



GOING LOCAL

HOW TO SET UP AN AUTONOMOUS RENAL UNIT

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DONAL O'DONOGHUE AND BEVERLEY MATTHEWS

Time to decentralise renal services

Achieving autonomy is the new way of working for a modern NHS. Foundation trusts are firmly established and flexing their muscles with new freedoms to make acquisitions and mergers. PCTs are focused on becoming world class commissioners and recognising the need to formally separate from or even divest themselves of their provider services. And with the introduction of individual budgets, patients are being given the opportunity to determine for themselves how to spend their allocation of some healthcare resources.

In August, NHS chief executive David Nicholson outlined the importance of the quality, innovation, productivity and prevention (QIPP) initiative in helping the NHS deliver a service with quality as its organising principle in a period of significant financial challenge. He called for engagement across the system.

In September, health secretary Andy Burnham outlined his vision for the next period in the NHS, which would see a continuing improvement in frontline services. That vision for better services can only be met and funded by taking on a bigger efficiency and productivity challenge.

Autonomous renal units fit in with the productivity component of QIPP because local services are also more efficient.

There are 52 kidney units in England, some of which have achieved separation from their hub. The lessons learnt from the journey so far are many, from the time it takes to get there (meaning the underestimation in almost every case of the capacity needed in addition to the day job), to the tenacious drive and enthusiasm needed by clinical leaders to stay the course – while managers and commissioners grapple with the politics and, of course, the money.

Importantly, the benefits are great.

Even for those patients who have a long-standing history of receiving care from the hub, this has proven to be a winner – a better experience, delivered from a more convenient location by highly skilled professionals who have passed on their tertiary skills to secondary care.

NHS Kidney Care was set up in April 2008 to enable consistent implementation of the national service framework for renal services.

This October, we brought together the clinicians, managers and commissioning leads from the autonomous units to develop a practical guide for other renal units that may be considering autonomous service developments in the future. The resulting toolkit has now been published (see page 3).

The sites that have been through the process would say go for gold from the beginning.

Don't be dissuaded by long drawn out debates over funding streams; they will come good in the end. Maintain sufficient focus on traditional and comprehensive planning so that the full business case stands up to scrutiny, time and changes in commissioners.

NHS Kidney Care is set to commission an academic organisation to investigate how changing the current model for delivering kidney services would impact on workforce, finance and patient flows. It is due to report in March.

The aim is not to create a model that we then test out, but to produce a provocative discussion paper that will challenge the kidney community to stop and think.

Are we moving in the right direction?

Or is now the time to strategically think together about taking a new path? ●

Dr Donal O'Donoghue is national clinical director for kidney care, Department of Health. Beverley Matthews is programme director, NHS Kidney Care.



INTEGRATED CARE

THE RIGHT TIME TO GO LOCAL

A centralised model of renal services is no longer fit for purpose in a kidney disease population that is older and has increasing co-morbidities

Adult renal services encompass a wide spectrum of a common disease that is affecting increasing numbers of people. As services expand to accommodate more patients they maintain the centralised model that was historically set up. With the kidney disease patient population becoming older and having more co-morbidities, a centralised model is no longer appropriate. These patients need quicker and easier access to the full gamut of renal services.

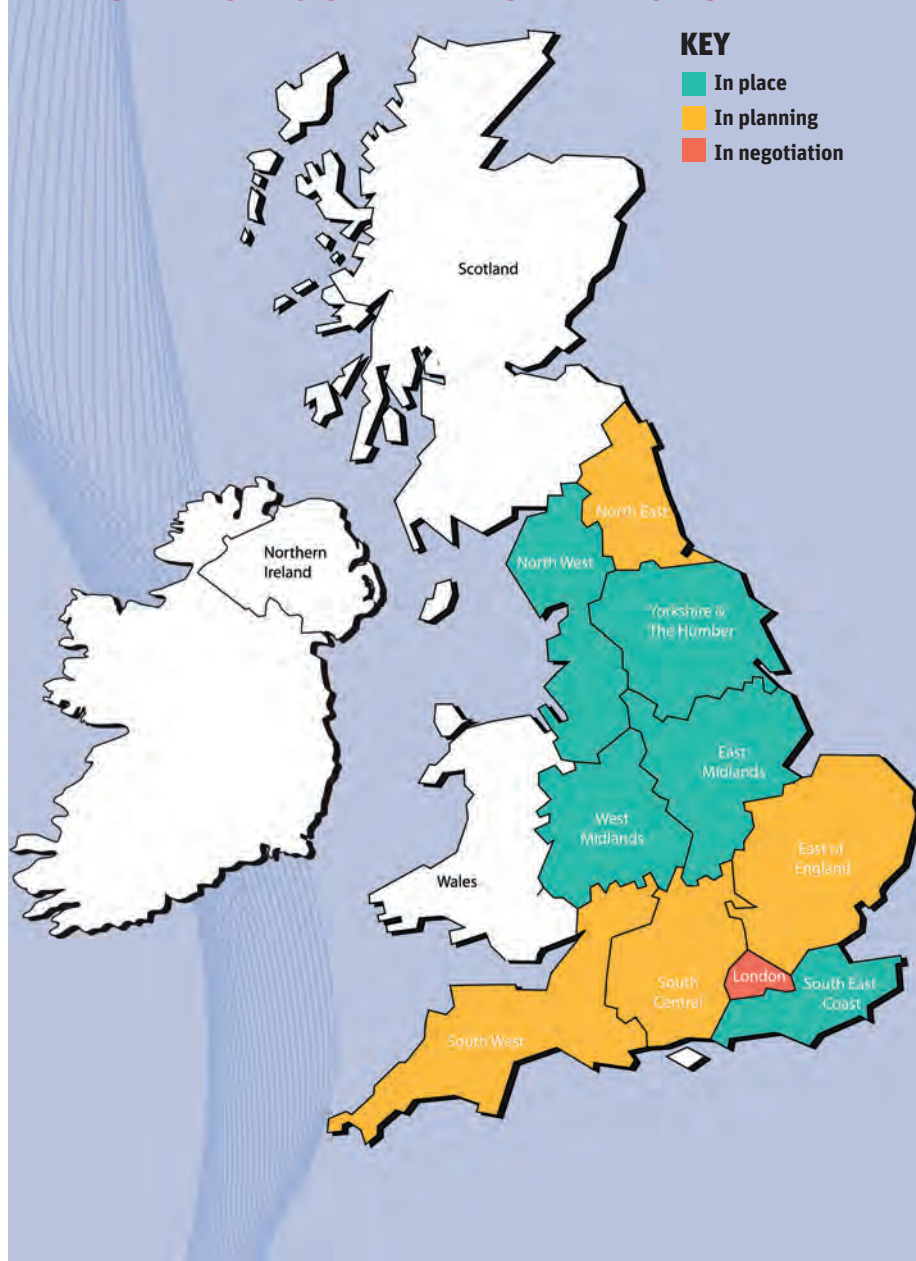
Chronic kidney disease is common, harmful and treatable, and occurs in about 10 per cent of the population. A significant proportion of these patients can have their metabolic complications and renal anaemia treated by GPs and community services.

A minority of patients require dialysis and transplantation, and that is where specialist, hospital based services are essential. They provide most of the patient's care in the year before dialysis starts and during dialysis; and the care of transplant patients. Specialist services need to be integrated with primary care for patients who move between primary and secondary care.

In England 20,000 patients are on dialysis and 20,000 patients have a functioning kidney transplant. Each year, 110 new patients per million of the population need to start dialysis or have a transplant, and 30 to 50 patients per million of the population will elect to have conservative management in the community.

Acute kidney injury is also common. It occurs in up to 20 per cent of the admitted

DEVELOPMENT OF REGIONAL KIDNEY CARE NETWORKS



SERVICES PROVIDED BY AUTONOMOUS RENAL UNITS

- Inpatient beds
- On site nephrologists
- Acute kidney injury care
- Chronic dialysis, on site or via satellites units
- Vascular access
- Multi-disciplinary support

population, in patients with co-morbidities who are at risk of renal failure. Prompt treatment by specialist services is essential to prevent the need for dialysis.

A National Confidential Enquiry into Patient Outcome and Death report this year highlighted the substandard care that patients with acute kidney injury often had when they were admitted to hospitals with no nephrology support. The report called for all hospitals that look after acutely unwell patients to have nephrologists on site.

It is essential for services to promptly identify early acute kidney injury. Early management to reduce the level of kidney dysfunction leads to shorter admissions and reduced mortality.

Centralised model

Kidney services in England have evolved into a centralised model. About 10 centres were set up in teaching hospitals in the 1960s and in the 1980s more centres were established in big district general hospitals. By the beginning of the 1990s there were around 45 centres. Today there are 52, roughly one centre per million of the population in England. All centres provide dialysis, and 19 also provide transplantation.

The past 15 years have seen the growth of satellite dialysis units, with parent units looking after an average of three to four satellite units in a hub and spoke model. There are around 200 satellite units, mostly located in other hospitals, but some are in local improvement finance trust centres, primary care settings and business parks.

The average age of kidney patients is over 65



BENEFITS OF AN AUTONOMOUS RENAL SERVICE

- Shorter transport times for patients
- Reduced lengths of stay for inpatients
- Less travel for staff
- Better integration with primary care
- Improved access to nephrologists for acute patients
- Cost savings

‘Over the past 25 years the dialysis and transplantation patient population in England has grown from 8,000 to 40,000’

Satellite units do not have inpatient specialist kidney services or the same level of staffing as the 52 kidney centres or the same access to diagnostics and interventions. Put simply, they only provide maintenance haemodialysis.

England's centralised model compared with the rest of the UK and elsewhere in Europe means many patients face lengthy journeys to get to their dialysis sessions. Staff also travel from the main centre to the satellites for outpatient clinics.

In addition, at any one time, around 15 per cent of the satellite dialysis patient population is being treated at the hub because they need attention that is not available at the satellite unit.

Over the past 25 years the dialysis and transplantation patient population in England has grown from 8,000 to 40,000. With that there has been a shift in the average age of patients from under 40 to over 65. Patients increasingly have co-morbidities – 20 per cent of patients who start dialysis have diabetes, which is a marker for other co-morbidities.

Case for autonomy

“Only a minority of hospitals in England have a full kidney service and yet the volume of work is such that there's a case to be made for establishing new autonomous units as opposed to increasing the size of the historical central units,” says Donal O'Donoghue, national clinical director for kidney care at the Department of Health.

The number of people requiring dialysis or transplant is expected to grow by six to eight per cent each year because of an ageing population, and an increase in vascular disease, obesity and diabetes.

And as improvements are made to keep dialysis and transplantation patients alive longer, the numbers swell even further.

“That is quite a complex phenomenon for commissioners to get their head around, because they think in terms of single, discrete episodes,” says Kevin Harris, deputy medical director at University Hospitals of Leicester Trust and clinical vice president of the Renal Association.

While there are effective strategies for treating kidney disease, there is no cure. Just 30 per cent of people who begin dialysis are considered suitable for transplantation, which means that transplantation successes will slow down but won't abrogate the need for increased dialysis services.

Similarly, NHS Kidney Care is keen to promote home dialysis because it offers better quality of treatment and improved

quality of life by removing the need to travel. But home dialysis is only suitable for a minority of patients. Regardless of improvements in transplantation and increases in home dialysis, the number of patients requiring maintenance dialysis will continue to grow.

Expensive therapy

Dialysis and transplantation consume around two per cent of the NHS budget for just 0.1 per cent of the population, making it an expensive form of therapy. Some of those costs are due to inefficiencies resulting from the centralised model of care.

In the 52 hospitals that have dialysis services, up to 50 per cent of their patient transport services costs are for dialysis. Lengths of stay are longer for patients who need to travel for an admission, and a centralised service makes it more difficult to integrate with clinical and managerial colleagues in primary care.

The answer is to decentralise the model of care in England and have more autonomous renal units that employ nephrologists, have an inpatient facility and can provide acute kidney injury care. A greater density of autonomous units would improve access to nephrologists for hospitals without a unit.

“We can't realistically provide inpatient beds and have a nephrologist on staff in every hospital, but we have to be able to respond to the needs of every acute hospital,” says Dr O'Donoghue. “Clearly, by having more hospitals where you've got on site nephrologists that would be helped.”

He estimates that 85 autonomous renal units in England – 33 more than the current 52 – would be an appropriate goal. There is no set population size; what is needed is a local decision by kidney care networks that balances travel time for patients with volume of work for providers.

Networks are comprised of the providers of care across the entire pathway, which includes representatives from primary care, secondary care, transplant services, patients and commissioners.

But the commissioning pathway for kidney services is fractured. Dialysis and transplantation fall under specialised commissioning, while early kidney disease, acute kidney injury, prevention and end of life care sit in primary care commissioning.

There is a tendency, however, for primary care trust commissioners to think of kidney services as being purely dialysis and transplantation, and so the territory of specialist commissioners. The reality is that PCTs are paying for the massive transport costs associated with dialysis, and for dialysis and transplantation via the devolved powers of the specialist commissioning groups. Dr O'Donoghue argues that there is a big preventative dividend to be gained by integrating specialist and PCT level commissioning. “We need to involve PCTs in helping shape their local services and we haven't previously done that as much as we might,” he says.

The benefits of a local service are clear: better integration with primary care, shorter transport times for patients and staff, and cost savings. ●



The entire pathways for dialysis and other kidney care must be planned for

A TOOLKIT FOR AUTONOMY

NHS Kidney Care has distilled renal units' experiences to produce a toolkit on how to set up an autonomous unit. Its six steps are outlined here

Acute trust providers and primary care trust commissioners will need to work collaboratively to set up an autonomous renal unit. NHS Kidney Care's toolkit has been developed to help them through it.

STEP 1: SETTING THE SCENE

Know your population

Understanding the local demand for the service is the place to begin, and geography and population size are important components of this. How far do patients have to travel to a renal unit for dialysis? Is underprovision a problem?

A joint needs assessment should be carried out by PCT commissioners, the acute trust and, to meet the demands of the world class commissioning criteria, the local authority.

Renal care provides for social needs as well as health ones, and transport is one example of where health and local government can work together.

Patient transport is the PCT's responsibility, but if the new service creates access problems it might be worth working with the local authority to improve public transport services.

Know your stakeholders

It is important, early on, to capture the whole hospital in the service development, not just the renal service. This is because creating an independent renal unit could have implications for broader hospital services, such as vascular and critical care, IT infrastructure, HR and the workforce.

Commissioners and providers need to see the bigger picture so that they can ensure the new service is a good fit strategically. Setting the scene in step one requires triangulating the commissioner of the service, the trust providing the service, and the renal service itself, so that the whole system is working together.

Kidney services are commissioned at different levels. Dialysis and transplantation fall under specialised commissioning, while early kidney disease, acute kidney injury,

STEP 1

SETTING THE SCENE

- Know your population
- Know your stakeholders
- Know who is paying

STEP 2

STRATEGY

- Identify a clinical lead
- Assign responsibilities
- Understand the money

STEP 3

SERVICE PLANNING

- Choose a model
- Develop a business case
- Allow time to recruit and train
- Get local lobby groups on side

Units will need the right number of suitably trained staff



prevention and end of life care sit in primary care commissioning.

Specialised commissioners may opt to take the strategic lead in setting up the new service, but they will need to make sure they consider any impact on the transplantation service or the local nephrology service.

Know who is paying

Getting to grips with who pays for what is an important part of setting the scene. Renal units already on the path towards autonomy have found this difficult, but there is now an indicative tariff for dialysis services that has simplified the issue. Be clear about where the funding to set up the service will come from. It generally comes through a business case, because of the major investment required. Some will come via the tariff, and commissioning for quality and innovation payments can be agreed between acute trusts and commissioners for improvements in outcomes once the service is operational.

STEP 2: STRATEGY

A detailed strategy should be developed that includes the outcomes to be achieved. It is important to propose a site for the service early on, and gain support from clinicians, managers and the public.

Identify a clinical lead

PCTs reconfigure, commissioners move on and politics change, so a clinician at the acute trust needs to lead the service development and take ownership of it.

"The consistent players that have to be in it for the long game and stay the distance tend to be the clinical lead and the business manager from the acute trust," says NHS Kidney Care programme director Beverley Matthews.

Assign responsibilities

Operational policies need to set out governance arrangements and clinical accountability so that there is no confusion over responsibility for the clinical management of patients along the pathway. What is the main renal unit responsible for and what is the new autonomous unit responsible for?

For example, when does the patient transfer from the main unit to the autonomous unit? What if there are complications and the patient needs to go back?

At each component of the pathway, whether it is pre-dialysis, dialysis, pre-transplant, post-transplant, and so on, responsibility should be clearly defined.

Understand the money

Use the indicative tariff and work from a robust baseline. In most cases, baseline information will be the number of patients, recorded as the weekly frequency of dialysis sessions. It is important to understand what is included in the tariff and to make sure that all of the costs are accounted for and correctly allocated. Ms Matthews says: "Be sure that the activity is being captured and coded appropriately to ensure it is reflective of the tariff."

STEP 3: SERVICE PLANNING

Choose a model

The difference between autonomous renal units lies in how they are established, not in what they deliver. All units will provide dialysis closer to patients' homes, but some will opt for a gradual transfer of patients from the main unit, while others will prefer to open the service only when it is ready to receive all patients.

Regardless of the chosen mode of set up, every new unit should be connected into a wider clinical network of other autonomous units. The network can provide a bigger professional base for discussing clinical issues, and could be an avenue for training and development.

Develop a business case

Avoid developing a business case that is too rigid or, for example, just tied down to delivering haemodialysis. The business case should be flexible enough to allow the units to grow and incorporate other parts of the pathway.

"Kidney services need to be focused on the needs of the local population," says Ms Matthews. "When considering developing an autonomous kidney service it is important to start with what should be provided in primary care so that the patient only has to go to a specialist service for treatment that cannot be delivered locally."

Allow time to recruit and train

Staff recruitment and training is a sizeable task and one that will take time. Decide what staff will be needed and when, and where they will be recruited from. Some staff will be new recruits while others will transfer from the main renal unit to the autonomous unit. Define what training is needed and how it will be provided.

Get local lobby groups on side

If anything can derail service development plans, it is local lobby groups, so get them on side early in the process. Lobby groups will voice concerns through the local authority

STEP 4

SYSTEMS

- Establish lines of communication
- Develop data systems
- Establish referral pathways

STEP 5

SUSTAINABILITY

- Future proof the service
- Invest in information systems
- Monitor the impact on patient choice
- Review costs

STEP 6

SEPARATION

- Financial separation
- Clinical separation

health overview and scrutiny committee, so it is important to keep them in the loop.

Ms Matthews says: "While [local lobby groups] won't understand the clinical arguments, they'll be interested in patient choice and access."

STEP 4: SYSTEMS

Establish lines of communication

Lines of communication need to be established at two levels, first with the acute trust board at the main renal unit, which needs to take ownership of the development. "If the whole hospital isn't behind the development it'll fall down," warns Ms Matthews. "It's no good just the renal service trying to push something through."

The board will not want every detail but it will need regular progress reports.

Second, regular updates should also be given to local lobby groups and patients, who will want to know how the project is progressing and how their care will be managed during any transitional period. The local authority health overview and scrutiny committee should also be kept up to speed, and in most cases there will be one councillor who will pass on information to the committee.

Develop data systems

Make sure the autonomous renal unit's IT system is connected into the main unit so that data can be collected and distributed, while complying with national standards.

Establish referral pathways

This comes back to the issue of being clear about governance and accountability at each stage of the pathway and understanding how and when patients are handed over from one unit to the other, or when they may need to go back up the pathway for more intensive care.

If, for example, a patient becomes acutely ill while having dialysis care, what is the pathway back to the specialist unit? And what is the pathway back out again? What is the clinical responsibility at each stage?

As Ms Matthews says: "You can't start a service if you haven't got these very clearly documented and understood and communicated."

STEP 5: SUSTAINABILITY

Future proof the service

Research from the Department of Health's vascular programme shows that primary care isn't identifying patients with chronic kidney disease as well as it could be. These are the patients who may go on to need dialysis or a kidney transplant, so there

could be an increase in patients with unplanned starts on renal replacement therapies.

Autonomous renal units need to have a built in potential to expand. Since each patient will require dialysis for the rest of their life, units will have to cope with the accumulation of patients over time.

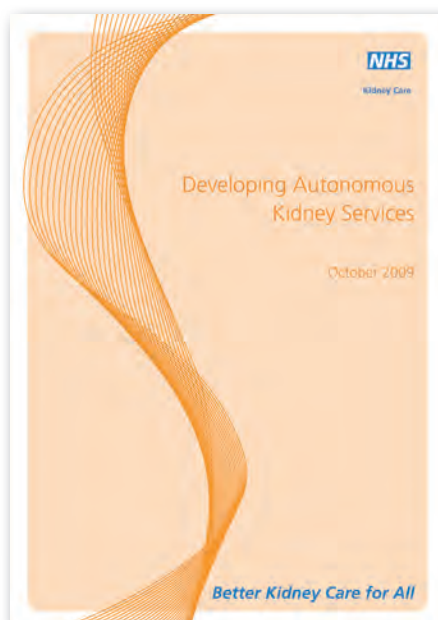
Space, equipment and staff need to be considered. Facilities should be built flexibly so that capacity can be stepped up and down as the demand for the service and resources fluctuate. Units will also need the right number of suitably trained and qualified staff, particularly nurses.

Invest in information systems

Most PCTs don't have enough information about renal services. Acute trusts are better at capturing this information, but often do not share it with PCTs for developing joint plans.

Investing in information and business intelligence systems should be a priority, and data needs to be updated and shared. Once fed with information, PCT commissioners

'Since each patient will require dialysis for the rest of their life, renal units will have to cope with accumulation of patients over time'



will be equipped to carry out needs assessments for the service.

Monitor the impact on patient choice

One of the main reasons for setting up autonomous units is to improve patient experience, for example by reducing travel time to dialysis sessions. It is important to monitor the impact of the new service on patient experience and satisfaction.

Review costs

Gain an understanding of how much each aspect of the service costs so that there is flexibility to move resources around if something in the service must be changed.

If there will be a slow transfer of services, make sure the contract allows for set up and parallel running costs in the early stages.

STEP 6: SEPARATION

Financial separation

The big issue for financial separation is getting the acute trust and the PCT commissioners to agree how to split the money. For acute trusts, the scenario is like creating a unit within a unit and there will be internal discussions about what part of the money stays with the main renal service.

The indicative tariff should smooth the process as there will be a non mandatory tariff in April 2010-11 and then a best practice tariff from 2011. Finance staff at the acute trust can then identify what portion of the money is moving out of the trust.

Clinical separation

Staff contracts need to be agreed before the service is up and running and new arrangements for governance, reporting or accountability should be risk assessed and tested out before the service goes live.

Normally any new arrangements will be distributed for peer review and comment, put into place for a three-month trial period and then reviewed.

While that is being done there should be a mechanism for any clinical concerns to be reported back up to the main unit and for those concerns to be acted on.

The joint working between the acute trust, renal service and PCT commissioner required in setting up an autonomous renal unit should achieve successful separation and improve patient experience, which is what has driven the change from the start. ●

For more information on the toolkit, visit www.kidneycare.nhs.uk



Renal nurse Debbie Starbuck uses the electronic prescribing system that was built in from the start of the scheme

KEYS TO SUCCESS

- Thorough business planning
- Contract that includes set up costs
- Clinical leadership
- Board ownership
- Good relationship with commissioners
- Patient support

The paucity of data on how many patients and with what conditions the trust could expect to take on made growth predictions difficult, and increased the time it took to agree the business plan. “There was some nervousness about the assumptions in the business plan; actually how robust were my projections,” says Mr Greenwood. “Managing that risk took a lot of persuading.”

As a result of that difficulty the trust bought a renal IT software package about four months after the unit opened. It is now used by clinicians and managers, who share the data with commissioners.

Clinical engagement

The acute trust agreed a contract with the commissioners that included set up costs, such as hiring two renal consultants and one specialist renal nurse before the unit opened. These clinicians established clinical governance structures for the renal unit and provided training and reassurance to the rest of the trust, where staff were apprehensive about having acutely ill renal patients on site.

Peritoneal dialysis patients were transferred from Sheffield in April 2007, and a month later the satellite unit was formally transferred to Doncaster. Transferring the satellite unit took more time than was expected because of staff transfer regulations.

Patients (apart from those on peritoneal dialysis who needed home visits) were given the choice of continuing at Sheffield or going to Doncaster and they were supportive of the new unit, which would reduce their travel times. A patient was on the project board to help with matters like patient experience.

Mr Greenwood concludes: “It wasn’t a perfect process but going from no renal service in 2005 to an all-singing all-dancing acute renal service in 2007 was a very big achievement and our local patients love it.” ●

STARTING FROM SCRATCH

Thorough business planning and clinical leadership were the big drivers in creating an acute renal service at Doncaster

Starting with no acute renal service, Doncaster Royal Infirmary, a major acute hospital of Doncaster and Bassetlaw Hospitals foundation trust, achieved a fully functioning 12-bed unit in the space of two years. It was opened by David Nicholson, who is now chief executive of the NHS.

The site was selected as the preferred provider by the specialist commissioners, who saw that patients had to travel long distances to the Sheffield hub. The hospital housed a satellite dialysis centre managed by the Sheffield Kidney Institute, and the task was to set up a new acute renal inpatient service.

The commissioners’ criteria included geographical location, and their objectivity was important to the process, says David Throssell, consultant nephrologist and deputy medical

director at Sheffield Teaching Hospitals foundation trust. Sheffield had an advisory role but no vote.

Also important was that once preferred provider status was secured, Doncaster had a good relationship with the commissioners, who sat on the project board led by Ian Greenwood, director of strategic and service development at Doncaster and Bassetlaw.

Tight business approach

Mr Greenwood and his team took a tight business approach, which Dr Throssell found impressive. He says: “They didn’t transfer any services until all the contracts underpinning that were signed and sealed.”

It was an opportunity for the foundation trust to test its business skills and find out if it was ready to take on significant

investment risks. The robust business planning included developing a business case, conducting risk assessments, doing market analysis, and looking at future demand.

Many of the clinicians found the process difficult at times, but Mr Greenwood says: “Once the project was finished it put the renal unit in a much stronger position because we’d done all the work prior to it opening.”

Board ownership of the development was achieved from the start and the project board was accountable to the trust’s board of directors. There were many conversations with the board about the potential for significant risk in taking on a new service, given the trust’s capital investment. What if renal patients continued to go to Sheffield and business didn’t come to Doncaster?

TOTAL TEAMWORK

Putting together an appropriate workforce is one of the most challenging aspects of setting up renal services, requiring a multidisciplinary team with specialist skills

Getting an appropriately skilled workforce in place is one of the most difficult parts of setting up a renal service.

Acute renal wards require a raft of specialist skills, including nurses who can do haemodialysis and peritoneal dialysis, nephrologists, dieticians and pharmacists with a special interest in renal pharmacy.

Physiotherapists and occupational therapists can help renal patients get out and stay out of hospital, while social workers and psychologists assist patients with the impact of a chronic disease on their lives.

Vascular surgeons and interventional radiologists are also needed, as are technicians to maintain the equipment.

There has traditionally been a shortage of nurses with dialysis skills, which was a consideration when the Northamptonshire Kidney Centre was being set up at Northampton General Hospital trust.

Training plan

The options were to recruit skilled nurses or to grow their own. They opted for the latter and brought in a band 7 haemodialysis trainer for 12 months on secondment from University Hospitals of Leicester trust. The unit still does not have enough nurses to provide round the clock dialysis but is on schedule to achieve that by early next year.

"The funding for the posts is there, it's finding the right people with the right skills," says Northampton consultant nephrologist Warren Pickering. "That is a very big issue for many renal units."

The acute ward has been fighting for the same pool of

nurses as the other acute wards and chronic dialysis units within the East Midlands renal network. Taking expertise from one has meant a need to backfill the other. It is a "big and ongoing problem", says Dr Pickering.

In New Zealand, he saw the value of social workers and psychologists and including these posts in Northampton's business case was a "master stroke", he says.

When the service started and Dr Pickering wanted to appoint a clinical psychologist, he was asked where he would get the money from. He was able to reply that the salary for the post was in the business case, which meant recruitment could go ahead. He was also able to gain support for securing a vascular access nurse and enough junior doctors by using this approach.

To make the case for which posts were needed, Dr Pickering and his consultant colleague Rob Preston used workforce planning documents from the British Renal Society, their own experience, and the experience

of Leicester, their senior partner. The hospital's experience was useful, because its staffing ratios were more generous than the British Renal Society's documents, and took into account issues such as sick leave and the possibility of shortfalls when nurses were moved around the directorate.

Evolutionary development

The Northampton renal service was set up in an evolutionary fashion, with services gradually devolved from Leicester, which appointed the first two nephrologists to work in Northampton and agreed to hold their contracts, provide their continuing professional development and take difficult cases. Northampton has made the most recent nephrologist appointments by itself.

Equally, Leicester holds the contracts for the outpatient dialysis nurses and Northampton holds contracts for the inpatient nurses.

Leicester made the initial appointments so that staff would know they had Leicester's

support while developing the service.

"It sent a clear signal that we weren't appointing people in isolation into a hospital that had never done any of this before, which we thought could have inhibited recruitment," says University Hospitals of Leicester trust deputy medical director Kevin Harris.

Having the right workforce ready on time to open the new acute renal ward was an ongoing discussion with managers. "You need to take the leap of faith at some point to open the ward, because you can't train people to do haemodialysis unless you have the patients," says Dr Pickering.

The ward was opened in phases, first for day cases, then a few inpatient beds, and so on. Leicester acted as a safety net, accepting any patients the new unit was not yet ready to treat.

Northampton's success has snowballed. Since 2004 its satellite haemodialysis capacity has gone from 100 to nearly 270 patients, which means more staff are needed. ●

POSTS REQUIRED FOR AN AUTONOMOUS RENAL UNIT

- Nurses
- Nephrologists
- Junior doctors
- Vascular surgeons
- Interventional radiologists
- Technicians
- Social workers
- Psychologists
- Dietitians
- Pharmacists
- Occupational therapists
- Physiotherapists
- Clerical staff



Ward manager Carol Setford and consultant Warren Pickering on the new renal ward

A VISION BUILT TO LAST

NHS Surrey's procurement programme for a new renal service has required detailed financial modelling of current provision with projections of future cost and activity



Better care and earlier diagnosis are Surrey's aims for a specialist renal service

Surrey is the only major county without a specialist inpatient kidney unit. In September 2007, NHS Surrey primary care trust published *Creating an NHS Fit for the Future in Surrey: making your healthcare better*. The trust included a commitment to develop a renal centre in Surrey and a renal programme commenced in May 2008.

The aims are simple: better care for patients and earlier diagnosis.

Conducting detailed financial modelling and evaluation of the current service provision was the first step in procuring Surrey's renal centre. The PCT needed to understand the financial implications of this decision, which meant determining possible future financial flows, financial mechanisms and aspects of patient access.

The review of the current service looked at what was being spent and with whom, and what the current pricing arrangements were for each

aspect of the service, including arrangements for satellite dialysis services currently subcontracted to private providers.

Data from contract monitoring reports and contract documents was also used to inform this process.

The PCT also looked at trends in costs and activity over time, to set the assumptions that could be used to underpin projections.

Cost considerations

Consideration was given to the possible introduction of payment by results in 2009-10 and the impact this would have on future pricing arrangements.

To assess future activity trends, the initial step was to determine the number of Surrey patients undergoing dialysis and post-transplant maintenance, and where they were receiving treatment – dialysis could be undertaken in Surrey at a number of satellite units as well as at main units.

Data from the UK Renal Registry was used to support analysis of the trends relating to the numbers of renal replacement therapy patients Surrey could anticipate entering the service in the future. The registry calculates expected numbers of replacement therapy patients based on population size and age profile. National historic growth rates were assessed from registry data and growth rates in Surrey patients were considered alongside, to determine growth assumptions.

A central consideration in setting up a renal service in Surrey has been to gain assurance that the service will be affordable and financially sustainable – in the short term while it is being established as well as in the longer term.

Having achieved a set of assumptions about cost and

'Scenarios that could arise from future variations in activity and costs were compared with the status quo'

activity trends, the PCT looked at how much renal services might cost Surrey in the future. Modelling work looked at possible scenarios that could arise from variations in activity growth rates, price inflation, and implementation profile of the new service. These were compared with the base case, status quo scenario – no new Surrey renal centre and services continuing to be provided as they are currently.

"This gave the opportunity to assess any potential risks both to

NHS Surrey and to any future provider," says PCT finance manager for planning Caroline Lovis.

Work was also carried out to examine the capital cost implications of implementing such a service, since providers could potentially become involved in major capital building projects that would require substantial funding.

All this work has been reviewed at Surrey PCT's board to test and provide assurance on the financial aspects of the proposed procurement. The financial modelling and evaluation has been extensively used in the development of the business case.

The financial implications of procuring a Surrey renal centre are clearly set out.

Ms Lovis says: "This will be used to support the testing of the affordability and financial sustainability of bids received from potential providers during procurement."

New process

NHS Surrey has chosen to pursue a competitive dialogue process, which it was felt would allow the PCT to work with potential providers to identify commercially viable and value for money solutions.

Competitive dialogue is a new procurement process introduced to the UK in 2006.

It is a procedure for use in complex contracts, allowing contracting authorities (in this case NHS Surrey) to enter into a discussion with potential providers, in order to identify a solution that offers optimal service and contract terms.

"Competitive dialogue enables us to maintain competitive tension in the market as well as ensuring risks and contractual terms are clarified during the process," explains Ms Lovis. ●



Patients and families benefit from shorter journeys to renal units

BRINGING CARE CLOSER

A new kidney unit in Surrey is set to improve the logistics of care for patients

Joanne Booth-Mason has been a kidney patient for the past 19 years. She has a disease for which there is no known cure and treatment has been aimed at prolonging the life of her kidneys. She sees a consultant every six to eight weeks at her local hospital, but it does not have a renal facility, so she attends a second hospital for transplant work-up, which includes electrocardiograms, circulation tests and glucose intolerance tests.

Ms Booth-Mason is on the waiting list for a transplant, which should happen in around two years, and will take place at a third hospital.

Her kidneys have deteriorated to the extent where she will go on dialysis within around nine months. Ms Booth-Mason says her treatment has been superb, but being seen at two different hospitals has caused some

difficulties that she hopes the new unit planned for Surrey will resolve.

One problem has been a lack of communication between the two hospitals. Last year she was rushed to her local hospital when septicaemia developed from an infection unrelated to her kidneys. None of the information about the care she received was transferred to the other hospital, which uses Renal PatientView, a website for patients to check blood results. Now there is a big hole in Ms Booth-Mason's notes.

Data sharing

The lack of data sharing has been a frustration. The notes on her transplant work-up stay with one hospital, while the notes from her regular consultant appointments remain with the other. When the new unit opens in Surrey she should receive all

this care under one roof. But she has also been campaigning, through being involved in the procurement process for the new unit in Surrey, for the electronic transfer of information between hospitals.

Journey times will also improve with the new unit. Travelling for transplant work-up appointments can take over an hour. At the moment each visit lasts three to four hours.

After the transplant, she will need to attend the unit four times a week to begin with, although the frequency of visits will decrease over time. Equally, after starting dialysis she will have to clock in every day until she is able to manage the treatment at home.

The new unit is set to be located centrally in Surrey, which would bring her travel times down to a maximum of 20 minutes.

Car parking is "a nightmare", says Ms Booth-Mason, because of costs at the one hospital (£7-8 per visit) and the lack of spaces at the other. The new unit is considering providing kidney patients with stickers so they can pay a reduced fee.

She is looking forward to having on site consultants at the new unit in case of emergencies. When she went to her local hospital with septicaemia she was put on a general medical ward but was lucky that the consultant in charge had experience of renal medicine and knew, for example, that kidney patients should not have a blood transfusion because it can introduce antibodies that might cause rejection of a new kidney.

Patients' priorities

Communication with other patients can be a big help, and is something Ms Booth-Mason hopes the new unit will facilitate.

"I've met a couple of people who've been through what I'm about to go through and they've been fantastically supportive and given me all sorts of tips," she says.

When patients in Surrey were asked for their priorities for a new unit, three main themes emerged. First, improving communication between GPs, hospitals and patients using modern technology. That means transferring data between hospitals, communicating with patients by text, phone and internet, and a patient support group. Second is dealing with the issue of car parking and third is single sex wards.

After each appointment Ms Booth-Mason leaves feeling positive about the staff and her treatment, but the technical issues and travel times are problems she hopes can be eradicated with the new unit.

"I have great faith in the team," she says. "It's just sorting out the logistics." ●

WISH LIST FOR THE NEW UNIT

- Improved communication between GPs, hospitals and patients
- Patient support group
- Reduced transport times
- Reduced parking costs
- Space to park
- On site consultants for emergencies
- Single sex wards