



**(Agreed Draft)**

**VOLUME TWO**

**Overview and Scrutiny of the NHS**

**Kent & Medway Joint Panel**

**Response to Consultation**

*'Transforming health care, for a better quality of life*

*Renal Services*

*Vascular Services*

*Interventional Radiology Services'*

## **NHS Overview & Scrutiny Committee – Kent & Medway Joint Panel**

### **Response to Consultation on review of Renal, Vascular and Interventional Radiology Services**

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## **Part 1 – The context of the consultation**

### **1. INTRODUCTION**

The Health and Social Care Act 2012 makes statutory provision for local authorities with social services responsibilities to extend their scrutiny and overview functions to cover the National Health Service. The Department of Health have issued regulations and guidelines for NHS Overview and Scrutiny Committees and set out the following aims:

- The focus of health scrutiny is on health improvement, bringing together the responsibilities of local authorities to promote social, environmental and economic well-being and the power to scrutinise local services provided and commissioned by the NHS
- To address issues of health inequalities between different groups, and working with NHS and other partners to develop a dialogue to achieve health improvement

In addition, there are duties placed upon NHS bodies to consult the local overview and scrutiny committees on any proposals it may have under consideration for any substantial development of the health service in the area. Using principles outlined in 'Keeping the NHS local – a new direction of travel', Kent and Medway Strategic Health Authority have produced a consultation document for the review of renal, vascular and interventional radiology services. This has followed the three core principles for the development of proposals for reconfiguration of services:

- Developing options for change with people, not for them
- Focus on redesign of services rather than relocation
- Taking a whole systems view, exploring the contribution of all health and social care providers, working together to build sustainable solutions for the whole community

On production of the consultation document and the start of the consultation period, both Kent County Council and Medway Unitary Authority were asked to respond. There was a conference for all stakeholders on 19 May and they were later involved in the drafting of the consultation document.

The guidance for the operation of Health Scrutiny published by the Department of Health on 17 July 2012, required both Kent and Medway are required to establish a joint committee for the purpose of responding to the consultation. Only the Joint Committee is allowed to comment back to the NHS body - in this case Kent and Medway Strategic Health authority. As the consultation period began before the guidance was published, in this case a joint panel was formed of Kent and Medway councillors to respond to the consultation.

This is the first report of the first Joint Panel established by Kent County Council's and Medway Unitary Authority's NHS related Overview and Scrutiny Committees, representing the Panel's views.

## 2. JOINT PANEL TERMS OF REFERENCE

The Joint Panel has been made up of seven elected members, although some were prevented from attending all the meetings because of holidays

In addition the Community Health Councils were co-opted on to the Panel. Mrs M Ratcliffe was the only attendee.

Dr Tony Robinson (Chairman)	Kent
Mrs Wendy Purdy (Vice Chairman)	Medway
Mr Mike Angell	Kent
Mrs Jane Etheridge	Medway
Mr Roy Ford	Kent
Mr Mark Jones	Medway
Mr Peter Morgan	Kent
Mrs Margaret Ratcliffe	Medway CHC

The Terms of Reference for this consultation were to:

- a) Examine the Options proposed by the Kent & Medway Strategic Health Authority
- b) Take evidence from stakeholders as far as possible within the consultation period
- c) Report its recommendations to the Cabinets and full Council of both local authorities, and to Kent & Medway Strategic Health Authority

The Joint Panel found this a difficult task without being able to listen to patients' views directly. Evidence of patients' views was provided from the Strategic Health authority notes only.

## 3. THE REVIEW PROCESS

The review has been designed to be as inclusive as possible within the consultation timetable of 1 July to 30 September, whilst recognising the need, in the absence of a legally constituted Joint Committee at this stage, to report the Joint Panel's findings to the respective Overview and Scrutiny Committees for Health.

The review has involved a range of key organisations and individuals from across the whole health economy. including Consultants from all three services, a Nurse Manager, East Kent NHS Trust, Primary Care Groups/Trusts, Kent Ambulance Trust, Community Health Councils, and patients' representatives. Unfortunately the time scale has not enabled the Panel to listen directly to patients' views and this has been a disappointment. The Panel hope that in future consultation processes the Committee or Panel conducting the review will be able to attend consultation meetings with the patients.

The review process has involved three hearings where information and views have been sought from a range of individuals, including consultants, Doctors and surgeons, a nurse, and representatives from Patient Transport.

The South West Kent Primary Care Trust led the process as they are the lead Primary Care Trust for Kent and Medway for commissioning specialist services. The importance of the Primary Care Trusts in the process is huge, as they will be

responsible for funding the changes and ensuring their implementation throughout the primary care networks and throughout the acute trusts. All Primary Care Trusts have signed up to their support of the consultation document.

The main drivers for change have been the need to ensure clinical quality combined with a critical mass of patients to ensure best use of scarce resources. This involves an assessment of the trade-offs between access – having a service at the local hospital - and being treated by specially trained, dedicated staff.

#### **4. HOW THE SERVICES ARE CURRENTLY ORGANISED IN KENT AND MEDWAY**

The consultation is concerned with the re-design of the services, not at this stage the relocation. However, the Joint Panel could only respond to the consultation when they understood the context of how the services are currently organised in Kent and Medway.

##### **4.1 Renal Services**

There is a central renal unit, together with five satellites in Kent and Medway, at Medway, Margate, Maidstone, Pembury and Dartford.

Pembury and Dartford are satellites to London hospitals, Guy's and St Thomas (GST) and King's College Hospital, and although in Kent, are owned wholly by those hospitals.

The consultation covers renal services in only part of Kent and Medway; there are no planned changes to the service for those patients who are patients at GST and King's College Hospital, and any further patients who go there from Kent and Medway. Currently renal services are provided for an estimated 1.3m population, the other 300,000 people being served by GST and Kings.

The Commissioning team for specialist services is based in the South West Kent Primary Care Trust. Although the service is provided by three providers, the Commissioning team are working with all three to ensure that there is equity of access to all the services regardless of which part of Kent and Medway patients live in and which provider runs the service. This will include negotiating with the SE London PCTs to ensure that the London hospitals expand their capacity to continue to serve the expanding population of the South Thames Gateway.

##### **4.2 The use of London Hospitals for Renal Services.**

All transplant surgery is done in London because the population of Kent and Medway alone is not large enough to sustain its own transplant unit and this will continue.

Most renal patients in South West Kent or Dartford are treated in the satellite units which although run by GST and Kings, are based at the local hospitals. Unless the renal patients are inpatients in the main units at GST or Kings, they would access basic vascular services locally at Pembury or Dartford.

The London services operated by GST and Kings are similar to the East Kent Health Trust service at Kent and Canterbury Hospital, in that they provide inpatient facilities centrally, and provide local satellite units which link to these. The commissioning team for all Specialist Services in Kent and Medway is based at Maidstone Weald Primary Care Trust. The commissioning team will ensure that the capacity provided for the

patients treated by London Hospitals will be increased appropriately, in exactly the same way as it is being planned in the other parts of Kent and Medway.

### **4.3. Vascular and Interventional Radiology Services**

- Vascular and Interventional Radiology services are provided at all seven hospitals in Kent and Medway – Darent Valley, Kent & Canterbury, Maidstone, Medway, Pembury, Queen Elizabeth the Queen Mother at Margate, and William Harvey at Ashford. There are currently nine clinicians classed by the Strategic Health Authority as vascular specialists distributed throughout the area – although all of these have general surgery caseloads also.
- Work is continuing to produce more detailed business cases for service models.

The consultation offers a review for these services for the whole population of Kent and Medway (1.6m population) Some vascular emergencies are treated in South East London hospitals and the loss of these would have some effect on income streams to London. The consultation response should thus be seen within the context of current services. Although the Joint Panel's response to the consultation is about the redesign of the services not the re-location, it cannot ignore the considerable services provided by the London hospitals when responding.

## **5. RANKING THE FACTORS FOR GOOD SERVICE**

The Joint Panel has sought to compare national standards where possible with what is proposed for Kent and Medway. Although there are not yet any National Service Frameworks for Renal and Vascular Services, the Kidney Alliance has produced 'End Stage Renal Failure – a Framework for Planning and Service Delivery'. It is expected that this will be adapted as a national service framework within the next few months. This report refers to the seven national service standards laid out within the Kidney Alliance's work. (Appendix 1)

In the absence of national services frameworks 'The Provision of Vascular Services' produced by the Vascular Surgical Society of Great Britain sets out the standards agreed by the profession nationally. Both of these documents have been used in the compilation of the consultation document and by the Joint Panel, when considering the options.

After the hearings and review of the written evidence, the Joint Panel assembled to rank the factors for good service. This was done individually and then the results were discussed, with the Joint Panel coming to the conclusions below. Rather than rank the factors for good service in order of priority, the Joint Panel preferred to rank them in groups of high, medium and low priority.

**Q1. These were the rankings of the Joint Panel of the factors for good service.**

**High Priority**

- c) Quality of clinical care during and following treatment
- g) Specialists to do the specialist jobs – recruitment and retention of key staff, plus development of team working
- h) Speed at which the option can be implemented – designing a realistic, yet ambitious phased development plan
- l) Affordability – what is needed to implement changes (both capital and running costs)
- j) Sustainability and flexibility, to be able to cope with future developments (*These two factors are closely linked*)
- k) Initiatives to help prevent the onset of disease

**Medium Priority**

- a) Communication and support
- d) Patient involvement in care and treatment (holistic approach)

**Low Priority**

- f) Transport time – to, from and within the hospital itself (*If the recommendations made can be addressed*)
- a) A standardised referral process between the General Practitioner and the specialist
- b) Waiting time to see specialist and commence treatment (*Rated low because of high percentage of emergency cases*)

In addition, the Joint Panel's findings for each of the factors are listed here, together with recommendations.

**Part 2 – The Factors for good service**

**1. A STANDARDISED REFERRAL PROCESS BETWEEN THE GP AND THE SPECIALIST**

The evidence obtained from consultants has been that there is no standardised referral process, and this is not needed.

There is already an established route for GPs to refer patients to consultants. One vascular consultant thought that this factor might refer to a central point of referral for a particular specialism. Clinicians share their work with a colleague so that they are both aware of one another's caseload whenever possible.

With regard to renal referrals, it was usual that the referrals were generic rather than specific so were picked up by the renal unit rather than by a particular surgeons or consultants.



However, diagnosis was rated as a problem in the patient discussions, and by vascular surgeons, and this is a separate issue to be addressed by the Primary Care Trusts. (See response to Question 2)

## 2. WAITING TIME TO SEE SPECIALIST AND COMMENCE TREATMENT

### Current situation

A comparison of replies from Vascular surgeons revealed the following variation:

Hospital	Wait to see Specialist	Wait to commence treatment
Darent Valley	2-3 weeks,	2-3 months
Maidstone	Emergency – seen immediately Urgent – within a week Varicose veins – less of a priority	Emergency – immediate On being seen at the clinic Day surgery lists are ‘not too long’

Hospital	Wait to see Specialist	Wait to commence treatment
Medway	Half of work load – emergency – seen immediately Urgent – within two days Elective surgery	Emergency – immediate  On being seen Not given

These were personal estimates quoted by the surgeons concerned, rather than statistically verified data.

The renal estimates were:

Hospital	Wait to see Specialist	Wait to commence treatment
Canterbury	Acute Renal failure – emergency	Immediately
	Other cases – depending on current renal function	Can by-pass the ‘working list’ if necessary if patients deteriorate.

The patients’ discussions did not raise waiting times to be seen by the consultant as a major problem. The vascular surgeons were all agreed that waiting times were not the problem; it was the setting up of an emergency rota.

### Waiting times for Renal patients

Within National Services Standard 2 of the Kidney Alliance’s Standard Framework, there are standards for referrals to specialists and for urgent referrals. This is an area that can only be improved through the Primary Care sector. It is suggested that Commissioners should audit the number of patients entering renal replacement therapy as late emergencies. This would be the first step to developing mechanisms to ensure that the proportion of late referrals is a minimum, and if resources allow, this seems a sensible way to auditing unmet need.

The National Service Standard 2 lays down that timely initiation of appropriate treatment demands unimpeded access to the different sorts of dialysis, which requires planned expansion of facilities in line with current prediction of need. ‘There would be no ‘waiting list’ for dialysis, nor should any patient be commenced on a therapy known to be inappropriate.’ Currently the Joint Panel has found no evidence to indicate that this is the case in Kent and Medway. However, it is clear that the number of satellite stations needs to

increase, particularly in those areas designated to have the largest population gains. The number on Renal Replacement Therapy is predicted to rise for 20 years before levelling out.

Although the transplant centre for Kent and Medway will remain in London, their staffing should allow transplant surgeons, physicians and co-ordinators to carry out clinics in renal centres to streamline screening of potential recipients. This will maximise morale and local organ retrieval, live donation and transplantation before it becomes really necessary, to comply with National Service Standards. In Kent and Medway there has been an emphasis on the benefits of live organ donation, as there are so few cadaver kidneys available. By doing this, the Kent and Canterbury Hospital Unit achieved 36 transplants in 2002 by encouraging live donation.

## **WAITING TIMES FOR VASCULAR PATIENTS**

### **Renal patients requiring vascular access**

It is also important that vascular surgeons are available to operate on patients so that they can receive haemodialysis. It is likely that vascular surgeons working in large departments will be best placed to provide renal support in the future if the work is pooled rather than concentrated on one individual.

The Job Plan of replacement or additional vascular surgeons should ideally include renal support as a core element.<sup>1</sup>

The preferred access in any Haemodialysis (HD) patient is an Arteriovenous fistula (AVF). The UK is lagging behind most of the large European countries with regard to the proportion of HD patients using natural AVFs (67% in UK, Germany 84%) and there are delays in installing these.

### **Vascular Patients without renal disease**

With regard to vascular services, a modelling exercise undertaken by the Health Technology Assessment programme revealed that there was a need to rationalise services to improve outcomes.

Specialised Interventional radiologists are needed for renal support. Radiology departments however are all working to capacity with demands exceeding their ability to provide. Planned and fully resourced expansion of radiology departments will be required if they are to provide renal support.

The annual acceptance of new patients in the UK of those measured has not risen in the past 4 years, and is lower than in most other Western European countries.

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<sup>1</sup> End Stage Renal Failure – A Framework for Planning and Service Delivery – The Kidney Alliance

### **3. QUALITY OF CLINICAL CARE DURING AND FOLLOWING TREATMENT**

Professor Alberti, President of the Royal College of Physicians, summed up many of the key issues in his letter to the Select Committee on Modernising Hospital Services in East Kent:

*“I personally would place more emphasis on the need for high-quality services which require a critical mass of appropriate specialists. In medicine we can adapt the training needs somewhat but you cannot make up for the deficiencies in cover that ensue from having too few consultants in specialities. Ideally for all the major specialities East Kent needs five consultants for it to provide both 24-hour cover, development of sub-specialities, and the ability to provide outreach programmes.”*

Although there have been three or four reviews of vascular services over the last ten years, it is now clinical quality and the need to serve a critical mass of patients which are the main drivers for change.

To assess the importance of this factor, it is simpler to look at the services separately.

#### **Vascular Services**

More than two years ago, a group of vascular surgeons and interventional radiologists were invited to take part in a consultation for a review of Interventional Radiology and vascular services across West Kent. This was originally a much more limited review than the current one. However, that reconfiguration became subsumed in the national targets to cut waiting lists. By 2003, it became obvious that the service could not stay as it was, because of the changes imposed by the NHS Plan with regard to Patient Safety. ('Building a safer NHS for Patients'). They would have to look at the whole Kent and Medway issue, for both renal and vascular services, for the whole population of 1.6 m. Patients would suffer without proper care.

Currently in Kent and Medway, it is not possible to compile an on-call rota for vascular emergencies. This is contrary to clinical governance. The need to provide an on-call rota for vascular emergencies means that surgeons need to work in teams of four or five. If vascular services centralised on to two sites, there could be a 24-hour on call or emergency service. The service is expanding, as the need for vascular surgery is an older age group problem. The greatest problem is not waiting times, but providing emergency rotas or cover. This is what is driving change, and has been done in Sheffield.

The idea of the new service models is to provide a network of care, and the vascular surgeons who spoke to the Joint Panel had clear ideas about the structures that were needed to improve the service.

The principles of a high quality vascular surgical service<sup>2</sup> are:

- Vascular emergencies should be dealt with by surgeons with adequate training
- All patients should have equal access to vascular surgical services on the basis of clinical need, scarce resources being distributed to provide maximum benefit.
- One full time vascular surgeon required per 250,000 population – that would be 6 in Kent and Medway as in the consultation document.
- A reasonable sized vascular unit should have 5 vascular surgeons to provide 24 hour, seven days a week cover – with a dedicated high dependency unit and emergency vascular radiology.
- Some types of vascular surgery, such as routine operations on varicose veins, may be identified separately

### **The provision of emergency vascular services**

Treatment of vascular emergencies has changed radically in recent years, becoming increasingly complex and involving a team approach, including specialists in Interventional radiology. Clinical governance decrees that vascular specialists should treat vascular emergencies, and there is an accumulation of evidence that outcomes are better when vascular specialists treat vascular patients.<sup>3</sup>

This does mean a need for a formal emergency rota – recommended for ‘1 in 4’ on call. All models for emergency vascular services involve some degree of collaboration and the need for clinical networks.

To justify a vascular unit, there needs to be 500,000 people – the ‘critical mass’, which would suggest at least two units in Kent and Medway. However it is not clear how many patients this mass of population would generate initially. The option that the clinicians prefer is the two-centre model, with a three-centre model a possibility in a few years. The opinion is that one centre would be too expensive, because the size of it would need considerable capital investment, which the NHS Trusts may not have.

The vascular surgeons were unanimous that two centres would definitely be the maximum number, but it would be possible, from the Doctors’ point of view, to manage with one. (The problems of patient transport are addressed in Paragraph 6) During the day they would be occupied with elective surgery, so it is important to have a critical mass of patients to occupy the surgeons’ full time. The surgeons preferred to work in teams of at least four, and preferably five or six, to create a centre of excellence. If there are too few surgeons together, it dilutes the expertise of the surgeons.

There would be a need for capital investment in a dedicated separate vascular ward, as currently vascular patients go into any available ward, sometimes causing difficulties in locating patients on the wards. Vascular surgeons were agreed about the infrastructure necessary to offer clinical quality. They believed that there would have to be some new build, even if there were two centres and there was a phased introduction. Even where a hospital could absorb extra patients, they would need more equipment and manpower.

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<sup>2</sup> The Provision of Vascular Services - VSSGBI

<sup>3</sup> The Provision of Vascular Services - VSSGBI

When considering vascular services it is useful to look at the differing needs of the various parts of the service. The service divides into:

- Emergency Vascular services
- Elective vascular services
- Interventional radiology, and
- Non vascular interventional radiology.

Currently where there are only two vascular surgeons, if they are on call, patients will get the specialist procedures. If not, patients have to be transported to London. The advent of the emergency rota in the SE London hospitals had encouraged Kent and Medway Doctors to send their emergency out of hours cases to London. Patients' care is thus affected by at what time of day they become ill.

When asked what were the biggest deficiencies in the service, the Doctors agreed it was the deficiency in the emergency service. Some patients had to wait all night or go to London. They could not carry on as they are; they require five surgeons at each centre to provide cover twenty-four hours a day, seven days a week.

All those who were consulted were unanimous that with a ruptured aneurysm it is better to be transferred to a specialist unit. This can take up to one hour. With a 'dead leg' there is six hours to save the limb. Vascular surgeons agreed that it is more important to get the correct surgeons than to be treated locally. With two vascular units, the two teams could alternate on emergency calls, thus increasing the amount of flexibility. The death rate is high for ruptured aneurysms. Once they have ruptured, 90% die – half at home and half before they get to hospital. Of those who survive, vascular surgeons are able to save 50%.

10-15% of patients with occluded limbs dies. Many of the patients are diabetics as well, and are increasingly older and frailer. Because of the high mortality rates from these emergency procedures, the Joint Panel felt that great emphasis should be laid on preventative measures.

Although in some hospitals general surgeons still operated on vascular emergencies, in most, patients are moved on to where there is a specialist vascular surgeon.

The vascular surgeons emphasised the importance of separating the emergency from the elective vascular services when considering the reconfiguration. Because Interventional Radiology, Vascular Services and Renal services all have common ground, this is an opportunity to rationalise and improve patient care.

### **A Strategy for Vascular Services**

The clinicians who spoke to the panel were had worked to modernise the services for years – 22 years in one case, and 10 years in another. Starting off alone, they now had expanded their services, and had developed a clear strategy on where the service was going. This had enabled the original team builders to recruit further specialists and attract nurses who could see how the vascular services were developing.

The vascular surgeons, although they may have a vascular nurse practitioner in each district, often have no vascular nurse specialists. Although nursing teams have developed their skills, with no dedicated vascular surgeon it is very difficult. Providing a

dedicated ward for vascular surgery cases would solve this: – optimally with a vascular theatre and an anaesthetist.

They were confident they could set up a structured programme, using existing staff. Half of the workload is emergency (treat immediately) or urgent (within two days). The other half is elective.

When asked about the need for nurses, the nurses explained that they would prefer that a skilled nurse accompanied every patient back from theatre. One of the problems is when vascular treatment is sometimes not successful and this leads to amputation. Currently there are no placements for rehabilitation for these patients.

## **Interventional Radiology**

Each hospital is doing its own radiology caseload, so there is no known total numbers of patients. There is agreement that the development would be a phased process:

Phase 1 – movement to two centres. Radiologists would work as one of 5 or one in six as a team.

Phase 2 – centralise the emergency work of those with vascular interests, using existing skills.

Phase 3 – Vascular and interventional radiologists working together. Within a year, there would be a need to recruit and it would be easier to assess the need.

The hospitals without vascular units would still receive services from vascular surgeons. Emergency vascular surgery, with full emergency cover, would be delivered at each vascular unit. The network care would comprise an adaptation of the hub and spoke model, where there might be clinics and elective vascular surgery at a number of places.

Overall, the Interventional Radiologist seen by the Joint Panel felt that the services would be improved by working as a team with renal and vascular services. They favoured a two-centre option with a view to three specialist centres of excellence later. The two centres would work collaboratively, thus maintaining availability of Interventional Radiology (IR) services in the district general hospitals.

## **Renal Services**

After the National Renal Review of 1992, published in 1995, the unit in Kent and Canterbury Hospital was placed bottom for quality out of 50-60 units. After this, new appointments were made and big improvements were needed in provision of dialysis. A transplant review found that they were short of transplants, there was under provision of services in Kent and Medway, and the services provided were not good quality.

However, Maidstone and Medway Health authorities did not take away their patients at this time (1995) even though they were receiving a poorer service than the London hospitals provided at that time. They retained their links with the Kent and Canterbury Hospital Unit, and this may have been due to ease of access, and their belief in the improvements, which were being made. The London hospitals have a long tradition of providing services to renal patients in the north and west of the area.

There are five types of renal treatment which renal units deliver:

1. End stage renal failure and renal replacement therapy – this involves haemodialysis by running fluid through a membrane into the body through a fistula or Peritoneal Dialysis running fluid through the peritoneal cavity. This is the ‘bread and butter’ service
2. Acute renal failure – where kidneys fail suddenly. Patients often recover satisfactorily but this must be investigated
3. Investigation of general kidney disease
4. Management of electrolyte balances
5. Management of hypertension

### **Haemodialysis**

Anyone with Acute renal failure will go onto Haemodialysis - Haemodialysis is thus known as the default modality. The key problem is that there are not enough facilities, and an over reliance on peritoneal dialysis. The funding in April 1995 – favoured peritoneal dialysis, because GPs prescribed the fluids needed and thus it was cheaper for the hospital to introduce this treatment. 70% of patients were thus on peritoneal dialysis, for which the long-term clinical outcomes were less successful. Over the last few years, the Haemodialysis/Peritoneal dialysis percentage has gone down to 60 - /40%, the ideal ratio is 75% Haemodialysis and 25% peritoneal dialysis, to provide a reasonable backup.

There were only enough dialysis facilities for two sessions per week, and to have a chance of a long life, patients need three sessions per week. The Kent and Canterbury Hospital unit has had to catch up to national standards and develop the service further. The national standards are:

- Haemodialysis should be provided three times each week for more than 90% of patients
- Haemodialysis adequacy should be assessed regularly and should achieve laid down standards
- Disconnect systems for peritoneal dialysis should be provided to all PD patients by 2001
- Peritoneal dialysis adequacy should be measured to meet national standards

There is also evidence in Kent and Medway of un-met need, which can be demonstrated by the acceptance figures for treatment, compared to national figures<sup>4</sup>. The renal unit in Kent and Canterbury Hospital has pressed for, and been successful, in extending the availability of satellite stations for haemodialysis. Although there has been expansion into Medway, Maidstone and Margate, in Ashford there are no dialysis facilities and this is large gap in the provision.

The consultants visit the satellite units four days per week, whereas Registrars remain in the central unit. There are also out-reach clinics which the patients like because they see the same person each week. The basic requirement is for a satellite station, to

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<sup>4</sup> The Renal Association – The Prevalence of un-referred chronic renal failure in East Kent

upgrade the concept of the hub and spoke structure into a network of care. The renal unit specialists do as much clinic work as possible in the 'spoke.'

Wherever the central unit is, to improve access to patients, as much work as possible should be done in the satellites. Support to other hospitals has increased through the expansion of satellites, and they will need to continue to extend to match increase in patient numbers. Each Haemodialysis unit can treat 4 patients per week. A satellite unit costs £1m. of capital money, and some have been funded partly by charities, partly from government grants.

There are, however, some high dependency patients who must always attend the central unit and are often admitted as inpatients. Acute renal failure will always be treated at the central renal centre. The inpatient beds have more than doubled since 1995 and there are now 27, but 40 beds are needed.

Renal patients are very likely to develop anaemia, and The Kidney Alliance National Service Standards maintain that correction of anaemia should be achieved to national standards - the unit has pioneered anaemia treatment, and now leads on this nationally.

Although it may appear that there is only the demand for one renal centre in Kent and Medway, this is artificially skewed because of the use of the London Hospitals as extra providers. National Service Standard 7 maintains:

"Commissioners should recognise that new autonomous renal units may have a greater impact on local acceptance and prevalence rates and consultant numbers than 'hub and spoke' expansion".

Although the clinicians are content with the current structure of one renal unit in Kent and Medway, and the use of the two London hospitals for north and part of West Kent, there is no doubt that with only one renal unit access to patients from north and west of the area is restricted to London hospitals.

### **National Tariffs**

With the introduction of national tariffs for all medical procedures, Kent and Medway Primary Care Trusts, as commissioners, will have to pay London tariffs for all those patients attending London hospitals. These are not yet calculated, but currently estimated to be 18% higher than Kent and Medway tariffs. Any consultation must take account of medium and longer term development of the new hospital in West Kent, and development in services in East Kent.

The alternative of building up the existing unit to serve the whole of Kent and Medway (1.6m.population) is not popular or practical, as the size of the one unit would need considerable capital investment and it would greatly increase journey times for those patients affected. The clinicians feel that they would lose the intimacy of a local unit, which has been praised by the patients in the consultation exercise. It is felt that recruitment of specialised nursing staff would be a problem in Kent and Medway, but forward planning could improve this. The clinicians' view was that there was no chance of staffing three renal units. They value the skills of their very experienced nurses; some of whom have over 10 years experience in this field.

### **Vascular services for renal patients**



Co-location of renal services and vascular services is important because of the need for a vascular surgeon to create a fistula. This joins an artery to a vein under the skin the vascular unit. Without this, patients have to begin haemodialysis with temporary access, which increases the risk of infection and thus the risk of death.<sup>5</sup>

The diseases are more prevalent in the elderly and in diabetics, and both link to Interventional Radiology. From the vascular surgeon's point of view, co-location is not so important. After aneurysm surgery, patients may suffer kidney failure, but some vascular surgeons were content to seek advice when the renal specialists made their regular visit to their hospital. As The Kidney Alliance National Service Standard 4 lays out the guidelines for effective delivery, including the importance of regular audits of standards and peer review, as they are such a powerful aid to continuous quality improvement. One of the main problems with the Kent and Canterbury Hospital unit in 1995 was that staff had not had the opportunity to visit other units, and this partly was the reason the quality of the unit had been low. It is important to carry out peer review and visit others to learn. Working in teams allows consultants more time to do this and encourages continuous improvements.

One of the developments over the last few years is the Renal Registry. When complete this will produce important comparative information, providing the basis for the comparative audit of outcomes in patients with renal failure. The comparative figures currently cover 72% of the UK adult population

The renal unit at Canterbury is currently preparing to join the register and their figures should be available for the 2002 report. This will enable all stakeholders to assess the quality of service compared to other units e.g. the London units, which are already measured. Also, the Renal Registry now holds statistics so those units can benchmark their results with others. All autonomous renal units and their satellites should be linked to the UK Renal Registry within 2 years.

Service providers should carry out regular audits of their compliance with current dialysis standards. Staffing levels in renal centres should reflect the time necessary to carry out systematic audit. Funding bodies and Trusts should support renal professionals engaging in peer review to help maintain continuous quality improvement. Commissioners and Trusts should support audit initiatives to improve the evidence base for standards.

For renal patients the administration is vast because of the length of time that patients are treated. In the early stages it is easier to do community visits, then the patient progresses to outpatients, then if they suffer End Stage Renal Failure to dialysis and inpatients, and then perhaps to a transplant. Their whole life has to be recorded. With the introduction of centralised vascular units, IT facilities are essential to ensure clinical quality. Notes can be transferred easily between vascular teams, the local hospital and centralised vascular units.

Future numbers of patients are likely to be rise proportionately to the greater numbers of older people in Kent and Medway. Nationally, the numbers of people over 70 is 15.9% of the population, and there are 18% in Kent and Medway. Chronic renal failure is rising exponentially.

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<sup>5</sup> Kidney Alliance National Service Standard 3

## **RECOMMENDATIONS - QUALITY OF CLINICAL CARE DURING AND FOLLOWING TREATMENT**

- **It is clear that in some areas, doctors and surgeons have worked hard to work out a clear strategy for their service. This needs to be built on and good practice extended across the whole of Kent and Medway.**
- **To ensure clinical quality it is essential to find the funding to provide a dedicated ward for vascular patients. This will enable the vascular surgeons to bring together all the strands of good clinical quality to ensure the reconfiguration is a success.**
- **Some consideration to be given to improving facilities for recovering amputees – a dedicated rehabilitation provision should be provided.**
- **There should be plans made and funding for the extension of the satellite units, and the setting up of extra satellite units where there are none now.**
- **Bring all renal services, apart from transplant services, back into Kent and Medway in the medium or longer term.**
- **Every incentive should be found to ensure that Information Technology is used extensively to keep patient records. Both vascular and renal services keep their patients for decades and if the options of treatment in primary care, at general hospitals, in satellite units and in central units are to be maximised, easy access to records is essential.**
- **Resources, funding and training should be put in place to ensure that the benefits of team working are not lost and the centralised units are truly centres of excellence, fulfilling national service standards and equalling or surpassing national averages for clinical quality.**

## **4. PATIENT INVOLVEMENT IN CARE AND TREATMENT (HOLISTIC APPROACH)**

It has not been possible to speak to patients directly while preparing this consultation response. For future consultations, it is hoped that patients will have the opportunity to share with the Overview and Scrutiny committees of Kent and Medway their experiences. Patients did outline their views at the consultation conference held in May.

They identified a need for:

- A Kent and Medway dedicated renal unit
- 24 hour support
- Single sex wards
- Higher staffing levels, especially specialist nurses

Most of their other priorities were connected with management change:

- Organisation of transport
- Lack of understanding by GPs

- Treatment of transplant patients at separate clinics

Or issues which are beyond the scope of the review:

- Accessibility for holiday dialysis

### **Single Sex Wards**

Patients regularly mentioned their dislike of mixed wards, but there seems to be no immediate answer to this, given the shortage of beds. Although possibly less important than issues of clinical quality which investigations revealed, patients see this as a violation of their rights as individuals. Nurses try to make the best of the use of bays and side rooms and be sensitive to patients' needs. However, if extra resources can be found to provide single sex areas when new wards are built, this would certainly contribute to the whole treatment of the patient.

The time scale of the review has not allowed portering to be reviewed in all hospitals, but the view of nurses was that portering standards had improved. Waiting for patients to be portered from their treatment was not raised as a problem by the Transport Planners interviewed.

Most of the basic standards of comfort and treatment of the whole patient are outlined within the consultation document and are also repeated, for renal patients, in National Service Standard 5. Some will be easier to achieve after the re-design of the services, but most can be implemented straightaway.

One of the most important standards was that of older patients, which revealed they nearly all had the presence of co-existing or additional diseases in addition to their renal disease. Patients felt that renal staff did often not pick up these issues when planning care, and the patients consulted at the conference also pointed this out. This is because patients and staff often find it difficult to know the most appropriate pathway for patients to seek help and advice in relation to managing other conditions alongside renal problems. This could be solved by:

- Comprehensive assessment in renal care planning to improve co-ordination
- Greater clarity in lines of responsibility for meeting needs
- Staffing should reflect numbers of older people now needing this treatment who have other diseases
- Staff to be more aware of the potential needs of older patients

The Kidney Alliance has issued National Service Standard 6, which deals with the patient's right to withdraw from treatment. This was not raised by any of the patients or clinicians in the Joint Panel's investigations - probably because of the patients sampled.

#### **4. RECOMMENDATIONS PATIENT INVOLVEMENT IN CARE AND TREATMENT (HOLISTIC APPROACH)**

- **It has not been possible to speak to patients directly while preparing this consultation response. However clinicians and patients' representatives would have been happy to put the Joint Panel in touch with patients if time had allowed. For future consultations, it is essential that any Select or Joint committee from Kent and Medway be helped to listen to the patients' point of view.**
- **The Standards of Care laid out in the consultation document 'The Patients' Perspective' to be implemented without delay.**

#### **5. COMMUNICATION AND SUPPORT**

**This factor is tied in closely with Patient involvement in Care and Treatment**

Communication and support is important at several different levels. Communication and support of the patient is the most important, but there is also communication between the health professionals themselves.

NHS agencies should work in harmony to meet the standards, and success will depend upon a common approach to the development of services and quality. The Regional Specialised Commissioning Group, based in South West Kent, should oversee joint working at all levels between NHS and partner agencies. However they cannot be expected to ensure that management changes are made successfully by individual health trusts and Primary Care Trusts when the Renal and Vascular review is implemented.

The Kidney Alliance found that communication was particularly important where patients already have continuing frequent involvement with a specialist unit – particularly diabetic patients. This also affected patients with transplants who then became pregnant. For older patients, it is important not think that they are less capable of understanding complex information.

Consistency of information was raised by patients in the consultations, and in a study of older patients commissioned by Age Concern<sup>6</sup>. Sometimes staff made arrangements

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<sup>6</sup> The Experience of Care of Older End-Stage Renal Patients in Receipt of Long Term Dialysis (City University)

for treatment days or transport without checking their convenience for the person involved as staff sometimes assumed that older people would be more flexible.

Pre-dialysis education is said by the Kidney Alliance to be an important means of preparing patients for long-term treatment, and all three Kent and Medway providers deliver this. None of the patients surveyed in the consultation mentioned its value, but further studies of this would reveal why Kent and Medway patients felt there was a lack of communication and what else was needed.

Patients were vocal in their criticism of lack of communication about travelling pick up times and waiting times within the hospital, and this is addressed in the Transport Review.

With regard to vascular patients, the vascular surgeons were committed to their part in preventative education and this is addressed in Preventative Measures.

## **5. RECOMMENDATION - COMMUNICATION AND SUPPORT**

- **Further study of the efficacy of pre-dialysis education would reveal if any changes were needed. Patients in the evidence submitted still feel that there is a lack of communication with them, and between, different health professionals.**

## **6. TRANSPORT TIME – TO, FROM AND WITHIN THE HOSPITAL ITSELF**

### **Patient Transport Services**

In Kent County Council's review of the modernisation of East Kent Hospital, there were recommendations for transport and access which hold good for the whole of the Kent and Medway area. The recommendations made in January 2002 are still 'work in progress' when the Joint Panel considered patient transport for this consultation response. The original recommendations are shown for information in Appendix 2.

The Select Committee then unanimously supported the concept of 'local services for local people' but recognised that accessibility and the quality of care need to be carefully balanced in order to ensure patient safety.

The Joint Panel looked at the Patient transport system in Kent and Medway in the context of this review and possible centralisation of vascular services.

The current transport infrastructure ensures that hospital services cannot easily be accessed from all points within Kent and Medway. However the Joint panel did not feel this was an outcome of the centralisation of some services – as the structures suggested include plenty of locally delivered services, but flaws in the way that Patient Transport is commissioned. The absence of reasonable public transport links across some parts of Kent and Medway makes improvements to the transport arrangements to hospitals for patients and visitors. All patients who need to access renal and vascular services are eligible to be considered for Patient Transport and about 50% use it nationally.

The Patient Transport Service (PTS) was established in 2001 and a voluntary car scheme complements the work of the PTS. The organisation of Patient Transport differs across the four health economies of Kent and Medway. For those in West Kent, Kent Ambulance Trust runs Patient Transport.

At East Kent the contract to run Patient Transport is held by East Kent NHS Trust themselves as an in-house provider. Because transport is provided according to the patient's **destination** and **not** their **home address**, it is East Kent Patient Transport who is responsible for providing all the transport for Kent and Medway patients who attend the renal unit. In some cases, East Kent Patient Transport will arrange with London Patient Transport providers to provide cars to London hospitals, as it is more cost effective..

The current criteria for qualifying for free patient transport is that the patient should have a medical need certified by the GP or consultant.

In Making the Connections, Chapter 11, the Social Exclusion Unit sets out new criteria for qualifying for Patient Transport: and these should begin from 1 April 2004.

- Medical: A failure to provide transport and care en route would be detrimental to the patients' health
- Mobility: Patients cannot get to their treatment facility by other means. This should also cover patients such as elderly patients with dementia and people with learning disabilities
- Inadequate public transport: in instances where the existing public transport is inadequate, taxis, community transport or volunteer car could provide door-to-door transport.
- Financial: PTS is to be available for people on low incomes, for people currently eligible for help under the Hospital Travel Costs scheme. Guidance to Primary Care Trusts, strategic health authorities and local authorities on the role of PCTs as patient transport commissioners is awaited.

### **Resourcing the Patient Transport Service**

Lack of resources is the main problem faced by the Patient Transport Service. In East Kent, Patient Transport is funded for 179,000 patient journeys per year, but now has to provide 200,000 patient journey per year. 19% of journeys are renal journeys, and as patients live longer through successful treatment, there is a huge increase in patients with poor mobility. As East Kent Patient Transport is an in house provider, they do not receive extra budget when they need to provide for extra journeys. Additionally, they are not allowed to recruit staff when there are vacancies when the budget is over spent. They make up the shortfall with more costly private ambulance services (currently £20,000 per month). Having authorised treatment, clinicians forget to add in the transport costs, and this seems to be magnified even when there are large scale system changes.

### **The Volunteer Driver Scheme**

There are 140 volunteers drivers in East Kent and 90 in West Kent, in East Kent, comprising 60% of the journeys. 23% of that 60% are renal journeys. Although volunteers are so important to the service, shortage of volunteers is a local and national

problem. Patient Transport feel it would be more cost effective to employ staff directly and run their own cars, as utilisation would be better. Patient Transport also uses taxis, and this is reasonably cost effective. Because it is difficult to recruit Volunteer drivers in certain areas Kent and Medway, Transport Planners thought that centralised vascular units would lead to 'dead mileage'. That is, a volunteer may live in Folkestone, then drive over to Dover for the patient and then to Ashford for the clinic, and then return. This is more a reflection of the difficulty in attracting sufficient local volunteers than of centralisation of services.

Recruitment campaigns do not work well, and new volunteers are recruited from word of mouth recommendations. Volunteer car drivers provide their own transport and are paid on a cost per mile basis, an element of which is subject to tax assessment.

Transporting patients to the renal unit is particularly demanding in that patients undergo dialysis from 7 am to 11 pm, and volunteers will refuse to do long and unsocial hours. Drivers normally work between 8 am to 6 pm but renal patients often need transport outside these hours. For early appointments in London hospitals, West Kent has to provide cars, as ambulance shifts do not start until 7 am. Ambulance teams work different shifts in different areas – for instance Thanet work 8 – 8 pm, Folkestone 9 am–5 pm. If Patient Transport were able to change the shifts they could put a double crew on one ambulance, and thus save money and double the use of the ambulances.

### **Further improvements**

Within two years, a patient transport integrated booking system and integration with outpatient booking should be in place. The patient will visit their GP, who will refer to a clinic – the GP's Practice Manager will be able to book the clinic appointment and the transport to get there at the same time, online. The software is now being tested by Patient Transport. There is no connection linking planning and appointments currently, but the choice of transport is based on clinical need.

For older patients, transport and waiting time issues are key areas of concern. 50% of patients are dependent on hospital transport, and it must be higher for the older age groups. It is unsafe to drive after haemodialysis treatment. Public transport or self-financed taxis are frequently too expensive.

The Kidney Alliance found that reduced waiting times considerably improved patients' quality of life. The national standard for one-way travel for haemodialysis is less than 30 minutes.

It is unlikely that all parts of Kent and Medway are currently within this journey time. It is also not clear whether there will be sufficient capacity to transport all patients to one or two centralised vascular centres. Patients consulted were particularly unhappy with journey times and the circuitous journeys caused by lack of volunteers and the need to fill all vehicles with as many patients as possible. The Audit Commission's report stressed that it is not always clear whether the complex arrangements for travel meet the needs of the users<sup>7</sup>.

The treatment of vascular emergencies requires a different approach from renal services. The ambulance service and the A & E departments need to be fully informed

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<sup>7</sup> Going Places The Audit Commission 2001

and in tune with the emergency vascular rota, understanding the need for occasional emergency transfer between the two hospitals when vascular emergencies must be operated on by the on-call vascular surgeon at the centralised unit(s).

Despite their difficulties, the Transport Planners wanted to be able to provide: *'Patient friendly transport which will be focused, integrated on the needs and wants of patients – seamless and under one roof'*

#### **TRANSPORT TIME**

- **Greater co-operation between Patient Transport services could reduce the number of 'dead miles' where ambulances and volunteers travel many miles from their base before they can pick up the patient.**
- **As volunteer drivers are so crucial to the service, a decision must be made to either make being a volunteer more attractive, or to augment the volunteers with extra vehicles and drivers for unsocial hours driving. This may include redesigning the service to avoid the tax disincentive.**
- **Co-ordination of Patient Transport ambulance drivers' shifts across the whole patch is essential for a service, which is equitable for all patients throughout Kent and Medway. To make best use of scarce resources, the introduction of two shifts (one early and one late) would help the least mobile patients get to dialysis.**
- **Every effort should be made to introduce Information Technology into the specialist referral system, with the introduction of the integrated booking and transport system as soon as is practicable.**
- **When evaluating business cases for the implementation of the review, planning patient journeys should include modelling of journeys for visitors and families.**
- **Any extra costs caused by the outcome of the Consultation should be added to the Patient Transport Unit's budget.**
- **The longest journey times to haemodialysis to be mapped and steps taken to ensure those patients' access is improved. If the national standards of 30 minutes cannot be reached, it is important to address the highest priority patients first.**
- **Patients should be encouraged wherever possible to use other forms of transport rather than Patient Transport services. Strategies could be devised to manage patients' expectations, so that their own arrangements are explored before expecting free transport.**



## **7. SPECIALISTS TO DO THE SPECIALIST JOBS – RECRUITMENT AND RETENTION OF KEY STAFF, PLUS DEVELOPMENT OF TEAM WORKING**

### **Sub-specialisation: -**

When the report 'Modernising East Kent Hospitals' was submitted to Overview and Scrutiny, there was an anticipation of movement into specialised teams in several disciplines. For some years it has been accepted that as medicine and surgery become more sophisticated and change with such rapidity medical practitioners have begun to specialise. These specialties thus require a 'critical mass' of patients to be able to spend most of their time in exercising their specialist skills.

The Vascular Surgical Society of Great Britain & Ireland stated in 'The Provision of Vascular Services' stated that,

*"There is evidence that patients are better cared for by a specialist vascular team than by those without a specialist interest. Specialist vascular surgeons achieve superior clinical outcomes in general and specifically in the management of aortic aneurysm, limb ischaemia and carotid artery disease."*

The benefits of specialist teams is that expertise can be shared, skills enhanced, best practice identified and implemented and duplication of effort minimised all of which result in better patient care. The development of specialist teams also ensures specialist medical cover can be provided 24 hours a day, 7 days a week. Therefore ensuring a more equitable and consistent service can be delivered, where it is the norm to be treated by the appropriate expert. The National Confidential Enquiry into Peri-Operative Deaths (NCEPOD), has analysed the causes of avoidable post operative deaths for over ten years and emphasises the need for greater involvement of multidisciplinary teams to improve patient care.

Since that report, the NHS in Kent and Medway has been through two years of constant structural change and national government initiatives, which perversely have slowed up the modernisation of the services. Shortages of properly qualified specialists have caused problems nationally and specifically in Kent and Medway when there are not enough specialists to provide the full emergency cover required.

The introduction of centralised vascular units would encourage the training of more specialists. Vascular surgeons though this would attract 'more senior juniors', in that they would be in their 4<sup>th</sup> and 5<sup>th</sup> year of training. Currently the juniors are in their 1<sup>st</sup> or 2<sup>nd</sup> year and learning general surgery when they work with vascular surgeons.

The Strategic Health Authority, in its performance management role, expects a clear strategy from the Acute Trusts with their recruitment and retention policies. They believe that when a centre has a good clinical reputation, it will attract staff. Where there is uncertainty about the future, it will be more difficult, so the resolution of the renal and vascular review should help recruitment. Surgeons will have to expect an element of travelling around, but their main work will be done at the centre. The managers feel that recruitment was even more difficult 10 years ago.

Many vascular surgeons want to retain an interest in general surgery, and the model can be flexible to allow some surgeons to specialise totally, and some may wish for this.

### **General Surgeons**

An important factor to be addressed is how other patients will be affected when skilled surgeons do less general surgery. Steps need to be taken to ensure that general surgery remains good quality when surgeons move into the new teams. A balance will be struck balancing the priorities, but some phases of the implementation may be delayed until staff is available. Junior doctors could interchange so that specialist training is built in and the vascular surgeons welcome this.

The implementation of the review of Renal and Vascular Services, however these services are designed, will cause gaps caused by vascular surgeons giving up their general surgery work. In addition, general surgeons call the vascular surgeons in an emergency. This is mainly where there is a problem with bleeding, as vascular surgeons are more used to bigger arteries and veins. Either further training will be needed for general surgeons to do this at hospitals where there will no longer be a vascular surgeon at night. A typical vascular surgeon is on call one night in eight for general surgery and does vascular surgery during the day. When the vascular units are set up, some vascular surgeons will not do both types of surgery and will come out of the general surgery rota. There would definitely need to be an increase in the number of general surgeons to avoid having an adverse effect on other patients.

Interventional Radiologists are currently provided at all seven hospitals and in future they will do a percentage of their days in the vascular units and possibly one day in the outlying hospitals. They will still do Outpatients clinics in all seven hospitals.

'Clinical Governance: Quality in the new NHS' highlighted the need for both multi-disciplinary and multi-agency working in order to improve services. This view is also being asserted by professional organisations such as the Royal College of Surgeons, who stated in 'The Surgical Workforce in the NHS' that;

*"The evolution and culture of team working in surgery is essential for the future. The days of the isolated surgeon as regards attitude, behaviour or indeed in single-handed practice must end."*

## **Staff Shortages**

National shortages in healthcare professionals such as doctors, nurses, therapists and scientists are placing added pressures on acute hospitals. This is further exacerbated by the fact that in order to comply with the New Deal and Working Hours Directive, all Acute Trust will need to increase their numbers of staff. Staff shortages exist at all levels in Kent and Medway and it is argued that centralisation of services will enable staff to be managed more effectively and to form specialist teams. It has also been suggested by the Strategic Health Authority that the opportunities to develop or take forward high quality specialist services will act as a significant incentive in recruiting staff.

Vascular surgeons felt that:

*'Recruitment of all types of staff is bad'* - in the context of delayed reorganisation. With a vascular unit the cream of available staff would be attracted and vascular surgery is an attractive specialism. At the moment the service in Kent and Medway is too fragmented and vascular surgeons feel that if too many units were to be created, this would dilute the available expertise.

## **7. RECOMMENDATIONS – SPECIALISTS TO DO SPECIALIST JOBS**

- **Training should give junior doctors the opportunity to rotate between the new specialised units and general surgery**
- **Measures should be taken to resource and attract extra general surgeons to fill the gaps that will be caused by the phases of the implementation process.**

## **8. SPEED AT WHICH THE OPTION CAN BE IMPLEMENTED – DESIGNING A REALISTIC, YET AMBITIOUS PHASED DEVELOPMENT PLAN**

### **Reorganisation difficulties**

The organisation of services in Kent and Medway has been dogged by uncertainties. The modernisation of the hospital services in East Kent has only just been settled, following the Independent Reconfiguration Panel's (IRP) decision, after three years of dispute.

There remains uncertainty over the Kent cardiac unit, and the relocation of the new hospital at West Kent. The IRP on the future of services in East Kent set out an interim strategic plan, and the SHA has said that a decision on the cardiac centre is to be made by 31<sup>st</sup> October. Negotiations continue with London hospitals to ensure the cardiac centre comes into Kent and Medway.

When asked whether they thought the reconfiguration of vascular services would happen, vascular surgeons described initiatives in the past that had got this far and then inertia had set in. They had remained positive and felt that, this time, something would happen. It is essential that this consultation process leads to a speedy implementation – even if the implementation is phased as seems most sensible. Any further delay leads to greater difficulties in planning for the future of the service. The clinicians felt that if the priority was that renal, vascular and interventional radiology all need to be in the same hospital and for vascular services to be centralised, it was important to 'get on with it.'

Although this was a consultation document produced by the Strategic Health Authority, the Primary Care Trusts would make the decisions and the Acute Trusts would implement them. Within its monitoring role, the Overview and Scrutiny Committees of Kent and Medway should receive a report on the progress of the implementation plan, once decisions are made.

### **Reorganisation Opportunities**

It is clear that much of the work in improving the service does not depend on the capital build beginning, but on education, communication, and initiatives within the primary care structure. The vast majority of patients do not require in-patient treatment, the 'top of the pyramid', and much of the work can be done now – the base of the pyramid of patients.

Clinicians and health commissioners have pointed out the greatest priorities to be addressed first. The speed of the full implementation will depend on a host of factors and the finance available, as well as the options chosen.

There will be some capital building necessary for all options. For some - for instance the choice of one large centrally placed new build vascular unit – implementation would take longer than two units based where there are already groups of vascular surgeons together with their specialised interventional radiology equipment.

The availability of finance will affect the speed of implementation. Although this is addressed in Section (I) Affordability, the context of financial difficulties in Kent and Medway health economies may affect the speed of implementation. If capital monies are phased over several years, options may be delayed because of waiting funding.

Primary Care Trusts are new bodies and have been faced with many problems since their inauguration on 1 April 2002. The Clinicians who spoke to the Joint Panel were very keen to move the process along. Once the decisions have been made, they were eager to begin on an implementation plan immediately. Although Primary Care Trusts have many management tasks ahead this enthusiasm for change must be supported by highly skilled managers, to ensure the implementation team does not lose momentum.

#### **8. RECOMMENDATIONS – SPEED AT WHICH THE OPTION CAN BE IMPLEMENTED**

- **Uncertainties within Kent and Medway about other aspects of the Health Services should not be allowed to impede a speedy implementation of improvements for renal, vascular and interventional radiology services.**
- **Primary Care Trusts should complete a quarterly report to the Overview and Scrutiny Committees of Kent and Medway on the progress of the implementation plan, once decisions are made.**

#### **9. AFFORDABILITY – WHAT IS NEEDED TO IMPLEMENT CHANGES (BOTH CAPITAL AND RUNNING COSTS)**

##### **Current Financial Difficulties**

It is clear from the evidence heard by the Joint Panel, that financial issues will be a decisive factor when evaluating the options. However at this point there are no business cases prepared so there is no way of measuring how much individual options will cost. The consultation document gives no indication even of the comparable affordability of the different options, it is difficult to assess this factor.

Respondents to the consultation are thus not sufficiently informed when opting for a preferred option.

After the decision on design of the services, business cases will be submitted by the Acute Trusts to the independent panel to assess. Values will be assigned to weighting criteria, and a decision on which business case(s) are successful will be prompted by the weighting criteria.

There is also the issue of cost-effectiveness. Those who attended the consultation conference were told that the current organisation (Option 1 in both cases) was not financially viable, as it was not cost effective. This would mean that for renal services,

there is only the option of co-location with vascular services and interventional radiology unit.

The Acute Trusts have struggled with financial difficulties in 2002/3. It is not clear from any evidence heard, or from the consultation document, how the chosen option will be funded. The preferred option, to be successful will require capital expenditure. This is likely to involve at least some new buildings or adaptations, the installation of equipment, extra car parking. Clinicians have expressed their worries that the implementation may be begun without proper facilities.

There are also the implications of the revenue or running costs. As well as the recruitment of extra staff, there is the calculation of recruitment costs (and pay) of extra general surgeons to fill the gaps. Extra nurses will need to be recruited and trained. This is all to be accomplished when at least two hospital trusts have ended deficits at the end of 2002/3 financial year. There are also no plans in current budgets to spend on expansion or development.

National Tariffs for most medical procedures will be introduced in 2005. This means that Kent and Medway will be funded for the national average cost (plus a small MFF or Market Forces Factor of around 2%). The tariffs for London hospitals are reckoned to be 18% higher. This means that the two renal satellite units in Kent and Medway which are owned by London Hospitals will cost 18% more for each patient than the Kent and Medway owned satellite units. This should be used as a lever to bring back specialisms, once the decision of which service model to implement is made. The experience of the cardiac unit, where there are still negotiations continuing with London hospitals where cardiac surgeons work, has shown finance still drives the process even after service reconfigurations have been decided. Finance - or the threat of losing revenue – still drives the process. The South London Hospitals will give a joint response to the consultation with their views about the future.

Clinicians are also wary about the financing of the consultation options because they have just been through a long period where a PFI bid at EK Hospitals Trust was mooted but has subsequently been abandoned, following the advice of the IRP.

#### **9. RECOMMENDATIONS - AFFORDABILITY**

- **When affordability is obviously a decisive factor in ranking options, there is no way that respondents to the consultation can assess the options in this way. For informed responses, perhaps some indication of relative cost could be included in future consultation**
- **Budgets should be adjusted as soon as information is available to take into account possible expenditure in implementing this review of services.**
- **As affordability is a decisive factor in ranking options, negotiations should begin with London hospitals to move services now purchased in London to Kent and Medway, as far as critical mass of population allows.**

#### **10. SUSTAINABILITY AND FLEXIBILITY, TO BE ABLE TO COPE WITH FUTURE DEVELOPMENTS**

The reconfiguration of Renal and Vascular services plan is designed to build enough capacity for the next five years. It is clear that there will not be enough critical mass of population within the foreseeable future to provide a kidney transplant unit.

Although it would be cheaper for satellite services to be provided by Kent and Medway it is by no means certain of the outcome of negotiations and if it is possible to provide renal services for all Kent and Medway patients locally – the most sustainable solution over the long term. Renal and vascular diseases are overall connected with increasing age, however the efficacy of preventive measures are improving and this may be the best way of reducing demand for treatment in secondary care.

The sustainability of a service depends on so many factors that being definite for a period over five years seems foolhardy. Also, the 12-year training period for a specialist surgeon means that it is not the redesign of the service that needs to be flexible but innovative ways of recruiting and retaining appropriately qualified staff.

The Joint Panel felt that with the announcement of extra houses for South Thames Gateway and Ashford it was important to include this extra population in health planning. The Kent and Medway structure plan has been adjusted to take into account the expected population of Kent and Medway and these figures could be used for planning future health needs.

#### **10. RECOMMENDATION - SUSTAINABILITY AND FLEXIBILITY**

- Flexibility of the design of the service must be backed up with appropriate forward planning for the skilled workforce at all levels.
- Primary Care Trusts' proposals for the redesign of these services must be evaluated with regard to their impact on the rest of the NHS services provided. It is recommended that the Kent and Medway Structure Plan is used to consider population growth to enable health services to be planned **before** they impact.

#### **11. INITIATIVES TO HELP PREVENT THE ONSET OF DISEASE**

##### **Current situation**

In parts of Kent and Medway, vascular surgeons have worked hard already to improve prevention and aftercare. At the vascular clinics, only one person in twenty needs surgery. Patients have physiotherapy plan, and enjoy exercise prescribed by the physiotherapists. There are many individual pockets of good work, for which links could be developed to provide a holistic approach when the vascular units are formed. There is risk factor analysis carried out for cardiac patients, which could inform the vascular unit. However preventative initiatives only go on between 9 and 5, and some may not happen. Although staff are geared up to deliver it, structuring preventative initiatives can take more time and effort than is available now while the services are so fragmented.

Vascular surgeons agreed that an arteriopath is never lost to the unit, and records needed to be kept for many years. They explained the effects of deprivation on the medical outcomes, and that mortality could be predicted by postcode. The main causes were:

- Diabetes – vascular disease three times more common
- Smoking
- Hypertension
- Age
- High Cholesterol

Vascular nurses could visit GPs to diagnose and use specialist equipment. The joint clinic held between Interventional Radiologists and vascular services has cut down waiting times to a week. By referring bad feet earlier to the specialist, they can reduce the need for amputation. Vascular surgeons felt that there should be much more education to GPs for early referral of diabetic feet.

It was agreed by all that affordability will drive the service, but that preventative initiatives were crucially important. Vascular surgeons run active training programme for young people, concentrating on the improvements gained by giving up smoking.

### **Future Plans**

The Primary Care Trusts will manage these issues and they will be monitored on their delivery. The Strategic Health Authority pointed out that this would be funded by the new GPs contract. There are clear, bigger incentives for GPs to do Preventative work within the new contract. GPs should give lifestyle advice to everyone identified as being at risk.

The Primary Care Trusts have schemes to be unrolled within the next year. They will be working with schools to raise increased awareness of preventative medicine. Individual PCTs do this, but it is not sustained throughout Kent and Medway. Primary Care Trusts already have prevention initiatives in their action plans, and will be inspected on this by CHAI. Although this factor is very important it is not necessarily addressed by this review of services – would this be more focussed if addressed by Primary Care Trusts or by ensuring sufficient communication between existing health campaigns.

Smoking cessation– improves the symptoms of intermittent claudication and reduces the complications of peripheral vascular disease<sup>8</sup>.

For kidney patients, the Kidney Alliance National Service Standard 1 maintains that the use of other treatments and cessation of smoking can reduce the number of referrals. Guidelines for timely referral into nephrology should be agreed locally.

As primary care is well placed to deliver these standards, the Kidney Alliance recommends adequate resources should be made available to allow them to succeed. Renal disease is predominantly a disease of the elderly. The median age of patients is now 67 (63 in 1998). As the population ages, the prevalence of the disease will obviously rise. Renal disease is also associated with diabetes, and the healthy eating and exercise recommendations for older patients can prevent the onset of this. Keeping blood pressure within standard limits helps to prevent the onset of renal disease and this would be an initiative taken forward by Primary Care.

The alternatives for those patients who already have severe vascular disease and the services that treat them are difficult. Mobility is critical, and it can cost £40,000 to

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<sup>8</sup> Kidney Alliance

rehabilitate a stroke victim and £30,000 to rehabilitate someone who has lost a limb. The answer lies in preventative measures.

## **RECOMMENDATIONS – INITIATIVES TO HELP PREVENT THE ONSET OF DISEASE**

- **Preventative Initiatives should be carried out in the Primary Care Sector**
- **Sufficient resources should be available for preventative measures to be pioneered, as these are comparatively cost effective**
- **Sufficient resources should be allowed into the vascular units to enable the best practice of out-reach education to be spread around the whole area**

### **Part 3 – Response to Questions 2 - 6**

## **2. OTHER FACTORS IN DELIVERING BEST SERVICE**

### **Problems in Diagnosis**

11% of people have kidney disease. With the development of IT in the Primary Care Trusts, it is possible to measure how many people have this – they will in the future be able to send the referral directly to the nephrologists by electronic means. The treatment of chronic kidney disease will be improved if patients with stable chronic disease are monitored; there is then less risk of them contracting cardiovascular disease.

### **Reduction of Health Inequalities – Bringing the services back to Kent and Medway.**

*‘New facilities developed in the context of managed clinical networks should aim to achieve equity of provision and a consultant based service with appropriate support services delivering uniform standards of care’.*

(Kidney Alliance National Service Standard 7)

It has not been made clear to the Joint Panel whether the service provided to renal patients now or in the future will be equal for all patients in Kent and Medway. If a full renal service were to be provided for all Kent and Medway patients, equality of access would be assured.

### **Patient Choice**

The Strategic Health Authority pointed out that after the review of services had provided for clinical emergencies with the construction of proper emergency rotas, the next new initiative to face will be patient choice. Thus waiting times might not be the only factor.

Life is going to be difficult for the GP because of the new emphasis on the patient voice. There will be more work to be done on educating patients and explaining the choices. Waiting times should not be the sole indicator of what service provider to choose. The emphasis on meeting waiting time targets, reflect on the efficiency of the NHS as a whole, rather than reflecting on successful outcomes.



The transport of patients to the provider of their choice will further complicate the current complex patient transport arrangements.

#### **RECOMMENDATIONS**

- **Problems in diagnosis can be helped by regular monitoring of those at risk.**
- **The provision of a full renal service for all patients in Kent and Medway provided within the area will reduce inequalities in the service.**
- **Patient Choice will alter the way that patients are referred to specialist services, and may alter the capacities needed to serve varying patient numbers in Kent and Medway (more if they are popular, less if other providers offer a more attractive service)**

#### **3 & 4 PREFERRED OPTIONS**

##### **THE JOINT PANEL'S PREFERRED OPTION FOR VASCULAR/ INTERVENTIONAL RADIOLOGY SERVICES**

**The Joint Panel's preferred, unanimous option is for Option 4, two centres**

This is the most practical option from both staffing and financing.

##### **THE JOINT PANEL'S PREFERRED OPTION FOR RENAL SERVICES**

**The Joint Panel's preferred, unanimous option is for Option 2, Co-location with central Vascular and Interventional Radiology unit.**

#### **5. STAKEHOLDERS**

##### **RECOMMENDATIONS**

**The Joint Panel recommend consulting with patients' carers and families.**

**National Service Standard 1 – Pre-Dialysis: Retarding Progression and reducing the Comorbid Burden in renal Disease**

- Diabetic renal disease should be the focus of efforts to reduce the incidence of ESRF by effective glycaemic and blood pressure control, use of ACE inhibitors and cessation of smoking
- The needs of the Asian community require special attention as they are at particular risk from diabetes and diabetic nephropathy.
- Diabetic patients who develop proteinuria (nephropathy) should be referred for local diabetology/ophthalmology assessment at an early stage. Guidelines for timely referral into nephrology should be agreed locally.
- Efforts to achieve the standards in the National Service Framework for Coronary Heart Disease for reducing cardiovascular risks in the population should be vigorously supported.
- Efforts to implement the recommendations in the National Service Framework for Diabetes should be supported.
- Since Primary Care is well placed to deliver these standards, adequate resources should be made available to allow them to succeed.

**National Service Standard 2 – Preparation for Renal Replacement Therapy (RRT)**

- All patients with chronic renal failure and a plasma creatinine above 150  $\mu\text{mol/l}$  and/or significant proteinuria ( $>1\text{gm}/24\text{hr}$ ) should be referred to specialist nephrology.
- Patients with creatinine  $>300 \mu\text{mol/l}$  should be referred urgently if there is no strong contraindication to further treatment as a significant number will be approaching or will have reached ESRF
- All patients with ESRF who, after discussion between the multidisciplinary team, themselves and their families, are deemed likely to benefit should be offered RRT
- Commissioners should audit the number of patients entering RRT as 'late' uraemic emergencies as a first step to developing mechanisms to ensure the proportion is reduced to a minimum
- Structured education and counselling of patients approaching ESRF involving the multidisciplinary team and other patients and carers should aim for the seamless entry onto RRT using the patient's chosen modality.
- Timely healthy initiation of appropriate RRT demands unimpeded access to the main dialysis modalities, which in turn requires planned expansion of facilities in line with current prediction of need. There should be no 'waiting list' for dialysis nor should any patient be commenced on a therapy known to be inappropriate.

- While it is accepted that the number of transplant centres in the UK will not increase their staffing should allow transplant surgeons, physicians and coordinators to carry out clinics in autonomous renal centres to streamline screening of potential recipients and to maximise morale, local organ retrieval, live donation and pre-emptive transplantation.
- Commissioners should be aware that the benefits of erythropoietin therapy in pre-dialysis patients (which is producing cost pressures in the service) are based on increasingly firm evidence.

### **National Service Standard 3 – Vascular and Peritoneal Access**

- Trusts with autonomous renal centres should ensure adequate surgical expertise and theatre time is dedicated to vascular and peritoneal access. One weekly theatre session per 120 patients (approximately) on dialysis is needed.
- Service level agreements between the renal service and departments of general or vascular surgery and radiology should stipulate case mix and numbers of operations/interventions required per annum. Arrangements involving transplant surgeons may be possible in some centres.
- Seniority and expertise of surgeons/radiologists involved should be audited together with survival rates of natural fistulae, tunnelled catheters and CAPD catheters.
- Access operations should be timely to ensure the majority of planned (non emergency) patients have functioning, 'permanent' access when dialysis commences. Overall the service should aim to have the percentage of new HD patients with natural arteriovenous fistulae (AVF's) approach the European average of 66%
- Efforts to reverse the decline in the proportion of HD patients using AVF's should aim to return to the European average for prevalent patients (80%) which will involve co-operation with surgical departments, Trusts and commissioning agencies.
- These initiatives will require an elevation of the profile of access surgery in manpower planning and continuing discussions between the Specialist Workforce Advisory Group (SWAF) and Postgraduate Deans.

### **National Service Standard 4 – Vascular and Peritoneal Access**

- Trusts with autonomous renal centres should ensure adequate surgical expertise and theatre time is dedicated to vascular and peritoneal access. One weekly theatre session per 120 patients (approximately) on dialysis is needed.
- Service level agreements between the renal service and the departments of general or vascular surgery and radiology should stipulate case mix and numbers of operations/interventions per annum. Arrangements involving transplant surgeons may be possible in some centres.

- Seniority and expertise of surgeons/radiologists involved should be audited together with survival rates of natural fistulae, tunnelled catheters and CAPT catheters.
- Access operation should be timely to ensure the majority of planned (non emergency) patients have functioning, 'permanent' access when dialysis commences. Overall the service should aim to have the percentage of new HD patients with natural arteriovenous fistulae (AVFs) approach the European average of 66%.

### **National Service Standard 5 – Patient/Carer Experience**

- ESRF patients should receive care and support which encourages inclusion of therapy into their overall lifestyle. Treatment should be in comfortable and convenient surroundings and delivered at times consistent with regaining or maintaining employment and maximising rehabilitation into society.
- ESRF patient should expect to access regular HD, CAPD and outpatient review as close to their homes as possible. Access to consultant time, nursing, dietetic, social work, counselling advice and pharmacy support should be equitable irrespective of place of residence or treatment. For the majority, one-way travel time for these services should be less than 30 minutes.
- HD centres should have parking, waiting and changing areas appropriate for 'life-long' attendance.
- RRT patients with intercurrent problems requiring hospitalisation should expect to be admitted to single sex areas in dedicated nephrology wards staffed by nurses trained in renal medicine and dialysis. Nephrology beds should be expanded in line with the expansion of dialysis stock so that the admission of a RRT patient to an 'outlying' ward is exceptional.
- Each patient should have a named nurse responsible for assessment and planning of care.
- Patients and carers, through their local KPAs and the NKF, should expect to be involved in local planning and the setting of Service Level Agreements and to be co-opted onto provider planning committees, onto renal sub groups of RSCGs and onto national initiatives including the setting of Clinical Standards.
- Dialysis patients should be free to holiday in the UK or overseas. This will require investment in the health economise of popular \UK destinations. It will require the creation of facilities in all HD units for temporary 'isolation' of patients returning from areas overseas which are high risk for blood borne virus infections.

### **National Service Standard 6 – Conservative management of ESRF, Palliative Care and Withdrawal from Dialysis**

- Patients with progressive renal failure in whom dialysis is deemed inappropriate or who choose not to start RRT should continue to receive the benefit of the resources available to the renal service to provide a robust support package.
- Service level agreements with funding authorities should recognise the value of anaemia management in alleviating many of the symptoms of ESRF in patients who are not receiving RRT.
- In the terminal phase of ESRF, a management plan, including the preferred location of care, should be agreed with the patient, his/her carer, family and GP. An 'open door' policy for urgent admission to the nephrology ward should be agreed with the Primary Care Team, District Nurses and the local palliative care services.
- Links with Hospices and agencies involved in terminal care should underpin a culture of 'openness' in the renal service in which patients can feel free to discuss withdrawal from dialysis and in which they can feel confident that care will be appropriate to allow death with respect and dignity.

### **National Service Standard 7 – Equity of Provision**

- Regions, in conjunction with the UK Renal Registry, should carry out yearly gap analyses to update an NHS register of patients receiving RRT which will allow poorly providing Health Authorities to plan to 'correct upwards' to UK then European levels for their particular population characteristics.
- Elimination of 'blank spots' will require new HD facilities which should be located to balance the need for local services for large towns, economy of scale and travel times.
- Commissioners should recognise that new autonomous renal units may have a greater impact on local acceptance and prevalence rates and Consultant numbers than "hub and spoke" expansion.
- New facilities developed in the context of Managed Clinical Networks should aim to achieve equity of provision and a Consultant based service with appropriate support services delivering uniform standards of care.

**Recommendations in Select Committee Report Modernising East Kent  
Hospitals - Patient Transport**

**RECOMMENDATIONS**

- **Local services must be provided for local people, where ever they can be provided safely and to a high quality. Hospital services must only be centralised when it is clear that this will improve the quality of health outcomes.**
- **The transport arrangements for patients and visitors must be developed and implemented, within the framework of the Health Partnership Transport Board, to meet the additional transport needs of the final Option selected.**
- **The County Council should continue to support the East Kent Hospitals NHS Trust in developing the public transport infrastructure in East Kent, through its involvement in the Health Partnership Transport Board.**
- **Moving people to hospital in a sustainable way should be a high priority of Kent County Council and be embodied in the Local Transport Plan.**
- **The East Kent Hospitals Trust in developing hospital services must ensure that the access to hospital sites and parking is improved.**