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Late Report for 28th July 2009 Scrutiny Board (Health)

Agenda Item 7 – Renal Services – Provision at Leeds General Infirmary

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Agenda Item 14

The Leeds Teaching Hospitals NHS Trust

Trust Board
30th July 2009

Report of	Maggie Boyle, Chief Executive
Paper prepared by	Sylvia Craven, Head of Planning
Subject/Title	Renal Haemodialysis Satellite Unit at LGI
Background papers	- Business case agreed at Trust Board in November 2007 for Renal Haemodialysis at Seacroft and LGI
Purpose of Paper	To describe to the Board the reasons for the proposal to discontinue the development of a renal satellite unit on ward 44 LGI
Action/Decision required	Support and approve the proposal to discontinue the development of a renal satellite unit on ward 44 LGI
Link to: ➢ **NHS strategies and policy**	
Link to: ➢ **Trust's Strategic Direction** ➢ **Corporate objectives**	Improving the way we manage our business Achieving excellent clinical outcomes
Resource impact	£1.3m no longer required from the capital programme
Consideration of legal issues	None Identified
Acronyms and abbreviations	KPA – Kidney Patients Association LGI - Leeds General Infirmary SJUH - St James's University Hospital

LEEDS TEACHING HOSPITALS NHS TRUST

BOARD MEETING - 30 JULY 2009

RENAL HAEMODIALYSIS SATELLITE UNIT AT LGI

1. PURPOSE OF THE PAPER

During public consultation on the closure of the Wellcome Wing in 2006 because of its very poor infrastructure, the Trust committed to building a dialysis unit on the LGI site although at the time the particular location could not be identified. Subsequently a location was identified in 2007 and the Trust agreed to move ahead. The location was changed to ward 44 in 2008 and the Trust again gave a commitment to delivery.

However, following a detailed review of the demands on the Trust's capital programme, and the current clinical priorities and patient safety issues that have emerged, the Senior Management Team have concluded that there is effectively no real business case which would support this development and as a consequence a dialysis unit on the LGI site should not be built. The purpose of this paper is to describe the issues and ask the Board to make a decision on outpatient dialysis at the LGI site.

2. BACKGROUND

2.1 The history

- At its meeting on 2nd February 2006 the Trust Board agreed that the Wellcome Wing at LGI should be closed as a matter of urgency due to the poor infrastructure including the electrical condition of the building and the costs of rectifying these problems.
- A plan was agreed which moved all clinical and non clinical services from the Wellcome Wing.
- The main contentious issue was around the renal haemodialysis unit. The LGI Kidney Patient Association (KPA) was adamant that dialysis should remain on the LGI site in the longer term. There was a lengthy and complex consultation period and the proposal for dialysis therefore became:
  - Creation of a temporary emergency 24/34 station unit on the Seacroft site
  - Redistribution of LGI dialysis patients between other Trust dialysis units according to clinical need with the majority to either SJUH or Seacroft
  - Creation of a new permanent 24 station unit (with capacity for 34 stations) on the Seacroft site adjacent to the temporary unit (completed in December 2008)
  - Creation of a permanent 10 station unit on the LGI site. The precise location was to be identified.
- A number of potential areas for the unit subsequently became available at LGI and the renal staff and members of the KPA were involved in choosing the

area where the dialysis unit should be sited. There was initial agreement that the size and location of ward 46 was the best site from a user and a clinical perspective; it was also the best, most practical location from a technical infrastructure point of view.

- However, following further discussion within the Trust, it was agreed that ward 46 LGI should be retained for use by other clinical services (as it would make excellent inpatient accommodation being a 26 bedded ward area)
- Subsequently the decision was taken to utilise ward 44 LGI (too small at 18 beds to be really suitable for inpatient care in the future) for the LGI renal haemodialysis unit (ward 44 is adjacent to ward 46 so the benefits outlined above remained).
- Work was then started to plan and brief the unit with the intention of building the facility during 2009/10.
- A public briefing note was issued in October 2008 confirming ward 44 LGI as the preferred site - again having discussed the location with representatives from the KPA.

2.2 Investment in renal since 2006

- Within renal services, significant investment has occurred in recent years
  - £262k investment in temporary facilities at Seacroft prior to the permanent development being completed
  - £1.7m investment in 2007/08 which saw the development of haemodialysis unit at Seacroft Hospital.
  - Investment of £60k in new facilities at SJUH to replace ward 32 previously in Wellcome Wing LGI.
  - Investment of £30k in an additional 20 - 25 drainage points to allow dialysis to take place in wards across the LGI site to ensure any patient in any specialty at LGI can be appropriately dialysed.
  - Included in the capital programme for 2009/10 is £1.4m for replacement of the renal water treatment plant at SJUH. The plant is of an age where there is a high risk of failure of the plant, and due to its age spare parts would not be available. The consequences of such a failure would have a devastating clinical impact for haemodialysis patient care.
  - Also included in the 09/10 capital programme is £50k to support the expansion of the renal transplant programme.

2.3 The clinical view

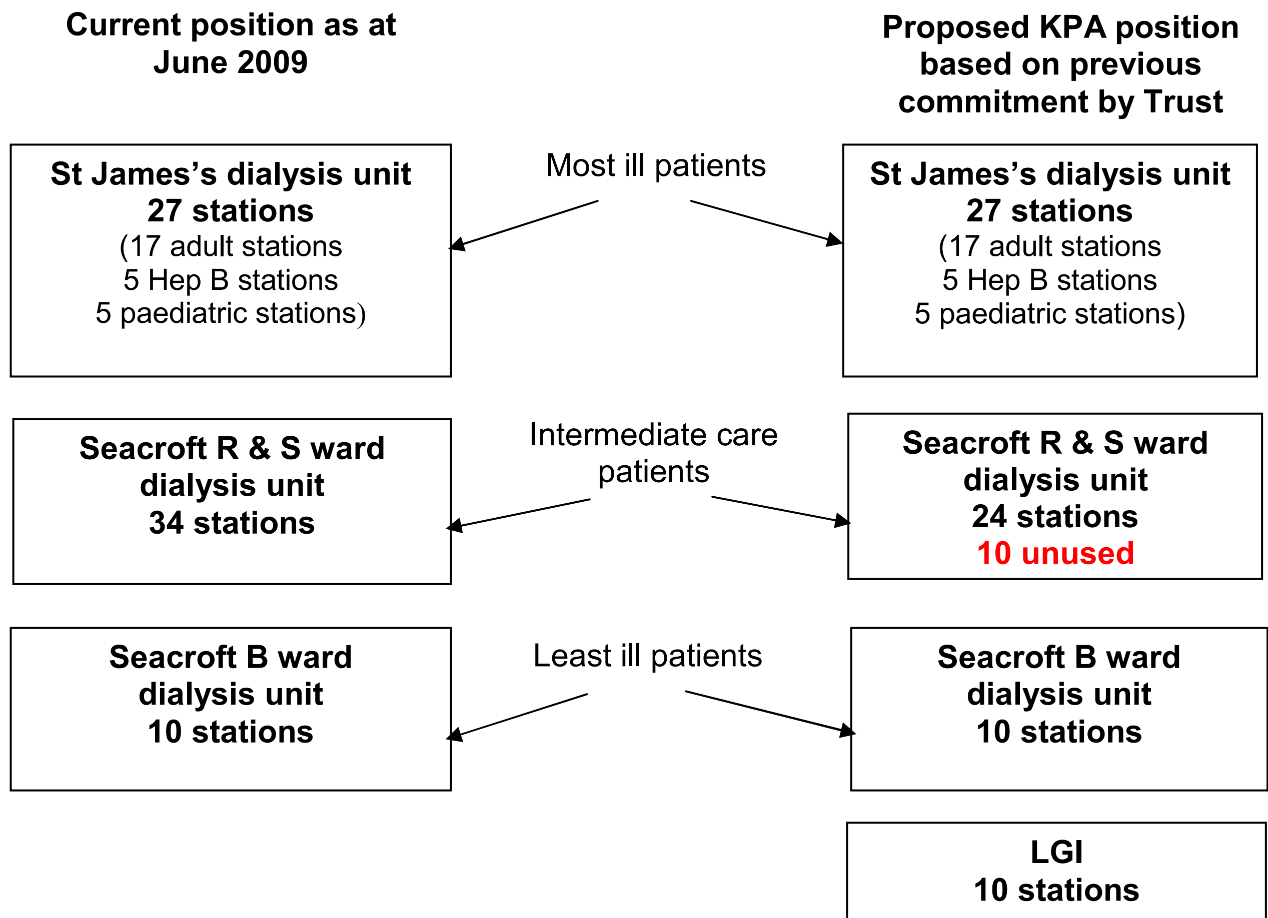
- The clinical view within the renal service is that the replacement of the renal water treatment plant is high priority as failure of the plant would:
  - Threaten patients' lives as we would be unable to dialyse patients appropriately and is therefore a major and significant clinical risk
  - Have an adverse effect on 97 patients per week , 20 of whom are acutely unwell
- The renal clinical view of the development of a renal haemodialysis satellite unit on ward 44 at LGI is that this scheme:
  - Is of a much lesser clinical priority than the potential failure of the water treatment plant and the implications for patient care

- Would be of benefit to a small number of patients in terms of ease of access geographically
- Failure to progress this scheme at the present time would not create a clinical risk as patients are cared for currently at Seacroft on the new unit
- Would provide a haemodialysis service to a maximum of 40 patients if all 10 stations were open. However in a recent patient survey only 11 patients expressed a preference to dialyse at LGI, which equates to 2.5 stations.

2.4 Current position re dialysis

There are 44 dialysis stations on the Seacroft site and 27 on the St James's site. Additionally many of the wards and intensive care units have dialysis points within the wards on both the LGI and SJUH sites so that those patients who are acutely ill and are either, having dialysis because of their ongoing kidney failure, or because they have kidney failure as a consequence of another condition, can have the necessary treatment.

The St James's dialysis unit generally deals with the sickest patients. The Seacroft R & S ward dialysis unit is the intermediate unit and the Seacroft B ward satellite dialysis unit is the unit least ill patients attend. There are also a number of other satellite units in other parts of West Yorkshire.



It is clear from the above distribution that when all the stations are fully staffed, there is already enough capacity in the Trust for all the dialysis patients who need it (with some left over). Most of the stations are currently run for two sessions a day.

More capacity can be created by instituting 'twilight' shifts which are already common in other parts of the country. These tend to benefit patients who are still working full time despite having renal failure. Introducing twilight shifts on existing machines would provide extra capacity without the need to fund a new capital development.

The Trust therefore has enough clinical capacity already to meet the clinical need: if we were to create 10 stations at LGI we would have 10 stations at Seacroft that would be empty.

2.5 Capacity and Demand

- The opening of a renal satellite unit at LGI would not increase overall capacity or activity as the ward 44 scheme involves a level transfer of 10 stations from Seacroft unit to LGI

Maximum patient capacity per unit (based on current 2 session day model)

Satellite Unit	Beeston	Halifax	Huddersfield	Sea - B	Dewsbury	Wakefield	Sea R&S	Wards 55/53	Total
Max Patient capacity	40	40	40	40	48	48	136	110	502

Renal Haemodialysis patients demand model

Current Demand	Projected demand LTHT - Regional Model				
	09/10	10/11	11/12	12/13	13/14
492	518	531	542	550	558

- To ensure efficient and effective use of resources at each renal satellite unit an active review is being undertaken and implemented and will identify opportunities for additional capacity to meet any increased demand over the next 3 - 5 years
- The feasibility of opening the dialysis stations for 3 shifts i.e. 3 cycles of dialysis per day per station instead of the current 2 cycles is being considered. This would increase capacity considerably, for example Seacroft R & S unit would increase capacity by an additional 40 patients by opening only 20 stations until 21.30 hours. To achieve this change a number issues would be considered, such as nurse staffing, patient choice and transport.

3. SUMMARY

The Trust gave a public undertaking in 2006, confirmed in 2007 and reconfirmed in 2008 that a dialysis unit would be provided on the LGI site.

There is a strong feeling being expressed by some patients and their representatives that there should be a dialysis unit at LGI.

The Trust has enough dialysis capacity to provide dialysis for all the patients who require it on an outpatient basis at Seacroft, St James's and in the satellite units in other parts of West Yorkshire.

The creation of a 10 station dialysis unit at LGI would not create more capacity but would involve the transfer of services from Seacroft leaving 10 unused stations in that unit.

Should more capacity be required in the future this can be delivered by running 3 session days in the existing facilities through the establishment of "twilight shifts".

The Trust also has significant capacity on wards at LGI (as well as at SJUH) to provide dialysis for any inpatients with another primary condition who also require dialysis on an inpatient basis.

The Trust is committed to providing the highest quality clinical care for **all** its patients.

The emerging Trust estate strategy is to reduce the amount of occupied space, not to increase it further.

There are approximately 490 patients currently on dialysis, 11 have said they would prefer to go to the LGI.

The Trust capital programme has to be committed as wisely as possible taking into account clinical priorities: a renal dialysis unit at LGI is not required clinically.

The Health Scrutiny Board has asked the Yorkshire and the Humber Specialised Commissioning Group which commissions NHS renal services across the region to provide a view on the option of a dialysis unit at LGI. Their report is attached at Appendix 1 and this suggests that 'a decision by the Leeds Teaching Hospitals Trust not to invest in the reprovision of renal dialysis facilities at the Leeds General Infirmary would be the right decision at this time' (reference page 4 of the Appendix).

4. CONCLUSION

Whilst recognising the feelings of the patients who wish the Trust to establish a dialysis unit at LGI, there is no clinical requirement to establish one, nor is there a capacity deficit which would require such a unit at LGI. There is therefore no prospect of an effective business case being produced to support the establishment of a renal dialysis facility at LGI.

5. RECOMMENDATION

The Trust Board is asked:

- to consider the information provided
- to agree that a renal dialysis unit is not created on the LGI site

Maggie Boyle
Chief Executive
23/7/09

COMMISSIONERS REPORT
PROVISION OF RENAL DIALYSIS AT LEEDS GENERAL INFIRMARY

The commissioning of NHS Renal Services across Yorkshire & the Humber is the responsibility of the Yorkshire & the Humber Specialised Commissioning Group.

1. Specialised Services

Introduction

Specialised services are those services which are not provided in every hospital (generally, they are provided in less than 50 hospitals nationally), because of:

- The small number of patients suffering from the condition and requiring treatment.
- The need for expert staff.
- The provision of expensive equipment.
- Frequently, but not always, the provision of these services will also be very expensive.

A specialised service is defined as a service with a planning population of more than one million people.

Specialised Services National Definitions Set

These describe specialised services in more detail. There are 35 individual definitions, including such services as bone marrow transplantation, rehabilitation services for brain injury and complex disability, specialised burn care services, specialised heart surgery, spinal cord injury and **renal services**.

The Carter Review (2006)

The purpose of this review, which was requested by the Department of Health, was to propose improvements in planning and providing specialised services in England. Within this review, Professor Sir David Carter, (former Chief Medical Officer for Scotland), acknowledged that patients requiring specialised services often have a long-standing relationship with the specialist centre providing their care, and have a high level of knowledge about their condition.

Professor Carter also recognised the significant financial risk of an individual Primary Care Trust having to fund expensive, unpredictable activity. This risk can be reduced by Primary Care Trusts grouping together to collectively commission specialised services and share the financial risk. Large-scale capital investment is often necessary, and the availability of other key specialities, (for example intensive care, 24-hour operating theatres and sophisticated x-ray services), is also critically important.

Specialised Commissioning Groups (SCGs)

An agreed recommendation of the Carter Review was that future responsibility for commissioning specialised services would rest with Specialised Commissioning

Groups, which would share the same boundaries as the relevant Strategic Health Authority; locally this is, of course, Yorkshire & the Humber. The Yorkshire & the Humber Specialised Commissioning Group (SCG) is a permanent Joint Committee of, and acts on behalf of, all the Primary Care Trusts in the Yorkshire & the Humber Strategic Health Authority area, of which there are 14.

The underlying aims of the new commissioning arrangements for specialised services are to: ensure fair access to clinically effective, high quality, cost effective specialised services across the region; to ensure that scarce skills are used effectively; and to prevent wasteful and potentially unsafe duplication of these services.

Specialised Commissioning Groups are required to pay particular attention to areas where significant increases in demand are likely to lead to pressures on services, e.g., renal replacement therapy (dialysis and transplantation).

Specialised Renal Services (Adult) – Definition No. 11

The purpose of a definition is to identify the activity that should be regarded as specialised, and therefore, within the remit of the Specialised commissioning Group. Each definition is drawn up by a process involving clinical staff, managers, commissioners and patient groups, and then endorsed by relevant national organisations. Definition No. 11 has been endorsed by the British Renal Society, the Kidney Alliance and the Renal Association.

Definition Introduction

The National Service Framework for Renal Disease was published in January 2004 (Part I) and February 2005 (Part II), and covers all aspects of renal care, including early renal disease, chronic kidney disease (previously known as chronic renal failure), dialysis, transplantation, acute kidney injury (previously called acute renal failure) and appropriate palliative care for patients in whom dialysis is not, or is no longer, appropriate.

Renal services for patients with moderate to severe chronic kidney disease are largely delivered by renal specialists working in the specialist renal centre itself and on an out-reach basis to surrounding local hospitals. With the growing occurrence of renal disease in the elderly population, there is an increasing need to provide care for pre-dialysis patients and low clearance renal patients receiving palliative care as close to home as possible; this can be done by increasing local hospital renal care provision and improving community and primary care services.

Specialist renal centres also treat patients with acute kidney injury.

Kidney transplantation services are provided in 20 of the 50 or so renal centres across the country; in Yorkshire and the Humber, they are provided in Leeds and Sheffield.
Specialist renal centre services include:

- ✓ Renal out-patient clinics on site and as an outreach service to local hospitals.
- ✓ Haemodialysis services on site.
- ✓ Satellite haemodialysis services.

- ✓ Support to patients on peritoneal dialysis and home dialysis.
- ✓ Renal anaemia management and specialist renal dietetic support.
- ✓ Conservative management programmes for established renal failure.
- ✓ Out-patient and in-patient services for acute kidney injury.
- ✓ Transplantation services.

Renal services require support from a variety of other services. Specialist surgery is necessary for haemodialysis vascular access and peritoneal dialysis catheter insertion and removal. Specialist radiology support is required for monitoring and intervention for haemodialysis vascular access, renal biopsy support and renal imaging and intervention.

Specialised Renal Activity

The renal patient pathway follows the early detection and treatment of chronic kidney disease, pre-dialysis, dialysis, transplantation, acute kidney injury and appropriate palliative care for patients in whom dialysis is not, or is no longer, appropriate. The early stages and treatment of chronic kidney disease are generally carried out in primary care in consultation, where appropriate, with a specialist renal centre. If the patient's kidney function worsens they are usually transferred to the care of a specialised renal centre for further care and, perhaps, dialysis and/or transplantation.

For patients who do not enter a dialysis programme, but instead receive conservative management (also known as palliative care), they will receive their care supervised by a specialised centre; increasingly, they will receive as much of their care as possible close to home, from their local hospital, community and primary care services.

2. Clinical Networks

Introduction

In his review, Professor Carter reported a clear need for Specialised Commissioning Groups to forge strong links with clinical networks, to ensure that commissioning and investment plans support the delivery of integrated care. GP practice and Primary Care Trust commissioning plans should be integrated with those relating to specialised services, to ensure continuity of patient care and appropriate use of resources.

The Yorkshire & the Humber Renal Network

As in many other areas of the country, new renal network arrangements have been established for Yorkshire & the Humber. These arrangements comprise a single Renal Strategy Group for the whole of the Yorkshire & the Humber region, supported by three Local Implementation Groups, which reflect and support local commissioning, provider and patient population groups and relationships. Every hospital providing renal services in the region has senior clinical and managerial representation on the Renal Strategy Group. All commissioning organisations (including the SCG) across the region are represented at senior level. There is also a patient representative.

3. Renal Haemodialysis Provision at Leeds Teaching Hospitals Trust

Background

Both the Yorkshire & the Humber SCG and NHS Leeds, (on whose behalf the SCG commissions renal services from the Leeds Trust), are aware that pre-existing renal facilities (both in-patient and dialysis) at Leeds General Infirmary (LGI) were assessed almost three years ago as unsafe under a number of mandated regulations. As a result, in-patient services were transferred to St. James's Hospital (SJH) – now the main renal centre for Leeds – and dialysis provision was temporarily transferred to Seacroft – where there are now permanent facilities.

A consultation with patients and an option appraisal were undertaken in February 2006 to agree the revised proposal. Commissioners are also aware that, as part of the consultation process that took place at that time, it had been agreed that, although in-patient facilities would remain permanently on the SJH site, some, but not all, dialysis provision would be returned to LGI – 10 stations, accommodating up to 40 patients.

Current Position

Renal dialysis is currently provided at four locations within the Leeds boundary, and the current, shared view of both the SCG, NHS Leeds and the Hospitals Trust, is that this will deliver sufficient immediate, medium and long term capacity, particularly given the joint strategy to repatriate those clinically suitable patients currently receiving their care in Leeds, to planned facilities closer to home, for example, in Huddersfield and Wakefield.

A recent patient audit has indicated that as few as 11 patients, out of a total of over 85, currently receiving dialysis at Seacroft, would prefer to re-locate to Leeds General Infirmary.

The SCG and NHS Leeds further understand that the capital cost of the planned move to the Trust would be in the region of £1.4m, which would, in this case, represent very poor value for money. Such an investment would also leave suitable existing facilities at Seacroft un-utilised.

Patient Transport

The issue of patient transport has also been raised. However, although it has been acknowledged that there are still a small number of delays, there has been a significant improvement in services and performance, which has, in fact, been commended by the National Clinical Director for Renal Services. A separate report, prepared by the ambulance service, will be presented to members in conjunction with this report.

4. Summary

It is the shared and agreed view of the Yorkshire & the Humber Specialised Commissioning Group, and NHS Leeds, that a decision by the Leeds Teaching Hospitals Trust not to invest in the re-provision renal dialysis facilities at the Leeds General Infirmary would be the right decision at this time. Such a decision would

also be supported by the majority of members of the Yorkshire & the Humber Renal Strategy Group. This support is based on the position outlined above, which does not demonstrate a robust case for change in respect of overall cost benefit at this time.

The SCG and NHS Leeds remain committed to continuously reviewing capacity, demand and future plans for investment in all types of renal replacement therapy, (not just haemodialysis) which may lead to future changes following further consultation.

There does remain, however, an issue for patients living in North West Leeds. A recent needs analysis revealed a small number of patients in this part of the city and there have been no reported issues to date regarding access to dialysis. There are insufficient numbers to consider opening additional units, however if access does become an issue NHS Leeds working with SCG will need to explore access to units in neighbouring areas.

Jackie Parr
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16th July 2009

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