DEPARTMENT OF RENAL MEDICINE

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Dear Ms Chambers

I am responding to your email dated 4 February asking for an update report for the March meeting of the Scrutiny Board regarding long-term plans for renal services in Leeds.

I would like to start by reminding colleagues that renal services are broad. There are a number of treatments for end stage renal failure, all of which are provided by the Leeds renal service:

- haemodialysis in main renal units at SJUH (Ward 55) and Seacroft (Parsons Unit)
- haemodialysis in satellite renal units (six in total) across West Yorkshire - five in NHS hospitals and one in a GP surgery. Two of these are in Leeds, at Seacroft (B Ward) and Beeston
- home haemodialysis - patients self care at home and can dialyse up to six times per week
- peritoneal dialysis (PD) - patients self care at home. There are three modalities: continuous ambulatory peritoneal dialysis (CAPD); automated PD (APD) and, recently, Assisted APD (AAPD), where the patient is provided with help in the home to start or sustain APD.
- transplantation - by far the most clinically effective, cost efficient and quality of life enhancing treatment.

In addition approximately 300 patients a year are treated for acute renal failure. This is kidney failure which almost always recovers but these are patients who are seriously unwell and need intensive inpatient care. Finally, largely outpatient review occurs for approximately 5,000 individuals with much less severe kidney disease. A proportion of these patients, however, do have kidney failure which is steadily progressing and these would be considered a "pre-dialysis/low clearance" cohort.

To update you on long-term plans for renal services in Leeds.

Leeds General Infirmary Haemodialysis Unit
This is planned to be sited in Ward 46 which is the area preferred by both staff and patient representatives. The works will go out to tender on 25 April. It is expected the Trust Board would agree the approved contractor at its meeting on 26 June with a start on site date of 14 July. Completion is anticipated on 12 December with commissioning between December 2008 and January 2009.

Main Seacroft Dialysis Unit
This is planned to be sited on Wards R and S, next door to the current temporary unit on Wards T and U. The schedule for this went out to tender today, 29 February. It is expected the Trust Board will agree the approved contractor at its meeting on 24 April with a start on site date of 13 May. Completion is expected 24 November with commissioning in the months of November/December 2008.

Inpatient Ward Reconfiguration
With the forced closure of Wellcome Wing the inpatient ward at the Leeds Infirmary (ex Ward 32) was relocated in a ward in Gledhow Wing (Ward 4) at St James's. The plan had been to move this ward into newer accommodation in the same wing as the whole of the rest of the inpatient renal beds and main haemodialysis unit at St James's and this move is happening today, with Ward 4 moving to Ward 62 in Lincoln Wing close to the rest of the renal clinical facilities.

Dialysis at Wharfedale General Hospital
I remember that the creation of a dialysis unit at Wharfedale General Hospital was broached at the Scrutiny Board. This we have said previously would have to be in addition to the LGI unit, not as a substitute – because of the far greater access issues for people in west Leeds getting to WGH than people in north Leeds getting to LGI – it would be a far smaller facility but would have a similar capital cost because of the critical mass costs of the plant. Staffing costs would also be disproportionate, again because of the critical mass required.

The Trust is therefore not considering putting any haemodialysis facility at WGH at the present time. Of course if the PCT wishes to prioritise satellite haemodialysis further and wanted to invest in a small facility at WGH, then we would be happy to discuss this.

Expansion of "Pre-Dialysis/Low Clearance" Care
There is an increasing volume of referrals from primary care colleagues for management of the patients in this position. Treating patients' anaemia, which involves injections of iron and a hormone, is the most important and difficult part of this treatment. We have been in negotiation with primary care colleagues with the intention of setting up a community renal clinic. In addition as part of the renal business case for the forthcoming financial year is the ambition to increase this service. However at the time of writing this depends on decisions about business planning priorities.

Transport for Patients Treated with Haemodialysis
Board members will almost certainly remember that this has been a significant problem with a poorer quality of service for patients requiring transport to and from haemodialysis treatment than we would wish. This is a problem throughout the whole country. A formal tendering process was embarked upon which attracted one bidder and Yorkshire Ambulance Service were awarded the contract. There are monthly meetings between Trust representatives and Yorkshire Ambulance Service senior management staff and there is no doubt the commitment of those colleagues to

deliver a good service. There have been a variety of initiatives including a central telephone hub to co-ordinate services.

At the present time this performance of this service falls below the agreed contract standard.

It may be that involvement of the Health and Wellbeing Scrutiny Board directly with Yorkshire Ambulance Service would be the most appropriate way to explore this further.

Live Donor Renal Transplantation
I am pleased to report that a Super-Regional Services bid to increase the volume of live donor transplantation activity in Leeds from 40 to 70 per year over the next three years was supported by the Specialist Commissioners. This is a highly significant investment which over time should make a real difference to the number of patients who receive a transplant.

Colleagues may be aware of the recent governmental report of the Organ Donor Task Force and the government commitment of significant financial resource with the intention of increasing the number of heart beating cadaveric organ donors, most likely by decreasing the current approximately 60% "relative refusal rate". If this plan is successful it would be expected to lead to considerable benefits for the patient population with end stage renal failure.

Unfortunately I am obliged to be in London on the day of the Scrutiny Board Meeting, it may be possible for Dr Mooney, who kindly substituted for me at a previous meeting, to attend.

Yours sincerely

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