committee in Common meeting in July 2020.

Subsequently, clinical and managerial leads at Epsom and St Helier and St George's have made a statement of support for a joint specialist renal inpatient unit, to be located at St George's hospital. NHS Surrey Heartlands, NHS South West London CCGs, NHS England specialised commissioning and North East Hants and Farnham CCG asked the Clinical Senates of London and the South East (Kent Surrey and Sussex), *to provide a further independent review on their proposals and options therein to merge the acute renal inpatient services currently provided separately at St Helier Hospital and St George's Hospital Tooting to the St George's hospital site, rather than the scheduled transfer of renal inpatient services provided by St Helier Hospital to the new hospital site at Sutton.*

Specialist renal services in the United Kingdom have developed on a hub and spoke basis with the key tenet of development of services being to provide as much of the service as possible closer to a patient's home.

Allied to this has been the understanding that there are 2 main types of specialist renal inpatient service, one providing all specialist renal inpatient care including acute transplantation (i.e. the transplant operation and immediate aftercare), and the other providing all specialist inpatient care except acute transplantation. Each of these would be considered a 'hub'. Provision of care as close to home as possible includes a home dialysis service and provision of satellite dialysis services and specialist outpatients generally provided from the spokes. Most satellite units are co-located with existing hospitals (usually those with accident and emergency services) and although there is usually outreach provision of specialist renal inpatient opinion the spokes do not normally have specialist inpatient beds.

The options presented for consideration either centralise specialist inpatient renal services in an eccentrically positioned acute transplantation hub at St George's Hospital, or propose movement of specialist renal inpatient services without acute transplantation from St Helier to Sutton (do minimum option, also eccentrically positioned within the South West London ICS). In all options existing satellite dialysis and specialist outreach outpatient services remain unchanged, as does the provision of a limited renal inpatient service at Frimley.

This report once approved and published will be included as a formal addendum to the original Clinical Senates' review of the PCBC undertaken in March 2019. Wherever possible and appropriate aspects of the narrative, KLOE and recommendations have remained consistent.

2. Review methodology

The Clinical Senates agreed to convene a focused expert review panel in order to review the additional reconfiguration options for renal services. Where possible and appropriate some panel members were drawn from the previous clinical senate review panels.

The panel membership is listed in Appendix 5. Great care was taken to ensure that all panel member's declarations of interest and confidentiality agreements were valid.

For continuity and consistency, the key lines of enquiry (KLOE) previously applied to the clinical senate review of the full PCBC were reviewed and refreshed where appropriate and similarly applied, see Appendix 2.

This report and recommendations constitute a formal addendum to the previous clinical senates' review as published March 2019.

The initial documentation supplied for this review was, a new draft PCBC describing future options for the disposition of acute renal services. It was provided to the clinical senates' team on 19th April 2021, who developed key lines of enquiry (KLOE).

The PCBC, impact assessments, additional resources and key lines of enquiry were shared with the panel on 19th April 2021.

A half-day panel meeting was held on 6th May 2021. Members of the IHT programme team alongside senior renal clinicians from Epsom and St Helier and St George's, presented a summary of the proposed clinical model and options and took detailed questions from the panel. The second half of the panel meeting was for the clinical senate panel alone to consider their response and recommendations. The full agenda for the panel is shown in Appendix 4.

The notes from the meeting and comments made were synthesised into a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the NHS Surrey Heartlands, NHS South West London CCGs, NHS England specialised commissioning and North East Hants and Farnham CCG for matters of accuracy on 25th May 2021, and for review, comment then sign off by the clinical senate councils.

3. General recommendations

The pre-consultation business case (PCBC) builds on the Improving Healthcare Together (IHT) decision-making business case (July 2020) and considers further options for the future configuration of renal services.

The decision to relocate renal services currently provided at St Helier Hospital to Sutton was taken by commissioners as part of IHT.

The most recent PCBC re-examines the location of future renal inpatient services, driven by clinicians, and proposes a number of options including the consolidation of specialist renal inpatient services at St George's Hospital.

The overarching senate recommendations are detailed as R1, R2 and so forth, with subsections providing additional detail.

R.1. The PCBC cites four challenges in the case for change: Epidemiology and public health, clinical, workforce, estates. The provision of a better quality service with better outcomes is the key driver for this PCBC but could be more clearly articulated and presented in the document.

R.1.1. It will be good to highlight succinctly and in a way the public can relate to, the benefits to patient care, outcomes and experience that will result from the reconfiguration proposed. Currently such benefits as are described are somewhat scattered round the PCBC and should be brought together to demonstrate the benefits to the population of the changes being proposed.

R.1.2. In proposing a co-located specialist inpatient service at St George's there should be a clear description that the alternative options to co-location involve inpatient services on at least 2 sites (the do minimum option), together with the existing Frimley inpatient service. The qualitative service improvements anticipated for each option proposed in the final PCBC should be stated.

R.1.3. The benefits of the proposed option for all patients and populations need to be described with particular reference to the Surrey Heartlands geography but also other localities where increased travel distances, deprivation and higher incidence of renal disease apply. It would be helpful to include more specific mitigations to further reduce any impact and unintended consequences for those populations, whether planned or already in place.

To this end additional clarity regarding provision of services at existing satellite dialysis, outreach inpatient and outpatient services and the renal inpatient service at Frimley, would be beneficial, specifically in terms of whether the current service provision would remain the same or be extended/improved.

R.2. Whilst the context and drivers for the development of the options was acknowledged and understood by the Clinical Senate Expert Panel, it is essential that all options put forward within the finalised PCBC are similarly assessed and described. It may be helpful to illustrate figuratively the benefits assessment of each option, thus enabling the reader to compare and contrast the potential impact for stakeholders, public and patients for each option.

R.3. The narrative appears somewhat 'acute-centric'. While this may be understandable as the main changes involve those to hospital based services, there could be greater reference to epidemiology and public health challenges including modelling and projections as well as how the preferred option can help to ensure high quality delivery of an 'end to end clinical pathway'.

R.3.1. The PCBC would benefit from additional references to any plans to work with the renal clinical alliance and primary care networks (PCNs) to integrate a virtual clinical model.

R.3.2. The narrative describing the proposed clinical model needs to illustrate transparently the risks and any required mitigations associated with the ambition to create a sustainable model for centralised renal services, fully integrated with primary and community care and provided as locally as possible to support patients in their own homes.

4. Population health/inequalities. Improved health outcomes and associated activity projections

R.4. The PCBC would be significantly strengthened through greater emphasis on the improvements in health outcomes for the population that arise from the reconfiguration. This would have more impact with patients and the public.

R.4.1. The case justification, as currently written is more on process and proxy measures, such as travel times, staffing, waiting times and co-dependencies, but connecting these more directly to the impact on patient outcomes would provide a more 'robust' case.

R.4.2. Greater opportunities should be taken within the PCBC to illustrate the impact of the proposed service reconfiguration for different communities, in particular those furthest from the inpatient centre with greater deprivation as described in R.1.3.

R.4.3. Greater clarity regarding the range of health inequalities would be beneficial, including any inequalities in outcomes or uptake of interventions for people with renal disease. The impact assessment focuses understandably on travel times, but the plans need to take account of other areas of impact described in less depth in the assessment. These include the impact of ethnicity and deprivation. The PCBC details prevalence of chronic kidney disease (CKD) across the geographies but this is in fact only CKD stage 3-5.

Two of the key risk factors for CKD as the PCBC details are diabetes and hypertension. The prevalence of adult diabetes and hypertension across Kent, Surrey & Sussex is 7.3% and 14.5% of the population respectively, it would be helpful to see the breakdown of these and other key public health profiles in the PCBC.[1]

The importance of prevention is acknowledged in the PCBC and there is reference to comments from the South London Renal Alliance and to enhancing outreach and prevention of acute kidney injury (AKI) in the strategic objectives. However, more detail on how the proposals will achieve this better than the 'do minimum option' would support the case, together with an understanding of the relationship of acute kidney disease to chronic kidney disease and the potential influence the proposals will have. Other areas of prevention that the PCBC could link up relate to the proposals for improved vascular access for dialysis. There is a significant difference in patient-related quality of life, morbidity and mortality and in the requirement for inpatient resource between patients with successful arteriovenous fistula creation versus those with failed fistulae, synthetic arteriovenous grafts and tunnelled central venous access.

R.5. As a single renal centre (third biggest in the country), the PCBC describes the opportunity to develop a research centre. This may be better described by linking to how this will further address local health needs and improve outcomes for patients. It may be helpful to revisit this within the narrative.

4.1 Catchment areas and populations in relation to the presented options: Travel

R.6. Whilst an assessment of increased travel time is described additional detail would improve the understanding of the possible impact on services. There are generalised statements that the increased travel times are mitigated by the improvements to the services. It will be important within patient and public engagement/consultation to gain a greater understanding of patient/carer views on the potential impact, weighed up against the general benefits of the proposal.

R.6.1. Whilst mitigation that details a 'trade off' between access and significantly improved services, is not unreasonable, it would be important for the narrative to map more specifically the catchment area population most affected and detail/quantify what clinical improvements would be anticipated.

[1] https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease/profile/cardiovascular

R.6.2. Additional data with respect to the population at higher risk of renal disease (which may not necessarily be the most deprived population), could significantly improve the relevancy of the current narrative and should be linked to access to the inpatient centre (own transport, public transport, hospital transport and affordability). This should encompass not just the patients themselves but also likely visitors and carers.

R.6.3. The current data should be reviewed and enhanced through the use of patient stories that include patients accessing centralised services at St George's from geographically distant locations, for example Haslemere, Horsham and Crawley areas and also Farnham.

5. Bed and activity modelling across the shortlisted options

R.7. The current 'cautious' activity and capacity modelling and efficiency assumptions would benefit from additional detailed rationale re assumptions and analysis.

R.7.1. The current modelling assumptions include a 1% improvement in LoS, and a conversion from inpatient stays to ambulatory cases. Additional detail should include the mitigations of the risks to the previous working relationships between the service at St Helier and the various communities feeding into the inpatient centre at St Helier, which may potentially be lost and therefore negatively impact LoS.

R.7.2. Specific reference to envisaged demographic growth (1.9% as per original IHT business case) would provide useful context to the detailed modelling rationale.

R.7.3. Confirmation that the planned capacity and growth assumptions (including 7% growth in transplant surgery), are sufficient to ensure that there is no perceived likelihood for a delay in the patient pathway (i.e. referral in from another hospital needs to be immediately transferred), should be included within the PCBC.

R.8. There is no detailed bed and activity modelling, including LoS for all options under consideration. The rationale and modelling should provide an understanding of the relative bed requirements of the key sub specialties (peritoneal and haemodialysis programmes, transplant programme, acute kidney injury and general nephrology). It is recommended that summary details on how these may change and be impacted upon by proposed prevention work are included.

R.8.1. Such projections will inevitably be estimates and a sensitivity analysis that describe a range rather than a specific number should be used, both for the demographics and the associated activity and bed numbers. It would be helpful to state that the activity assumptions are implicit within the global growth figures used for both the main IHT FBC and the renal projections. Risk and mitigations should be described for the forecasts.

R.8.2. The PCBC should detail any projected % increase in activity at the St George's site taking account of the prevention agenda, provision of 'local, District Hospital services' at St Helier, community based initiatives, and projected population growth.

6. Clinical Model

R.9. The Getting It Right First Time (GIRFT) summary report for St Helier highlights as an exemplary area of practice the "highly de-centralised model of care, with nephrology, dialysis and acute kidney injury support close to patients". The PCBC needs to explain how the new joint specialist model of care will align with/improve this assessment.

R.10. Patient service pathways should be reviewed in association with any projected capacity challenges. The narrative should be revised to provide further information with respect to working collaboratively at a network level with associated disciplines (including imaging and interventional radiology (IR), critical care and vascular services).

Additional data and analysis would provide reassurance specifically around IR and critical care capacity within the centralised service option at St George's.

R.10.1. The PCBC states that the impact on critical care, cardiology, therapies etc. will be subsumed by existing capacity at St George's and are not significant when considering the scope of St George's services. Some data to support that statement would strengthen the case. (It is anticipated that data evidencing the existing demand on critical care, cardiology and therapies from the St Helier specialist renal inpatient service is likely to be available and could be utilised.)

R.10.2. The benefits and risks (including mitigation) of merging the acute renal services on to one site would benefit from further detail. It will be important to demonstrate the basis of the premise that renal inpatient care will be better in a combined centre at St George's as compared to St Helier services transferred to the new Sutton site. The use of patient stories illustrating the benefits would significantly enhance the narrative e.g. Assessment and treatment, Acute kidney injury pathway, vascular access (VA) surgery pathway, interventional radiology (IR), transplantation emergencies pathway.

R.10.3. The key components of high quality and sustainable vascular access service would include:

- IR capacity (including radiologists, radiographers, specialist nurses and theatre standard imaging facilities)
- Vascular access personnel
- 24/7 consultants
- Theatre space
- Day case
- GA theatres

The narrative should illustrate how access to these components at St George's are assured, what potential risks have been identified and how they may be mitigated.

How would this differ for renal services located on the new Sutton site, what would be the anticipated benefits?

R.11. Describe in further detail the anticipated benefits (improved patient treatment and outcomes) of unifying the teams on the St George's site.

R.11.1. The narrative needs to clearly describe access to the VA service from the Frimley satellite beds for both the do minimum and combined services at St George's options.

R.11.2. It would be helpful to quantify the anticipated benefits (i.e. how will it be better?) to the vascular access service. The narrative would be improved by using a patient illustration.

R.12. Whilst capacity has not been described as a barrier, greater detail regarding the pre-dialysis pathway is required, including clear indications of any necessary changes to the pathway.

R.13. Further detail is required regarding the pathway and access to day case surgery. There is an opportunity to align within the PCBC responses to the GIRFT recommendations re day case surgery.

R.13.1. The narrative needs to detail future plans for day case surgery inclusive of beds and the anticipated numbers of patients 'converted' to a day case surgery route and should state any anticipated risks and mitigation re theatre access. For example, describe how this change in service provision will benefit the patient.

R.13.2. Additional narrative re theatre availability and usage is required in terms of the proposed day case surgery pathway, including theatre session requirements, day case bed capacity and activity modelling. Within each option the siting of the services should be confirmed.

R.14. The PCBC needs to describe how a centralised model at St George's aligns with the provision of outreach services at Frimley. The panel heard a summary of potential future developments on Panel Day – the current PCBC does not include any details. Additional narrative is recommended.

R.14.1. There needs to be more emphasis on the service access requirements for the patient population that is furthest away from a centralised service at St George's. Evidence suggests that access to specialist inpatient services is inversely related to distance from those services.[2] [3] [4]

R.14.2. The current clinical model needs to be supplemented with a clear assessment and plan for the provision of sustainable outreach/satellite services, (i.e. nephrology – dialysis - advanced kidney care, podiatry – diabetic foot care), to ensure that the potential unintended consequences of centralising specialised acute renal inpatient services at St George's do not result in a net increase inequalities in health and access.

R.14.3. A tabulated break down, using clinical scenarios ((e.g. VA, acute inpatients – (acute pneumonia and dialysis, palliative care), day case surgery and day case procedures)), of the variances to the pathway for inpatients from satellite units would illustrate any potential differences in the proposed model and provide assurance re risk identification and mitigation. A similar analysis for outpatients and rehabilitation would also be valuable.

R.15. Further narrative confirming the pathway for patients presenting with AKI, dialysis and transplant related emergencies and general nephrology emergencies at the new centralised inpatient site as compared to the Sutton option should be referenced including clarity re access to dialysis.

R.16. The 'end to end patient pathway' must be reflected within the PCBC to include reference to community care pathways and improved management of patients at home particularly if changes to LoS are envisaged that may directly impact on ongoing primary community and integrated care plans.

---

[2] Barnett S, Roderick P, Martin D, Diamond I. A multilevel analysis of the effects of rurality and social deprivation on premature limiting long term illness. J Epidemiol Community Health. 2001 Jan;55(1):44-51. doi: 10.1136/jech.55.1.44. PMID: 11112950; PMCID: PMC1731764.

[3] Levesque, JF., Harris, M.F. & Russell, G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health 12, 18 (2013).

[4] The National Service Framework for Renal Services. Available from https://www.gov.uk/government/publications/national-service-framework-kidney-disease

R.17. The clinical model should be positively supplemented through the inclusion of additional detail outlining how existing, critical, local relationships with primary, community, rehabilitation and local authority services at a local place and system level will be sustained and developed within an option that centralises services at St George's.

R.17.1. Planned actions to mitigate any unintended consequences to these relationships should be highlighted within the PCBC, including specific reference to delays to discharge management – integrated discharge teams social care/AHPs – robust discharge management arrangements and the challenges to delivering integration at scale.

7. Ambulance triage, transfer and capacity

R.18. It will be important to make a clear distinction between the Patient Transport Service and Emergency Ambulance parts of the pathway, including where responsibility lies for operational delivery.

R.18.1. As plans develop early engagement with London Ambulance (LAS) and South East Coast Ambulance (SECAmb) is recommended.

R.19. Consideration needs to be made of the impact on the ambulance service for conveyance of other patient groups i.e. journey times and turnaround for the ambulance service may be significantly increased.

R.20. There is no mention of the impact on LAS and SECAmb services and the potential implications to their fleets and staff levels and future workforce planning.

R.21. The potential additional pressure on the ambulance services, specifically Patient Transport Services (PTS) and or any additional CCG patient transport contracts, is not necessarily accounted for.

8. Workforce strategy and issues

R.22. The trusts are grappling with workforce challenges relating to their major acute services that are far from unique across the country, and many other reconfigurations are being driven by the same pressures. It would help to paint this contextual national picture, so that it is clear this is a shared problem.

R.23. Greater clarity is required through detailing a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce, training and education, and the opportunities provided by new roles and ways of working.

R.23.1. The narrative currently focuses on the medical workforce, particularly consultants, with only very limited mention of other staff. There should be more detail provided on the requirements for nursing staff, allied health professionals (AHPs) and all relevant health professionals across the services and sites.

R.23.2. The proposed changes to the configuration of renal services may improve prospects for recruitment, retention and opportunities for new roles.

R.24. Whilst granular workforce modelling and analysis is not required within a PCBC some additional detail would provide increased confidence that a full assessment of the potential impact of the proposals on the workforce has been undertaken.

This would include:

- Clear reference to the underpinning organisational workforce strategies.
- The workforce recruitment and retention assumptions made through combining acute renal services.
- Assessment of workforce challenges that may arise in co-dependent services e.g. diagnostics including IR, critical care etc.
- An assessment of the unintended workforce consequences of merging the two units.
- Assessment of clinician capacity to meet demand. (Doctor, Nurse, AHPs diagnostic and support staff). Changes required to working patterns e.g. move from 5/7 to 7/7 working.
- Clarity of a proposed workforce model that identifies the risks and mitigations for safe and sustainable rotas.
- Assessment of the impact on workforce within co-dependent services.
- Potential opportunities afforded by new roles and new ways of working.
- Acknowledgement of the potential impact of the proposed model on out of hospital, primary and community care workforce modelling, with proposed mitigation.

8.1 Training

R.25. The current uncertainty about filling specialist training programmes may be partly mitigated by the centralisation of acute renal services on to one site.

R.25.1. There are advantages to working in larger centralised acute services, but the re-designation of beds will likely have an impact on training programmes and rotations and should be more fully considered with the post-graduate deans:

- Number of training posts feasible on a single acute site may be less that the current two site model.
- Centralisation of trainees potentially denies them opportunities for learning and experience in home dialysis, satellite dialysis and peritoneal dialysis.

- It is important to consider training as part of the whole process and to consider the trainee input to the future roles – engage with and encourage assist/co-design.

R.26. The PCBC could be strengthened by further describing what plans there are in place to increase opportunities for research and education/training (through a concentration of patients and diversification of case mix).

9. Level of patient, public and clinical engagement

R.27. Whilst the PCBC reflected some evidence of patient and public engagement, there needs to be greater illustration of how patients and public could help co-design future services and treatment environments using 'experts by experience' (formerly 'expert patients').

R.27.1. The PCBC needs to detail further evidence for how the public and patients have been involved with the co-design of the proposed new clinical model and pathways to date. Opportunities for model and pathway co-design both as pre-engagement and in later consultation should be sought, capitalised upon and reflected within the PCBC and Consultation document.

The current narrative within the PCBC suggests that engagement to date with the wider public re proposed changes has been limited.

R.27.2. Assumptions have been made based on previous pre-engagement with a 'selected informed group', i.e. historical Kidney Association and renal patients and carers accessing current services. Engagement with the broader public across the whole affected geography will be essential.

R.27.3. Brief patient stories, capturing the service population catchment area, summarising critical service issues identified through pre-engagement will provide confidence in terms of breadth and depth of engagement, demonstrating a thorough and inclusive approach.

R.28. Clinical engagement to date should be widened and needs to become more inclusive of all stakeholders, clinicians and support staff.

R.29. Broader stakeholder engagement should be undertaken. This will be important to prioritise including impacted acute units (i.e. St George's, Frimley etc), neighbouring acute providers, local authority, community and primary care.

It will be important not to rely on the engagement undertaken to date with regards to the broader IHT programme but to ensure a very tailored and focused approach for the renal proposals.

10. Digital

R.30. There is some evidence that proposals and plans are in place with respect to overarching digital strategies, however the PCBC could be strengthened through a more detailed summary that confirms that plans are in place to address the following:

- **Integrating IT systems: PACS, CB5, Cerner.**
- **Digital information sharing – shared care records, access to primary care records (Surrey).**
- **Operational risks associated with satellite services; what mitigations are proposed?**
- **Shared digital learning - COVID19.**
- **Near patient monitoring.**
- **A description of the use of Renal patient View.**

11. Sustainability

R.31. There is some evidence that proposals and plans are in place with respect to overarching sustainability strategies, particularly around the new build and zero carbon ambitions. However, additional detail evidencing how the zero carbon ambition will be met, e.g. ways of working/reduced use of disposable would enhance the PCBC overall.

R.32. More detail within the sustainability plans to include reference to any proposed models for green nephrology would be beneficial.[5]

Kidney care has a disproportionately high water and carbon footprint, for example each haemodialysis session consumes approximately 400 litres of water and annual carbon emissions are equivalent to 7.1 tonnes of CO_2 per dialysis patient. Please detail how a new build centralised inpatient unit will address this.

[5] Barraclough, K.A., Agar, J.W.M. Green nephrology. *Nat Rev Nephrol* **16,** 257–268 (2020). https://doi.org/10.1038/s41581-019-0245-1

12. COVID-19

R.33. Additional narrative detailing how COVID-19 has altered clinical delivery especially reflections on 'lessons learnt' such as the use of virtual clinics, increase in day case procedures and surgery, digital, working with PCNs, using the KA and flexing of ITU capacity would enhance the current PCBC.

R.34. It would be helpful to understand what has been done differently with reference to the proposed clinical models and pathways and to understand what should now continue, what requires further adaptation in order to ensure sustainability and what should be stopped for example the discharge integrated hub which is a COVID model.

13. The options appraisal process

R.35. Whilst it is not the role of clinical senate to make recommendations on option appraisal process issues, the current narrative focuses predominantly on the option to centralise specialised acute inpatient care on the St George's site as a preferred option. A more balanced narrative that outlines the relative challenges and opportunities for all options under consideration would improve the case overall.

14. Clinical evidence and standards

R.36. The current PCBC would be improved through broader reference to the following suggested documents:

- GETTING IT RIGHT FIRST TIME: Renal Medicine Review EPSOM AND ST HELLIER UNIVERSITY HOSPITALS NHS TRUST. Summary Report and Next Steps
- GETTING IT RIGHT FIRST TIME: Renal Medicine Review St George's Healthcare NHS FT. Summary Report and Next Steps
- Kidney Health Inequalities in the UK: An agenda for change. Kidney Research UK. March 2019
- Patient Reported Experience of Kidney Care in the UK 2020. Available from: https://renal.org/kidney-patient-reported-experience-measure
- UK Renal Registry (2020) UK Renal Registry 22nd Annual Report – data to 31/12/2018, Bristol, UK. Available from www.renal.org/audit-research/annual-report
- NICE Quality Standard 76: Acute Kidney Injury. Available from https://www.nice.org.uk/guidance/qs76

- NICE guideline [NG148] Acute kidney injury: prevention, detection and management. Available from https://www.nice.org.uk/guidance/ng148
- NICE guideline [NG107] Renal replacement therapy and conservative management. Available from https://www.nice.org.uk/guidance/ng107
- NHS Commissioning: Specialised services: A06 Renal Services. Available from https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a06/
- Renal Association Clinical Practice Guidance. Available from: https://renal.org/health-professionals/guidelines/guidelines-commentaries

15. Conclusion

There has been extensive and detailed work undertaken in constructing the draft PCBC, with evidence of initial clinical engagement and involvement. There are clinical benefits stated for consolidating the acute renal services on to the St George's site, particularly with respect to maintaining sustainable critical clinical co-dependencies, and for the potential to create a single centre of excellence from a research and training perspective. The ambition to create a sustainable model for acute renal care that culminates in a better quality service with better outcomes is well placed.

However, the PCBC could be improved further by including a more detailed description of the impact of consolidating services at St George's on access and clinical outcomes for the population of Surrey, description of the proposed patient pathways, of the role and modus operandi of the 'satellite' sites and outreach services, the activity and bed modelling and a detailed and comprehensive outline of the workforce requirements reflecting an aligned workforce strategy. This would provide additional confidence in the plans in terms of deliverability and sustainability.

The risks involved with placement of the only specialist renal inpatient centre within the South West London ICS and the associated mitigations should be described and further consideration should be made as to how best to present the options for consideration.

Renal services across a whole geography

The terms of reference for the Clinical Senates' expert panel review were to examine and critique the 4 options presented in the PCBC, not the totality of provision of renal services for South West London, Surrey Heartlands and Frimley ICSs.

Nonetheless, there is a concern that some patients requiring an inpatient renal service, notably those living in certain geographies may be disadvantaged. Both centralisation of inpatient services on the St George's site and the do minimum option of continuing with the

move of specialist renal inpatient services from St Helier to Sutton perpetuate this disadvantage. The concern is not for satellite dialysis services or for specialist renal outpatient services (which remain as before and are not part of the review), neither is the concern for specialist inpatient transplantation, because that will be unaffected under any option. Additional detail describing the stated development of the delivery of the single clinical model at the Frimley to provide all renal inpatient services short of acute transplantation could be included.

It would also be helpful to acknowledge that whilst the proposals provide a vibrant, viable and sustainable solution for renal services in South West London and close surrounds, the options presented do not provide as great a benefit for the population of Surrey and particularly the population in the South Eastern part of the geographical catchment. As a consequence, this highlights a need for future work to examine how long term and more sustainable solutions for these populations could be commissioned.

Clinical senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to ensure that the proposals going forwards are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the populations of South West London and Surrey Heartlands ICSs as they finalise their proposals prior to public consultation.

16. Addendum Appendices

Appendix 1 Recommendations

Number Ref.	Recommendations
General Recommendations	
R.1.	The PCBC cites four challenges in the case for change: Epidemiology and public health, clinical, workforce, estates. The provision of a better quality service with better outcomes is the key driver for this PCBC but could be more clearly articulated and presented in the document.
R.2.	Whilst the context and drivers for the development of the options was acknowledged and understood by the Clinical Senate Expert Panel, it is essential that all options put forward within the finalised PCBC are similarly assessed and described. It may be helpful to illustrate figuratively the benefits assessment of each option, thus enabling the reader to compare and contrast the potential impact for stakeholders, public and patients for each option.
R.3.	The narrative appears somewhat 'acute-centric'. While this may be understandable as the main changes involve those to hospital based services, there could be greater reference to epidemiology and public health challenges including modelling and projections as well as how the preferred option can help to ensure high quality delivery of an 'end to end clinical pathway'.
Population health/inequalities. Improved health outcomes and associated activity projections	
R.4.	The PCBC would be significantly strengthened through greater emphasis on the improvements in health outcomes for the population that arise from the reconfiguration. This would have more impact with patients and the public.
R.5.	As a single renal centre (third biggest in the country), the PCBC describes the opportunity to develop a research centre. This may be better described by linking to how that will further address local health needs and improve outcomes for patients. It may be helpful to revisit this within the narrative.
Catchment areas and populations in relation to the presented options: Travel	
R.6.	Whilst an assessment of increased travel time is described additional detail would improve the understanding of the possible impact on services. There are generalised statements that the increased travel times are mitigated by the improvements to the services. It will be important within patient and public engagement/consultation to gain a greater understanding of patient/carer views on the potential impact, weighed up against the general benefits of the proposal.

Bed and activity modelling across the shortlisted options	
R.7.	**The current 'cautious' activity and capacity modelling and efficiency assumptions would benefit from additional detailed rationale re assumptions and analysis.**
R.8.	**There is no detailed bed and activity modelling, including LoS for all options under consideration. The rationale and modelling should provide an understanding of the relative bed requirements of the key sub specialties (peritoneal and haemodialysis programmes, transplant programme, acute kidney injury and general nephrology). It is recommended that summary details on how these may change and be impacted upon by proposed prevention work are included.**
Clinical Model	
R.9.	**The Getting It Right First Time (GIRFT) summary report for St Helier highlights as an exemplary area of practice the "highly de-centralised model of care, with nephrology, dialysis and acute kidney injury support close to patients". The PCBC needs to explain how the new joint specialist model of care will align/improve this assessment.**
R.10.	**Patient service pathways should be reviewed in association with any projected capacity challenges. The narrative should be revised to provide further information with respect to working collaboratively at a network level with associated disciplines (including imaging and interventional radiology (IR), critical care and vascular services). Additional data and analysis would provide reassurance specifically around IR and critical care capacity within the centralised service option at St George's.**
R.11.	**Describe in further detail the anticipated benefits (improved patient treatment and outcomes) of unifying the teams on the St George's site.**
R.12.	**Whilst capacity has not been described as a barrier, greater detail regarding the pre-dialysis pathway is required, including clear indications of any necessary changes to the pathway.**
R.13.	**Further detail is required regarding the pathway and access to day case surgery. There is opportunity to align within the PCBC responses to the GIRFT recommendations re day case surgery.**
R.14.	**The PCBC needs to describe how a centralised model at St George's aligns with the provision of outreach services at Frimley. The panel heard a summary of potential future developments on Panel Day – the current PCBC does not include any details. Additional narrative is recommended.**
R.15.	**Further narrative confirming the pathway for patients presenting with AKI, dialysis and transplant related emergencies and general nephrology emergencies at the new centralised inpatient site as compared to the Sutton option should be referenced including clarity re access to dialysis.**

R.16.	**The 'end to end patient pathway' must be reflected within the PCBC to include reference to community care pathways and improved management of patients at home particularly if changes to LoS are envisaged that may directly impact on ongoing primary community and integrated care plans.**
R.17.	**The clinical model should be positively supplemented through the inclusion of additional detail outlining how existing, critical, local relationships with primary, community, rehabilitation and local authority services at a local place and system level will be sustained and developed within an option that centralises services at St George's.**
Ambulance triage, transfer and capacity	
R.18.	**It will be important to make a clear distinction between the Patient Transport Service and Emergency Ambulance parts of the pathway, including where responsibility lies for operational delivery.**
R.19.	**Consideration needs to be made of the impact on the ambulance service for conveyance of other patient groups i.e. journey times and turnaround for the ambulance service may be significantly increased.**
R.20.	**There is no mention of the impact on LAS and SECAmb services and the potential implications to their fleets and staff levels and future workforce planning.**
R.21.	**The potential additional pressure on the ambulance services, specifically Patient Transport Services (PTS) and or any additional CCG patient transport contracts, is not necessarily accounted for.**
Workforce strategy and issues	
R.22.	**The trusts are grappling with workforce challenges relating to their major acute services that are far from unique across the country, and many other reconfigurations are being driven by the same pressures. It would help to paint this contextual national picture, so that it is clear this is a shared problem.**
R.23.	**Greater clarity is required through detailing a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce, training and education, and the opportunities provided by new roles and ways of working.**
R.24.	**Whilst granular workforce modelling and analysis is not required within a PCBC some additional detail would provide increased confidence that a full assessment of the potential impact of the proposals on the workforce has been undertaken.**
Training	
R.25.	**The current uncertainty about filling specialist training programmes may be partly mitigated by the centralisation of acute renal services on to one site.**
R.26.	**The PCBC could be strengthened by further describing what plans there are in place to increase opportunities for research and education/training (through a concentration of patients and diversification of case mix).**

Level of patient, public and clinical engagement	
R.27.	**Whilst the PCBC reflected some evidence of patient and public engagement, there needs to be greater illustration of how patients and public could help co-design future services and treatment environments using 'experts by experience' (formerly 'expert patients').**
R.28.	**Clinical engagement to date should be widened and needs to become more inclusive of all stakeholders, clinicians and support staff.**
R.29.	**Broader stakeholder engagement should be undertaken. This will be important to prioritise including impacted acute units (i.e. St George's, Frimley etc), neighbouring acute providers, local authority, community and primary care.** **It will be important not to rely on the engagement undertaken to date with regards to the broader IHT programme but to ensure a very tailored and focused approach for the renal proposals.**
Digital	
R.30.	**There is some evidence that proposals and plans are in place with respect to overarching digital strategies, however the PCBC could be strengthened through a more detailed summary that confirms that plans are in place to address the following:** • **Integrating IT systems: PACS, CB5, Cerner.** • **Digital information sharing – shared care records, access to primary care records (Surrey).** • **Operational risks associated with satellite services; what mitigations are proposed?** • **Shared digital learning - COVID19.** • **Near patient monitoring.** • **A description of the use of Renal Patient View.**
Sustainability	
R.31.	**There is some evidence that proposals and plans are in place with respect to overarching sustainability strategies, particularly around the new build and zero carbon ambitions. However, additional detail evidencing how the zero carbon ambition will be met, e.g. ways of working/reduced use of disposable would enhance the PCBC overall.**
R.32.	**More detail within the sustainability plans to include a proposed model for green nephrology would be beneficial.**
COVID-19	
R.33.	**Additional narrative detailing how COVID-19 has altered clinical delivery especially reflections on 'lessons learnt' such as the use of virtual clinics, increase in day case procedures and surgery, digital, working with PCNs, using the KA and flexing of ITU capacity would enhance the current PCBC.**

R.34.	**It would be helpful to understand what has been done differently with reference to the proposed clinical models and pathways and to understand what should now continue, what requires further adaptation in order to ensure sustainability and what should be stopped for example the discharge integrated hub which is a COVID model.**
The options appraisal process	
R.35.	**Whilst it is not the role of clinical senate to make recommendations on option appraisal process issues, the current narrative focuses predominantly on the option to centralise specialised acute inpatient care on the St George's site as a preferred option. A more balanced narrative that outlines the relative challenges and opportunities for all options under consideration would improve the case overall.**
Clinical evidence and standards	
R.36.	**The current PCBC would be improved through broader reference to the following suggested documents:**

Appendix 2 KLOEs

General KLOEs
Do the proposals deliver improved and high-quality patient outcomes?
Are the needs of the population and any health inequalities addressed - How will the planned reconfigurations improve health outcomes for the populations of the ICS/CCGs?
What is the potential impact of increased travel times (ambulance, patient transport and private transport; public transport for visitors).
How have you mitigated for the slight adverse impact due to longer journey times and greater complexity of journeys using public transport?
How do you plan to ensure that patient transport services remain in place and fit for purpose in the long term and remain a viable option for patients?
Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce, training and education, and the opportunities provided by new roles and ways of working?
Co-dependencies of related clinical services: Has the impact on critical care, operating theatres, medical and surgical specialties and support services, especially diagnostics and therapies been fully articulated?
How will the hospitals network services and deliver seamless clinical information sharing?
Are there plans for the necessary digital clinical information sharing across multiple care delivery sites across the trust, and alignment of the digital strategies of the two relevant ICSs?
Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan/21/22 Planning Guidance.
What approaches have been taken to ensure that the future clinical model for kidney care takes full account of sustainable healthcare requirements for the future. (*The Centre for Sustainable Healthcare has identified kidney care as creating a disproportionately high water and carbon footprint, for example each HD session consumes approximately 400 litres of water and annual carbon emissions are equivalent to 7.1 tonnes of CO2 per dialysis patient.)*
Has the relevant system learning from COVID-19 been taken into account as part of the plans?
Has the breadth and depth of clinical engagement been sufficient?
Has the breadth and depth of patient and public engagement been sufficient? The PCBC does not give a sense of co-creation with patients
Sutton is a new hospital and all the different specialties and teams will be presumably starting afresh whereas St Georges is an existing location into which a new team will be parachuted in. What work has been undertaken to ensure seamless integration and acceptance of the much larger service and the new team?
Service specific KLOEs
Acute inpatient renal services - Non elective: General Nephrology, AKI, Kidney transplant emergencies, haemodialysis and peritoneal dialysis emergencies
General comments on the patient pathway. Using a patient in Farnham and a patient in Horsham as examples describe what happens to me now if my fistula thromboses acutely and what would happen in the future under the proposals put forward. What about if I am a transplant patient and I develop acute rejection? Describe the key quality improvements.
What impact may the proposals have on the pathway for end stage kidney failure including Advanced Kidney Care Clinics/RRT- conservative management?
Do the proposals reduce variation and co-ordinate improved provision of protocoled, holistic care for patients with diabetes and end stage kidney disease?
How do the proposed pathways support the potential for reduction in emergency hospitalisation of HD patients and reduction in emergency hospitalisation of transplant patients?
Does the current activity and capacity modelling demonstrate that planned bed capacity will be sufficient to ensure there is no delay in the patient pathway i.e. referral in from another hospital needs to be immediately

transferred? The future flexibility critical success factor (CSF) described is the ability to accommodate projected activity to 2030 and the commercial viability CSF is that the service will be operational by 2025 – this suggests a lifespan of only 5 years.
Is there a clear and deliverable workforce plan?
Is there confidence that any patient transfer service pathways and capacity issues have been sufficiently addressed? What plans are in place to work collaboratively at a network level with associated disciplines (including imaging and IR, critical care and vascular services)?
Are the benefits and risks (including mitigation) of merging the acute renal services on to one site clearly articulated and why will renal inpatient care be better in a centre at St Georges as compared to Sutton: • A&E (ED) • Assessment and treatment Acute renal pathway • Vascular access surgery pathway • Transplant emergencies • Critical care • Interventional radiology • Cardiology • Urology • Others (optimal inpatient care would need rapid access to most medical and surgical specialties).
Will the co-location of the various key clinical support specialties and services support the proposed model? Are there any risks to optimal inpatient services where rapid access to specified medical or surgical specialities is not possible?
What approach and mitigation have you taken to any potential unintended consequences of centralising acute inpatient services e.g. introducing delayed discharge through loss of existing relationships with community care and community rehabilitation services.
What consideration has been given to coordination of care and support in the community following an inpatient stay. If I am a patient in Haslemere how does that happen now and what will happen under future proposals?
The PCBC details that there will be a renal inpatient centre still at Frimley – What plans are in place to mitigate any risk of unwarranted variation in the quality of care received at Frimley as opposed to at St George's?
Are there additional clinical standards beyond those referenced?
Acute inpatient renal services - Elective: general nephrology (including renal biopsy), transplantation and renal replacement therapy.
General comments on the patient pathways.
Will the co-location of the various key clinical support specialties and services support the proposed model?
What is the proposed model for the provision of kidney biopsy, inpatient or day case? How will the patient pathway address potential complications (bleeding, requiring interventional radiology) and also access to rapid result and renal histopathology?
Is the interface and pathways between the acute hospital renal service and the community renal service (home haemodialysis) adequately described (so that unnecessary transfers to hospital can be avoided)?
Is there a clear plan in place to improve the overall standard of home-dialysis training quality and efficiency, with a view to increasing home-dialysis uptake?
Is there a clear and deliverable workforce plan?
With a model of centralised inpatient care how will the renal service across the ICS assure that the inpatient nephrology opinion in the 'local' hospitals will be or continue to be high quality and accessible?
Are there sufficient published clinical standards referenced in the PCBC?
Is the renal surgical /transplant pathway clear and sound?
Outpatient renal services: Additional support in early stages of dialysis care, Home/satellite haemodialysis training

Is there a clear and deliverable workforce plan?
Are there sufficient published clinical standards referenced in the PCBC?
Are the plans aligned with the Renal Services Transformation Programme?
Are the plans to increase opportunities for research and education/training (through a concentration of patients and diversification of case mix) in the new centre robust and sustainable?
Are they inclusive of all relevant professions? (Medical, nursing, pharmacy, dietetic, social work and therapies training opportunities).
KLOEs relating to the preferred option (Option 3 and 4) for future acute renal services configuration
Are there option-specific issues that need highlighting in relation to: • Impact on quality of care and clinical outcomes • Equitable access for the population across the two CCGs • Clinical co-dependencies between services • Impact on specific major inpatient clinical services. • Workforce implications • Capacity (A&E, beds, theatres, critical care) • Patient flow?
Is the impact on neighbouring hospitals clearly described for the preferred option, and are there any associated issues of concern not described in the PCBC?
Is the impact on surrounding acute trust's renal services clear (including specialist/tertiary services)?
Are there option-specific issues that need highlighting in relation to: • Impact on quality of care and clinical outcomes • Equitable access for the population across the two CCGs • Clinical co-dependencies between services • Impact on specific major inpatient clinical services. • Workforce implications • Capacity (ED, beds, theatres, critical care) • Patient flow?

Appendix 3 Glossary

AHP	Allied Health Professionals
AKI	Acute Kidney Injury
BAU	Business as Usual
BYFH	Building Your Future Hospitals
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
CiC	Committees in Common
CIP	Cost Improvement Plans
CQC	Care Quality Commission
CSF	Critical Success Factors
DH	District Hospital (as defined in the PCBC and not equivalent to a 'district general hospital')
DMBC	Decision Making Business Case
ESRF	End Stage Renal Failure
ESTH	Epsom and St Helier University Hospitals NHS Trust
GIRFT	Get it right first time
HD	Haemodialysis
HEE	Health Education England
HIP	Healthcare Improvement Plan (New Hospitals Scheme)
HPCG	Health Premises Cost Guides
IA	Impact Assessment
IHT	Improving Healthcare Together
IR	Interventional Radiology
IMD	Index of Multiple deprivation
JSNA	Joint Strategic Needs Assessments
KLOE	Key lines of enquiry
KPAs	Kidney Patient Associations
LA	Local Authority
LoS	Length of Stay
NEL	Non-elective activity (i.e. urgent or emergency)
NPSV	Net Present Social Value
OB	Optimism Bias
OBC	Outline Business Case
PCBC	pre-consultation business case
PD	Peritoneal Dialysis
PDC	Public Dividend Capital
QIPP	Quality, Innovation, Productivity and Prevention programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care.
RRT	Renal Replacement Therapy
R&D	Research and Development
SECH	Specialist Emergency Care Hospital
SGUH	St George's University Hospitals NHS Foundation Trust
SGUL	St Gorge's University of London
SHOs	Senior House Officers
SLRCA	South London Renal Clinical Alliance
SWL	South West London
ULA	Useful Life of Asset

Appendix 4 Review Panel Agenda

London and South East Clinical Senates Expert Review Panel - 6th May 2021:
Improving Health Together: Advice on proposals for consolidating acute renal services within South West London, Surrey Heartlands and Frimley ICSs.
*(Please note: Clinical Senate Panel **only** Pre meet 13.00-13.30pm)*
Via TEAMs link Click here to join the meeting

Item	Time	Item	Lead
1.	12.45	**Registration/Join TEAMS (*Clinical Senates panel only*)**	
2.	13.00	**South East Clinical Senate Expert Review Panel *only* pre-meet.**	**PS/MG**
	13.30	***IHT: South West London, Surrey Heartlands and Frimley ICSs - Consolidating acute renal services team to join the meeting***	
3.	13.30	**Welcome, Introduction, context and approach to the review.**	**PS/MG**
4.	13.35	**Presentation from the IHT team**, summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, criteria used for options shortlisting and brief overview of options.	**IHT Team**
5.	13.45	**Discussion and Q&A** between the clinical senate panel and the IHT team, relating to the strategic approach and overarching themes and options overview KLOE (Q&A).	**PS**
6.	14.15	**Clinical Models and Pathways presentations and discussion:** **Each model presentation to be followed by Q&A** Review of the proposed clinical models and pathways: **1. Acute inpatient renal services – Non elective:** • General Nephrology • AKI • Kidney transplant emergencies. • Haemodialysis and peritoneal dialysis emergencies **2. Acute inpatient renal services – Elective:** • General nephrology (including renal biopsy) • Transplantation • Renal replacement therapy. **3. Outpatient renal services: Additional support in early stages of dialysis care, Home/satellite haemodialysis training**	
7.	15.25	**Options presentation followed by Q&A** Review of each of the shortlisted options for service reconfiguration including any option specific issues in relation to delivery of the proposed clinical models and pathways. **(Presentation 10 mins: Q&A 10 mins)**	
8.	15.45	**IHT Team to leave the meeting - Comfort break**	
9.	15.30	**Panel Discussion:** Key findings, evidence base and emerging themes for recommendations.	**MG**
10.	16.50	**Summing up, next steps**	**MG/PS**
11.	17.00	**Meeting close**	

Appendix 5 Joint Clinical Senates' Expert Panel members

Name	Roles
Mike Gill	London Clinical Senate Chair
Paul Stevens	KSS Clinical Senate Chair
Ione Ashurst	Head of Therapies, Royal Marsden
Aileen Buckton	Social Care subject matter expert
May Bullen	PPE, KSS
Sinéad Burke	Renal and Diabetes Therapy team Multi-professional Clinical lead, London Kidney Network
Jeremy Crane	Vascular Access Surgeon, Imperial College Healthcare NHS Trust
Elizabeth Dalby	Lead Vascular Access Nurse, Imperial College Healthcare NHS Trust
Karen Jenkins	Consultant Kidney Nurse, East Kent University Hospitals Foundation Trust
Claire Joyce	PPE, Kidney Care UK
Richard Leigh	Consultant Podiatrist, Royal Free London Foundation Trust
Geeta Menon	Postgraduate Dean
Jonathan Richenberg	Consultant Radiologist, Royal Sussex County Hospital
John Scoble	Former Clinical Director at Guys and St Thomas' NHS Trust
Matt Smith	Public Health England, South East
Mark Spencer	GP, London
James Tomlinson	Specialist Renal Physician, Imperial College Health Care NHS Trust
Peter West	PPE, London
Jane Barrett	Hampshire Thames Valley Clinical Senate Chair
Helen Bell	KSS Clinical Senate Programme Manager
Grace Coombs	London Clinical Senate Programme Manager
Ali Parsons	KSS Clinical Senate Manger
Emily Webster	London Clinical Senate Senior Programme Manager

Declarations of Interest and Confidentiality

Name	Personal pecuniary interest	Indirect pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Mike Gill	None	None	None	None	None
Paul Stevens	None	None	None	None	None
Ione Ashurst	None	None	None	None	None
Aileen Buckton	None	None	None	None	None
May Bullen	None	None	None	None	None
Sinéad Burke	None	None	None	None	None
Jeremy Crane	None	None	None	None	None
Elizabeth Dalby	None	None	None	None	None
Karen Jenkins	None	None	None	None	None
Claire Joyce	None	None	None	None	None
Richard Leigh	None	None	None	None	None
Geeta Menon	None	Works at Frimley Health Foundation Trust	None	None	None
Jonathan Richenberg	None	None	None	None	None
John Scoble	None	None	None	None	None
Matt Smith	None	None	None	None	None
Mark Spencer	None	None	None	None	None
James Tomlinson	None	None	None	None	None
Peter West	None	None	None	None	None
Jane Barrett	None	None	None	None	None
Helen Bell	None	None	None	None	None
Grace Coombs	None	None	None	None	None
Ali Parsons	None	None	None	None	None
Emily Webster	None	None	None	None	None

Appendix 6 IHT Group Membership

Name	Roles	Organisation
James Blythe	Specialised Care SRO	South West London ICS
Carrie Gardner	Programme of Care Manager Internal Medicine	NHS England
Marlene Johnson	Head of Nursing, Renal, Haematology and Oncology	St George's University Hospitals NHS Trust
Ciara Jones	Divisional Director of Operations for Renal	Epsom and St. Helier University Hospitals NHS Trust
Dr Daniel Jones	Consultant Nephrologist & Clinical Director for Renal, Haematology, Oncology and Palliative Care	St George's University Hospitals NHS Trust
Susie Mallinder	Divisional Director of Nursing for Renal	Epsom and St. Helier University Hospitals NHS Trust
Ralph Michell	Deputy Chief Strategy Officer	St George's University Hospitals NHS Trust
Dr Ginny Quan	Consultant Nephrologist and Joint Clinical Director, Renal Services	Epsom and St. Helier University Hospitals NHS Trust