APPENDIX 2

LEEDS TEACHING HOSPITALS NHS TRUST

PROVISION OF RENAL DIALYSIS ACROSS THE TRUST

BRIEFING ON THE FACTS

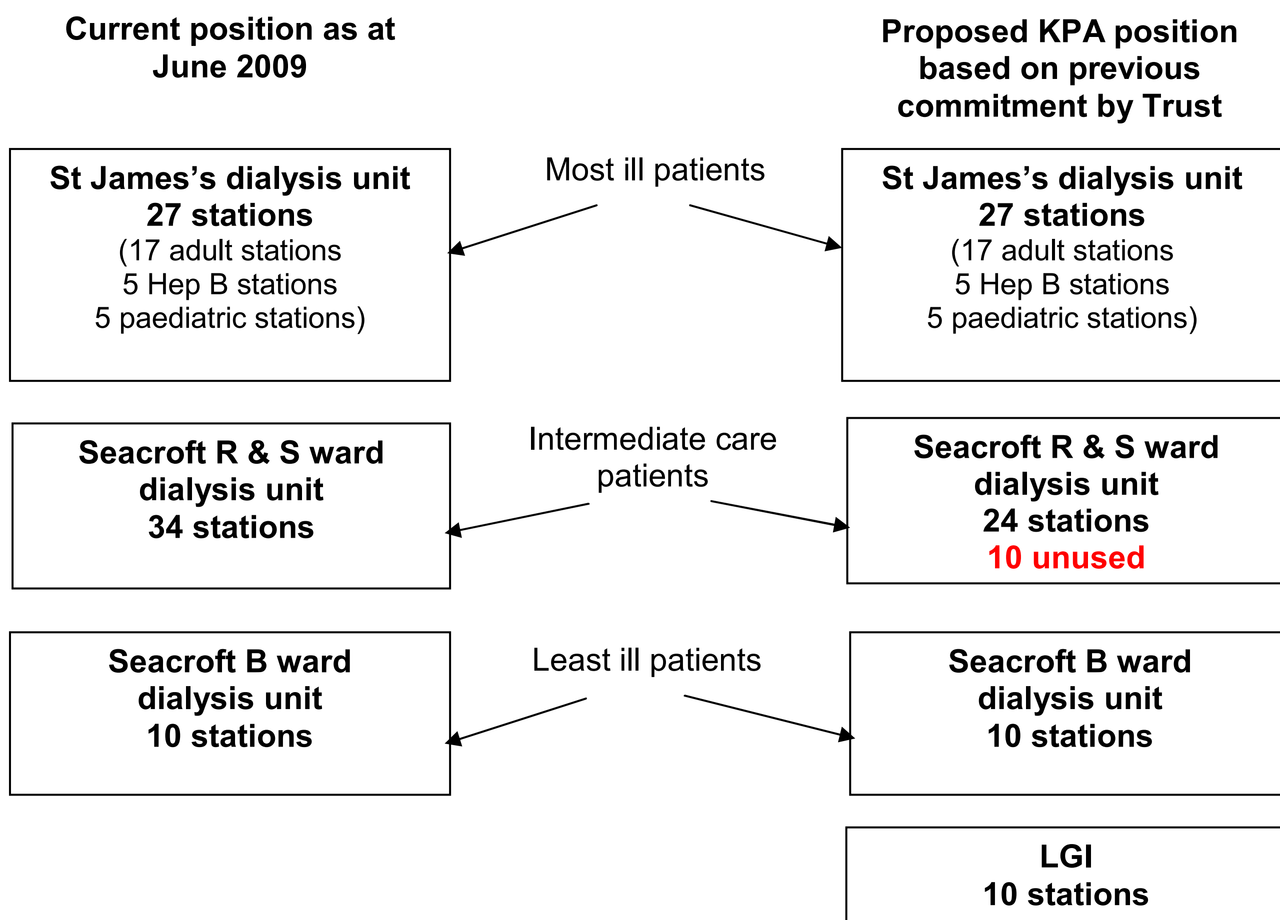
1. BACKGROUND

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 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 Trust is reviewing this decision and difficult choices will have to be made in the light of both the promise that has been made to create the dialysis unit whilst knowing that there is enough clinical capacity for dialysis in the Trust without building any more.

2. 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.

3. CAPITAL

The position with capital is that the Trust is allowed - and can only afford - a certain amount of capital spend each year. There are always many more things that are either required or desired from this amount of money each year and decisions have to be made on an annual basis about the prioritisation of this spend. When faced with difficult choices the need to provide safe and effective clinical care to all patients has to be the deciding factor.

The capital spend is not only for buildings but is also for medical and scientific equipment and for information technology.

We need to spend the capital for buildings both on maintaining the infrastructure of the Trust buildings and for developing accommodation for new services or improving the accommodation from a patient's point of view.

Similarly, we have to replace old items of medical equipment and purchase new ones to meet the opportunities of developing technologies.

The Trust commits a proportion of the overall capital available for replacement of infrastructure or equipment each year, in order to ensure that we are providing a safe environment and that relevant Health and Safety issues are being addressed.

This year, 09/10, we have £58.5m to spend on capital. Of this, at the start of the year, the following was already committed either because schemes had already started, or because the Trust has agreed to spend a certain amount on infrastructure in order to maintain the upkeep of buildings, or because external organisations had provided the money for specific projects.

£13m on buildings infrastructure
£6.m on medical and scientific equipment
£2.5m on information technology
£33m on clinically related schemes

This left approximately £3.5m to be used for the highest clinical priorities. In making decisions about allocation of capital, the Trust Board will always put clinical need and patient safety at the heart of decision making. Value for money and cost effectiveness also have to be considered.

29 June 2009