LEEDS TEACHING HOSPITALS NHS TRUST

Response to Scrutiny Board Health follow up questions on Renal Services provision at Leeds General Infirmary

Strategy

Question 1
Please explain the rationale (including the clinical need) that informed the decision concerning the provision of a 10 station haemodialysis unit at the Leeds General Infirmary (LGI) in 2006 and outline what has subsequently changed.

The provision of a 10 station dialysis unit at LGI was not always part of the longer term plan for the provision of renal services following the decision to close Wellcome Wing.

During the early part of 2005, deficiencies in the infrastructure of Wellcome Wing gave rise to an uncertain future for the building.

In July 2005, the Leeds Renal Service issued to all services in Leeds Teaching Hospitals NHS Trust (LTHT) and to the 2 Kidney Patients' Associations (KPA) a document entitled 'The Reconfiguration of the Leeds Renal Service. 1st Draft Proposals - Position at 22 July 2005.

There was no proposal in that document to provide a chronic haemodialysis facility at the LGI.

The comments received by the requested timescale of early September 2005, did not indicate any clinical need for a chronic haemodialysis facility at the LGI. Neither KPA responded to the draft proposals.

By November 2005, LTHT had distilled its planning to 2 options, for discussion with staff, patients and the KPAs:

- Reprovide the services at SJUH and Seacroft Hospital
- Upgrade Wellcome Wing, to a minimum standard to meet the immediate health and safety requirements.

LTHT conducted 2 open meetings with patients and their carers on 11 December 2005 and 8 January 2006. At these meetings there was a considerable amount of concern expressed from users at the thought of losing any of the services at LGI and it was in response to this that the Trust proposed the 10 station unit.

There remains no clinical need for such a facility at LGI. Access to nephrology opinion and acute renal failure services at the LGI has been provided since October 2006 to the present day, by a small team of renal nurses and doctors.

Question 2

- *Please provide an outline and details of how and when the Renal Replacement Strategy was developed.*

  The Yorkshire & Humber Specialised Commissioning Group (SCG) agreed, towards the end of 2008, to develop a Yorkshire & Humber-wide strategy for Renal Services, supported by a Regional Strategy Group and Sub-Regional Local Implementation Groups, based around clinical networks for Renal Services.

The new Renal Strategy document currently exists in draft format and, subject to the approval and recommendation of the Renal Strategy Group at its meeting on Monday 28th September, will be circulated widely, for further consultation. The final document is due for publication early in the New Year.

The draft document focuses on the following priorities:

i. Prevention of the occurrence of renal disease, through systematic identification of at-risk groups, and reduction of risk factors.
ii. To slow the progress of renal disease, through ensuring high coverage of disease management interventions across primary and secondary care.
iii. Ensuring early identification and referral of patients likely to need Renal Replacement Therapy, and adequate preparation and choice of treatment type.
iv. To ensure timely availability of Renal Replacement Therapy for those likely to benefit, in designated Renal Units (or associated satellite units), transplant centres, or home-based therapies.

- *Please provide confirmation of the Renal Centres across Yorkshire & the Humber, including the services/treatment provided, the population/geographical areas each centre serves and the current number of patients accessing haemodialysis.*

There are six Renal Centres in the Yorkshire & Humber region, based within the following NHS organisations:

- Bradford Teaching Hospitals NHS Foundation Trust
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust
- Hull & East Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust*
- Sheffield Teaching Hospitals NHS Foundation Trust*
- York Hospitals NHS Foundation Trust

Renal services for patients with chronic kidney disease are largely delivered by renal specialists working in the specialist renal centre itself, and on an outreach basis to surrounding local hospitals. Specialist renal centres also treat patients with acute kidney injury. Specialist renal centre services include:

- Nephrology (Renal) out-patient clinics within the organisation and available as an outreach service to local hospitals.
- Haemodialysis services within the organisation.
- Satellite haemodialysis services.
- Support to patients on peritoneal dialysis and home haemodialysis.
- 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 – provided at Leeds & Sheffield.

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 specialist 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 or primary care services.

Nephrology out-patient clinics in local hospitals are provided on an outreach basis by medical and nursing staff from the specialist renal centre and will include general nephrology clinics and specialist clinics such as pre-dialysis clinics and anaemia clinics.

In-patient nephrology services are provided at the specialist renal centre. These are used for investigation and treatment of renal diseases including kidney biopsies, management of fluid and electrolyte disorders, initiation of immunosuppression and treatment of hypertension. Nephrological conditions covered include all forms of glomerulonephritis, kidney disease associated with systemic diseases such as diabetes mellitus, systemic lupus erythematosis and vasculitis and other causes of chronic kidney disease. In-patient services are also used for the management of patients with acute kidney injury, complications in patients on dialysis and the investigation and treatment of patients with functioning renal transplants.

The kidney transplant service includes:

Activities taking place at <u>all</u> specialist renal centres:

- Assessment of patient need and suitability for transplantation.
- Organising tissue typing and testing for antibodies.
- Registration of appropriate patients with NHS Blood & Transplant.
- Live donor screening.
- Live donor work-up.
- Post-transplant follow-up (for life).
- Post-transplant immunosuppressant drug therapy (for life).

Activities <u>only</u> taking place at the renal transplant centres:

- Donor organ (cadaver) retrieval.
- Live donor organ retrieval.
- Cadaveric kidney transplant.
- Non heart-beating kidney transplant.
- Live donor kidney transplant.
- Desensitisation of potential transplant recipients who have high panel reactivity.

The six Renal Centres serve a total Yorkshire & the Humber population of 5.278 million (ONS sub-regional population projections), and the SCG commissions specialised renal services on behalf of this population. There are no geographical restrictions on where patients can access renal services, (with the exception of renal transplant, which can only be undertaken at the Leeds and Sheffield centres). The SCG is committed, however, through its planning processes, to ensuring that as many patients as possible can access services as close to home as possible, wherever this is an expressed preference and is clinically appropriate.

The current number of patients accessing haemodialysis across the region is as follows:

Bradford Teaching Hospitals:	**No. of Haemodialysis**

	Patients
St. Luke's Hospital, Bradford	156
Skipton Satellite	36
Total	**192**
Doncaster & Bassetlaw Hospitals:	**No. of Haemodialysis Patients**
Doncaster Royal Infirmary	90
Bassetlaw Satellite Unit (Worksop)	28
Total	**118**
Hull & East Yorkshire Hospitals:	**No. of Haemodialysis Patients**
Hull Royal Infirmary	157
Bridlington Satellite	26
Grimsby Satellite	63
Scarborough Satellite	30
Scunthorpe Satellite	47
Total	**323**
Leeds Teaching Hospitals:	**No. of Haemodialysis Patients**
St. James's University Hospital (Wards 55/53)	83
Beeston Satellite	40
Halifax Satellite	40
Huddersfield Satellite	40
Seacroft B Ward Satellite	40
Seacroft R&S Ward	119
Dewsbury Satellite	48
Wakefield Satellite	46
Total	**456**
Sheffield Teaching Hospitals:	**No. of Haemodialysis Patients**
Sheffield Teaching Hospital (Renal F & G Wards)	285
Barnsley Satellite Unit	65
Chesterfield Satellite Unit	62
Sheffield Satellite Unit (Heeley)	80
Rotherham Satellite Unit	80
Total	**572**
York Hospitals:	**No. of Haemodialysis Patients**
York Renal Unit	66
Easingwold Satellite Unit	26
Harrogate Dialysis Unit	40
Total	**132**
Y&H Regional Total	**1,793**

- *Please provide: confirmation of the current number of kidney transplants per annum (regionally and locally).*

The Sheffield Centre carried out 56 kidney transplants during the year 2008/09, exactly in line with plan. This figure excludes transplants carried out on children, who are generally referred to the Nottingham Centre from South Yorkshire. The 2009/10 plan is for 56 transplants. Additional transplant activity will be funded, should the opportunity arise.

The Leeds Centre carried out 163 kidney transplants during the year 2008/09, 19 more than planned. This figure includes transplants carried out on children.
The Leeds centre also carried out 42 organ retrievals from live donors. The 2009/10 plan is for 190 transplants and 55 live donor organ retrievals. Additional transplant activity will be funded, should the opportunity arise.

During 2008/09, an additional £697k was invested in kidney transplantation in Leeds, taking total investment in transplantation for the year to well over £4.5m. As indicated above, further additional investment is being made for 2009/10.

- *Please provide: confirmation of the current number of patients using home dialysis (regionally and locally).*

  During 2008/09, there were 57 patients across the region receiving home haemodialysis. A further 384 patients were receiving peritoneal dialysis.

- *Please provide: confirmation of the 'ambitious targets' for increasing the number of transplants and the level of home dialysis (regionally and locally), including details of how this will be delivered.*

  In January 2008, UK Health Ministers accepted the 14 recommendations of the Organ Donation Taskforce to improve organ donor rates. The expectation is a 50% increase in organ donation rates in the UK within five years – resulting in an additional 1200 organs a year and significant clinical and cost effectiveness benefits.

  The Taskforce recommendations focus on the need to invest significantly in the infrastructure of organ donation. They include the need for a UK-wide organ donor organisation established as part of NHS Blood and Transplant; a strengthened network of dedicated Organ Retrieval Teams working with critical care teams in hospital to procure organs for transplant; a doubling of the number of front line donor coordinators – about an extra 100 donor transplant coordinators – and the need to make organ donation a usual rather than an unusual event supported by additional staff training and a monitoring of donation activity in all Trusts. Additional national funding of £11m was made available for 2008/09, with further funding agreed for subsequent years.

  The implementation of the Taskforce recommendations is being overseen by Professor Sir Bruce Keogh, the NHS Medical Director, and Mr Chris Rudge, Medical and Transplant Director of NHS Blood and Transplant, has joined the Department of Health to lead day-to day implementation.

  It has been acknowledged that some changes can be made quite rapidly, but full implementation may take up to three years.
  Yorkshire and Humber has also made significant progress already, in increasing the number of live donor kidney transplants.

The SCG is currently developing plans, consistent with the aims of NHS Kidney Care, and the National Clinical Director for Kidney Care, as part of its new strategy for Renal Services across the region, to increase the number of patients on home haemodialysis.

The Leeds Renal Centre is already committed to providing home haemodialysis for all suitable patients, although there have been some delays in carrying out the necessary training due to nurse staff absence as a result of a 10 year peak in maternity levels.
It should, however, be noted that the majority of patients are not clinically suitable for home therapies, and that even where patients are clinically suitable, not all have a carer who could assist them. Exceptionally, patients can self-dialyse at home unaided, but this is very rare. Equally, in some cases where home haemodialysis might otherwise be an option, not all patients have space for a machine to be installed in their property, or by means of an extension.

Previously agreed plans

Question 3
The statement is one attributable to the NHS Leeds Trust Board: it is not a statement from LTHT. At the time LTHT provided NHS Leeds with the information - as reported in October 2008, this being that; discussions were ongoing with KPA representatives, a Project Team was in place and design work for a dialysis unit on ward 44 was taking place. Design work was not stopped until 1st June 2009.

The statement from NHS Leeds regarding 18 stations at Seacroft refers to an options paper produced on 2nd February 2006. Subsequently events moved on (see section 4 for further details).

- *Please explain when discussions about proposals not to proceed with the dialysis unit at LGI first take place within LTHT and who was involved.*

  Discussions began in the context of developing the capital programme for 2009/10 and were held with members of the Capital Planning Group within LTHT. The first discussion on the overall capital programme was on 28th January 2009.

  Members of the Capital Planning Group included the Director of Finance, the Director of Estates & Facilities, the Head of Planning, the Head of Estates and a Divisional General Manager.

- *What, if any, considerations were given to involving other interested parties in these discussions, i.e. commissioners, patients and carers (i.e. KPA) and the Scrutiny Board.*

  No discussions were held with commissioners or patients and carers about any of the options that were under consideration at this time. Each clinical area potentially within the capital programme was discussed. As the options themselves affected many hundreds of patients potentially in many different specialties it was therefore not practicable until the options had been agreed in principle to have any discussions outwith the Capital Planning Group which had been given the mandate to recommend the capital programme for 2009/10 to the Senior Management Team.

- *Why is there evidence to suggest that there was a parallel process running during the early part of 2009, whereby the KPA were still involved in discussions around the delivery of a unit at LGI?*

  A parallel process was in evidence during the early part of 2009 with the KPA still involved in discussions around delivery of the unit at LGI because the decision was still to deliver the unit at this time, pending any future Trust Board decision. In the spirit of openness, the Trust Medical Director and the Head of Planning met with Mrs Black to discuss with her the likely recommendation to the Board that the dialysis at LGI would not go ahead.

- *When did NHS Leeds and SCG first become aware of LTHT's proposals not to proceed with the dialysis unit at LGI?*

  NHS Leeds and SCG first became aware of LTHT's proposals after 2nd June 2009. This was because the Trust took a decision to talk to representatives of users and carers via the KPA before any other group.

- *Does this signify a breakdown in communication between LTHT and NHS Leeds as commissioners?*

  We do not feel that there has been a breakdown in communication between LTHT and NHS Leeds but recognise that improvements regarding communication channels can be made. Whilst the position regarding dialysis is of course the top priority for the patients using the service, out of the 1,000,000+ attendances at Trust hospitals (inpatients, day cases, outpatients, A&E) and the many specialties delivered by the Trust, change is occurring all the time and discussions are occurring all the time.

- *What does this situation say about the general relation between local NHS bodies?*

  This question is addressed in response to question 14

Question 4
Please explain the provision of 34 stations on R&S Ward at Seacroft Hospital.

The discussion within the Trust has always been about finding the right footprints within which the haemodialysis units could be established. We did not feel it would be a particular concern that we were able to accommodate more units than were required at this time.

24 stations were originally in LGI Wellcome Wing, running 6 days a week, with additional twilight sessions.

The timescale for vacating Wellcome Wing was such that the permanent unit could not be created in time, so it was agreed that there would be a temporary unit built in the former T&U wards at Seacroft Hospital, replicating the 24 stations in Wellcome Wing. There would also be 4 additional stations to decompress SJUH. In October 2006 the temporary unit opened with 28 stations. The former LGI twilight patients moved to the St James's twilight sessions.

The work on the permanent unit in R&S wards was continuing concurrently. At this point a decision had to be made around the number of stations to be installed.

In March 2007, the Yorkshire and Humber Commissioning Group approved, on the recommendation of the Regional Renal Services Strategy Group, an LTHT bid for 8 additional dialysis stations to service West Yorkshire (2 stations in Wakefield and 6 in Leeds).

The LTHT case of need had cited a lack of progress in developing local satellite facilities in the mid Yorkshire district. The longer term location of the additional capacity would be the subject of a strategic dialogue with the Yorkshire & Humber SCG and the Regional Renal Strategy Group.

As the planning of the permanent unit in R&S wards demonstrated the footprint was large enough to take 34 stations without significant additional cost, 34 stations remained in the brief. This constituted the original 28 stations plus 6 additional stations as recommended by the Regional Renal Services Strategy Group.

As stated earlier there was never any suggestion that having more stations than at first identified was going to be a problem.

At this point there was no suggestion internally that we would not be going ahead with the dialysis unit at LGI and there was no consultation apparently required. The Trust would not normally advise the Scrutiny Board when it was creating additional capacity.

The proposal not to have haemodialysis stations at LGI has only come about as the Trust has further carefully scrutinised clinical need, capacity and cost.

Question 5
Please explain at what point did the planned unit at LGI involve the level transfer of stations from Seacroft

The planned unit at LGI always involved the transfer of stations from Seacroft and was articulated to the early user group consultation meetings when the suggestion of a dialysis unit at LGI was suggested by the Trust in 2006.

Demand and capacity

Question 6
Please complete the summary table at Appendix 1, for LTHT Renal Centre.

Appendix 1 is attached and is accurate as at September 2009. The column headed 'projected demand (2013/14)' has not been completed for the reasons explained below, under Question 7 - the methodology that predicts local demand.

Question 7
Please explain the methodology used that predicts local demand to rise by less than an average of 2% over 5 years.

For the purposes of clarity, the summary table presented at Appendix A to the Scrutiny Board's follow-up questions, shows a projected increase in demand of over 13% over 5 years, with an average annual increase of 2.7%, and not less than 2% as indicated.

However, it has been 2 years since detailed modelling work has been undertaken on the likely future numbers of end stage renal failure patients in the Yorkshire & the Humber region. Since then, the Renal Strategy Group has actively engaged with the Department of Health, who have developed new modelling software, designed to give consistent methodology for the whole country. This new "MORRIS" Model is auto populated with routinely available data (from the National Renal Registry & the Office for National Statistics), and is as accurate as it can be without bespoke data collection.

The input parameters are as follows:

- Initial Renal Replacement Therapy Population.
- Transplant Supply.
- Renal Centre Distribution.
- Take On Rates.
- Mortality Rates.
- Modality Split – Dialysis.
- Graft Failure Rates.
- Population Projections.

The user is able to modify any/all of the input parameters to estimate the impact of a wide variety of potential scenarios. The results of this 'what if' scenario planning can be easily exported from the model.

Output from the model is given by PCT, by Renal Centre and by Local Authority. A Strategic Health Authority summary is also available. Output (projected need) is split into dialysis (with sub modalities) and transplant. Both are expressed with ranges of uncertainty (confidence intervals, largely reflecting uncertainties in how input parameters will change over time).

Further work is needed to develop confidence that MORRIS will be able to provide accurate and robust predictions of future need. Initial analysis, undertaken very recently, has concluded it is a complex, comprehensive modelling tool, and preliminary results indicate a higher level of predicted future demand for some areas of the region, than have been predicted previously. It is important to stress however, that the model is still in draft form at this time.

Question 8

Please confirm the number of patients (both regionally and locally) awaiting pre-dialysis education.

Locally, in August 2009, a total of 404 patients were in the Leeds Renal Centre's pre-dialysis service, derived from the centre's total West Yorkshire catchment area (ie 4 PCTs - Leeds, Wakefield, Kirklees and Calderdale).

Of these 404 patients, 248 had received education regarding their treatment options, which include haemodialysis (in renal haemodialysis units), peritoneal dialysis (patients self care) or conservative care.

132 patients were awaiting education. Professional consensus suggests that optimal time to prepare a patient and their carers for renal replacement therapy is around 1 year before dialysis is expected to be necessary.

The remaining 24 patients will be referred back to the Renal service following clinical review.

In August 2009 no other patients, whether in the pre-dialysis service or arriving at the renal service acutely, were awaiting access to chronic haemodialysis treatment.

Question 9
Please comment on the suggestion that some patients are receiving a reduced level of haemodialysis

In August 2009, 10 patients were receiving dialysis twice per week rather than the standard 3 times per week. 3 of these patients were new patients for whom twice weekly dialysis was indicated. The other 7 patients dialysed twice per week either by personal choice or because their blood test results indicated this to be appropriate.

Question 10
Please provide evidence that the home haemodialysis service has adequate resources and capacity to offer the service to a wide group of patients in the short, medium and longer term.

In April 2003, the Regional Renal Services Strategy Group agreed to a proposal from LTHT to increase the number of patients on home haemodialysis from 3 to 23 ie a net increase of 20 patients. By November 2006, the number had risen to 10 and by August 2009 to 15. The rate of conversion is dictated primarily by the willingness of patients and their carers and the many other criteria (e.g. medical, social, psychological, practical, etc) that make a conversion to home care feasible.

Since May 2009, 8 patients have expressed an interest in converting to home haemodialysis. One patient started training in September. The seven other patients were found to be unsuitable for conversion, either for medical reasons or required re-housing.

Patient Survey

Question 11
Please provide a full summary of the survey that stated '…in a recent patient survey only 11 patients expressed a preference to dialyse at LGI…' and confirm when the survey was carried out, etc.

At the joint KPAs/LTHT liaison meeting on 17 March 2009, it was discussed that NHS Wakefield and LTHT, in partnership, were to survey the patients at the Wakefield and Leeds haemodialysis units to ascertain how many patients with a Wakefield postcode would prefer to dialyse in Wakefield itself or Pontefract, or in fact any other nurse led renal haemodialysis unit. Later in March, NHS Wakefield interviewed all the patients at the satellite haemodialysis unit at Clayton Hospital, Wakefield.
Also in March, LTHT constructed a survey letter and reply form, signed by the Renal Clinical Director and Renal Matron, intended solely for haemodialysis patients with a Wakefield postcode. That letter was issued to the relevant patients at B ward at Seacroft

Hospital and at ward 55, SJUH. Unfortunately and in error, the letter was sent to all the patients on R&S Ward.

11 of the 87 patients on R&S ward who replied marked a preference to dialyse at LGI.

The letter and survey form were in the same format as the one used a year previously and endorsed by the KPAs.

Patient Transport

Question 12
Please provide details of the catchment areas for the current satellite units. i.e. Where are patients currently travelling from and to for their treatment?

Please see Appendix 2 and its 4 sheets:
Sheet 2.1 - Numbers of patients by all dialysis treatment modes and unit
Sheet 2.2 - Numbers of patients, by haemodialysis unit and non-Leeds postcode
Sheet 2.3 - Numbers of patients, by haemodialysis unit and Leeds postcode
Sheet 2.4 - Numbers of patients, by haemodialysis unit and grouped postcodes.

The data in Appendix 2 dates from April/May 2009, hence the minor differences in patient numbers from those quoted in Question 2 and Appendix 1 in Question 6, both of which are accurate at September 2009.

The most striking figures are the disparity between demand and capacity for haemodialysis in Wakefield (133 against 96); Huddersfield (66 against 40) and Halifax (50 against 40).
Appendix 1 has shown the excess of capacity in Leeds against demand.

Using these data, along with the potential capacity illustrated in Appendix 1 and the new Department of Health 'MORRIS' model on future demand, LTHT is in close dialogue with the Yorkshire & Humber SCG Regional Renal Strategy Group and local NHS provider Trusts to establish how best, strategically, to meet the current, local shortfalls and the future demands.

Question 13
What are the travelling times for patients from the North/North West of the city, who haemodialyse Seacroft?

Please see Appendix 3.

The 2 sheets present the number of journeys undertaken from April 2009 to the end of July (ie the date the data was presented by YAS to Scrutiny Board), based on patient journey times to and from both the Seacroft dialysis units, involving patients travelling to and from the Leeds postcodes LS16, 17, 18, 19, 20, and 21.

Role of the Scrutiny Board

Question 14
The legislation and guidance around health scrutiny places a duty on local NHS bodies to consult with the Scrutiny Board on any proposed substantial development or variation in the provision of local health services. The guidance also states that NHS Trusts should

discuss any proposals for service change at an early stage, in order to agree whether or not the proposal is considered substantial. In this instance it is clear that the local NHS bodies involved have failed in this duty.

- *Please explain how this has happened and outline what steps will be taken to prevent a similar situation arising in the future.*
- *What evidence is there to demonstrate that the statutory role of the Scrutiny Board is recognised, understood and valued within the organisations that make up the local health economy?*
- *What assurances can be given to the Board that this situation is not reflective of a wider indifference to the role of scrutiny?*

The length of this document and the depth of its content demonstrate that Leeds Teaching Hospitals place great emphasis on the role of the Scrutiny Board and shows where, why and how Scrutiny and service users have been engaged. The Trust is anxious to work closely with Scrutiny now and in the future and to this end a number of discussions have been held between the Chair of Scrutiny and the Chief Executive of Leeds Teaching Hospitals to explore ways of working better together so that each body can appropriately carry out its role. We understand that the Health Proposals working group is being reinstated so that there is a forum for very early discussion of possible change and the Trust is organising a special presentation to members of Scrutiny in November 2009.

In relation to the Specialised Commissioning Group;

The Establishment Agreement of the Yorkshire & the Humber Specialised Commissioning Group (SCG), Section 2, Functions of the Specialised Commissioning Group, Paragraph 2.3, states that:

The SCG will undertake the following functions……., including:
To maintain close links with PCT's and providers, and other statutory authorities, including Local Authorities and Criminal Justice System agencies, in the SCG area……..

The Establishment Agreement of the Yorkshire & the Humber Specialised Commissioning Group (SCG), Section 6, Accountability of the SCG, Paragraph 6.1.4, also states that:

In order to ensure that time is allowed for consultation with the constituent PCT's and with other stakeholders wherever possible, adequate notice will be given of proposals to change commissioning policies, commit resources and/or enter into service agreements and contracts.

The Yorkshire & the Humber Specialised Commissioning Group (SCG) also has a Strategy for Involving and Engaging Patients and the Public in Specialised Commissioning.

This strategy sets out the aims and objectives of the Yorkshire & the Humber Specialised Commissioning Group in order to involve the public and patients in the commissioning of specialised services. The strategy makes clear the role of NHS Barnsley as the host of the SCG, the Specialised Commissioning Team and individual PCT's.

Section 5, Stakeholders to Public and Patient Engagement, states that:

There are a number of stakeholders in Public and Patient Engagement – each of which may have a different perspective. It is important to be clear that the SCG must engage with all stakeholders.

Patients, carers, parents or families of patients care most about the quality of their everyday interactions with professionals rather than about how the service is organised. Citizens often care passionately about perceived threats to services more broadly; about how resources are allocated and about health risks.

There are a range of other stakeholders that represent the views of both patients and the public. These include local councillors (particularly those involved in Overview and Scrutiny Committees where substantial changes are proposed) and a range of Voluntary and Community Sector agencies that may be patient advocacy groups or deliver services to specific groups. There is a particular need to ensure that 'seldom heard' groups are involved in commissioning decisions.

Service providers are important stakeholders; both as organisational units and clinicians working within them. The establishment of feedback from patients using services into commissioning decisions is an important priority here. The involvement of groups that traditionally have little voice in service planning is particularly important.

Section 6, Aim and Objectives of the Yorkshire & the Humber Patient & Public Engagement Strategy, states that:

This strategy is a three year strategy, covering the period from April 2009 to March 2012. The strategy sits within the SCG work plan, will be reviewed annually, and specific objectives set within a work programme. An annual report will be made to the SCG (more frequently be exception).

As the host of the SCG, this work also sits within the NHS Barnsley approach to Improving Patient Experience. There are also other links between this strategy and Patient and Public Engagement in other region-wide health agencies, and a region-wide approach to Overview and Scrutiny.

Section 6.1, Aim,

To involve patients and the public so that their views are taken into consideration during the planning, improvement, monitoring and evaluation of all specialised services in Yorkshire & the Humber for which the Yorkshire and the Humber Specialised Commissioning Group has responsibility.

Section 6.2, Specific Objectives – April 2009 to March 2010, sets out a more detailed proposed work programme setting out specific activities that will be initially undertaken, including:

Section 6.2.5: Develop an on-going positive relationship with Overview and Scrutiny Committees in Yorkshire & the Humber, both individually and through the Yorkshire & the Humber Health Scrutiny Network.

A senior member of the Specialised Commissioning Team is due to attend the October meeting of the Yorkshire & the Humber Overview and Scrutiny Officers meeting, with specific reference to Section 6.2.5 above.

By way of practical example, the SCG consulted widely with Yorkshire and the Humber Overview and Scrutiny Committees on national and regional plans for the reconfiguration of Specialised Burn Care Services.

Responses to additional questions raised by Mrs Lillian Black (Kidney Patient Association)

Transport - addressed in response to question 12 above

It should also be noted that of the 118 patients at R&S ward at Seacroft, 41 (35%) live outside Leeds.

Similarly, of the 81 patients on ward 55 at SJUH, 41 (50%) live outside Leeds.

Prior to the unit at Beeston opening in 2005, the 24 patients who had been dialysing in a temporary unit at Cookridge Hospital were given the option of moving to other units, including Ward 50 at the LGI. 23 patients moved to Beeston; one moved to 'B' ward at Seacroft and none chose LGI.

Renal clinical standards - I can confirm that LTHT and the Renal service are aware of the various national guidance around haemodialysis services and utilises this guidance within its service plans

"The current Renal Association Guidelines & the draft future guidelines quote the following:

Guideline 1.3 – HD: Haemodialysis Facilities
"We recommend that, except in remote geographical areas the travel time to a haemodialysis facility should be less than 30 minutes or a haemodialysis facility should be located within 25 miles of the patient's home. In inner city areas travel times over short distances may exceed 30 minutes at peak traffic flow periods during the day".

The 28 patients who dialyse on the twilight shift at SJUH do so at their own request.

Patient survey 2008 **-** addressed in response to question 11 above

Capacity - the need for continued skilled and committed staff within the renal service is recognised and staffing levels within all the haemodialysis units remain under regular review by the Matron and Divisional Nurse.

The Seacroft Unit offers a haemodialysis service to patients. This allows many patients within the renal satellite service to be treated in a Nurse-led environment. The Seacroft Unit also benefits from dedicated medical cover between the hours of 09:00 to 17:00 Monday to Friday.

Due to the nature of the work carried out at the Seacroft Unit the requirement for fully trained nurses in dealing with a medical emergency is paramount. All nurses at Seacroft undertake annual mandatory basic Life Support training. To date all staff at Seacroft has undertaken this training with competence achieved at the required level. Many of the nurses at Seacroft have also participated in further training to a higher level (Intermediate Life Support ILS).

In relation to nurse staffing, the Renal Service is currently experiencing its highest rate of maternity leave in more than 10 years, with 10% of the nursing workforce currently on, or planning to be on maternity leave. This has clearly placed additional pressures on the Renal service; however additional posts have been approved and are being recruited to ensure the continued provision of the Renal service.

The availability of trained haemodialysis staff, nurses in particular, is a concern being expressed by all the renal units across Yorkshire & Humber. The newly formed Yorkshire & Humber Regional Renal Network has recognised this as an early priority.