

# HOSC/06/10

**Committee** Health Overview and Scrutiny

**Date** 6 January 2010

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## **Regional Chairs Forum**

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There are four items arising from the meeting that require attention by the Committee:-

### **NHS Constitution**

The NHS Constitution was published on 21 January 2009. As part of its implementation, a consultation on new patient nights is taking place between 10 November 2009 and 5 February 2010.

The Regional Chairs view was that it should be left for each individual HOSC in the region to comment if they wish.

A copy of the consultation document is attached.

### **Regional Joint Overview and Scrutiny Committees (JOSC)**

The Forum has agreed a generic draft terms of reference for use should any JOSC be required to look at a particular topic. These Committees can comprise all or some of the 11 HOSCs within the region and they subsume the powers of all the HOSCs who participate.

The Forum is keen to keep any JOSCs to a manageable size and would like to see the introduction of a membership of 'one HOSC one representative'. To enable this to happen, each HOSC must agree to waive the rules of proportionality. Should this not happen it looks likely that JOSCs of 30 plus members might be required.

The Committee is invited to make a decision on whether to agree a waiver or not in so far as Essex is concerned.

## Regional Renal Study

The East of England Specialist Commissioning Group has recently commenced a consultation on an updated regional renal strategy. A copy of this is attached and additional details are available on [www.escg.nhs.uk](http://www.escg.nhs.uk). If this strategy needs to be considered this will have to be done by a Regional JOSC. However, the Forum has asked if detailed consideration is actually required, given that the strategy aims to develop services rather than cut them back.

At this stage the Committee is therefore asked to comment on the principle of where the strategy needs to be scrutinised by a Regional JOSC.

All 11 HOSCs in the region are being asked a similar question.

## HOSC Review of the Dialysis Services for the residents of Essex

This review was reported to the May 2009 meeting of HOSC and a copy of the report is available in the scrutiny folder in the Members Quiet Area and Group Offices. It contains twenty one recommendations which were scheduled to be reviewed at the end of December 2009.

Copies of the report were sent to all the appropriate agencies with responsibility for the services covered by the recommendation. It was very well received including a commendation on the National Renal Tsar's web site.

Attached are copies of responses from the Princess Alexandra Hospital NHS Trust and the Department of Health. During November, David Moses, Head of Member Support & Governance met with representatives of the East of England Specialised Commissioning Group who also welcomed the report. They explained that the recommendations from the HOSC review had informed their current consultation document. Members may therefore wish to postpone the review of how their recommendations have been implemented until the outcome of the consultation process is clear.

## East of England Ambulance Service Trust

The Committee has noted concerns about this Trust in the past. These are shared by other HOSCs in the region. The Forum has agreed to ask the Chairman of the Trust to attend its next meeting (a) to explain how the Trust proposes to improve the standard of service across the region; and (b) to answer specific concerns about the level of service provided.

Regrettably no response or acknowledgement has been received from the Trust to a specific query from this HOSC, despite a reminder having been sent.

# The NHS Constitution:

A consultation on new patient rights



**THE NHS  
CONSTITUTION**  
the NHS belongs to us all



## DH INFORMATION READER BOX

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<b>Action required</b>	Respond to the consultation
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# The NHS Constitution:

A consultation on new patient rights

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# Foreword

by the Secretary of State for Health

In January this year we published the first ever NHS Constitution, demonstrating our commitment to safeguarding the NHS for generations to come and to pressing forward with the process of reform and renewal of our NHS services. This innovative approach was widely welcomed for the clear picture it presented of the values and enduring principles of the NHS. For the first time everyone could see in one place what the NHS stands for, and what they can expect and are entitled to from it.

We developed the NHS Constitution in partnership with the patients who use the NHS, the public who fund it and the staff who work in it. This spirit of partnership has ensured it is a document that everyone can understand, support and be proud of. As we move forward the NHS Constitution will underpin the delivery of high quality care throughout the NHS.

To ensure the NHS Constitution fulfils this vital role it must remain relevant to everyone receiving or providing NHS care, and reflect the needs, desires and aspirations of patients, staff and the public. *Building Britain's Future* signalled the areas where we were considering extending the NHS Constitution to deliver these benefits.

Our intention in bringing forward the new proposals in this consultation shows our commitment to strengthening patient and public entitlements. By ensuring the NHS Constitution remains relevant, we are continuing the shift from centralised control and targets towards an NHS where power is in the hands of patients and the public.

In the past, consistent standards throughout the NHS have been delivered through clear targets based on what people wanted. In recent years this has helped deliver improved performance, especially in reducing waiting times. Where these targets have been met, we now have an opportunity to create clear and meaningful rights for individuals. Empowering patients in this way will ensure that all patients, regardless of where they live or who they are, are guaranteed these levels of care. It will mean that patients themselves have the power to ensure that there can be no return to the unacceptable standards of care which were common in the NHS we inherited in 1997.

Alongside these new rights, we will continue to remind patients of their responsibility to other patients to use the NHS wisely and to do their part to help it work effectively.

The proposals in this document celebrate the successes of the NHS and secure them for the future. This is why I'm pleased to publish this consultation, and look forward to hearing your views on these proposals.

A handwritten signature in black ink that reads "Andy Burnham". The signature is written in a cursive, flowing style.

**Rt Hon Andy Burnham MP**  
Secretary of State for Health



# Executive summary

The NHS Constitution, published in January this year, brought together in one place what the NHS does, what it stands for and the commitments it should live up to. It describes the values and enduring principles of the NHS.

The NHS Constitution renews our commitment to the principles of the NHS – a service that is for everyone, paid for out of taxes, based on clinical need not ability to pay, and without discrimination of any kind.

To guarantee that the NHS Constitution is enduring it needs to reflect what matters and continue to be relevant to the needs of patients, the public and staff in the 21st century.

We have always said the NHS Constitution should be an evolving document, which reflects the expectations people have of the NHS, and that we would have an open and transparent debate on any changes to it.

The progress in reducing waiting times for elective care and for access to cancer specialists gives us the opportunity to turn these achievements into rights for patients, locking in the improvements the NHS has made. Further than this, if it is not possible for an individual to be treated within the expected waiting times, we propose that the NHS does everything within its power to offer that patient a range of alternative providers where they could be treated sooner.

This consultation also proposes that our commitment to the NHS Health Checks programme, which assesses an individual's risk of heart disease, stroke, diabetes and kidney disease, becomes a right for all people aged 40 to 74. This will ensure that everyone who stands to benefit from the programme will be guaranteed the opportunity to take part.

This consultation document also welcomes views on areas where we believe we will soon be able to offer rights, such as dentistry, evening and weekend access to GPs, personal health budgets and the ability to choose to die at home. In September, the Prime Minister announced our intention to develop rapid access to diagnostic tests. Here we provide more detail of what a right to those tests would mean.

We welcome your views on all these areas. The NHS belongs to us all and its Constitution is designed to reflect what matters. This is a chance to help shape the future of the NHS Constitution and how it will benefit us all.

# 1. Introduction: The NHS Constitution and *Building Britain's Future*

## The NHS Constitution

- 1.1 The NHS Constitution, published on 21 January 2009, brings together for the first time the principles, values, rights and responsibilities that underpin the NHS.<sup>1</sup> It is designed to make sure that the NHS and its founding principles are protected in the 21st century.
- 1.2 The NHS Constitution supports patients, the public and staff by clearly setting out their legal rights. It contains 25 rights for patients and the public, covering all aspects of care from access to services to quality of care. It also includes 14 pledges to patients and the public, expressing an ambition to improve, going above and beyond the legal rights.
- 1.3 The NHS Constitution (and its accompanying Handbook, which describes in more detail how each right and pledge takes effect) was based on extensive consultation and research. The formal consultation process was led locally by primary care trusts (PCTs) and allowed many thousands of people to take part in the discussion and have their chance to shape the final document.
- 1.4 An independent Constitutional Advisory Forum, made up of leading experts and stakeholders, was established to oversee the process and make recommendations on how to improve the NHS Constitution and embed it in the NHS. As such, the NHS Constitution represents a lasting settlement between patients, the public, staff and the NHS itself.
- 1.5 The NHS Constitution can be found at:  
[www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm](http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm)

## Legal status

- 1.6 The NHS Constitution itself is not a piece of legislation: it is a 'declaratory' document, which articulates the existing legal position. Its value is in bringing together existing law alongside pledges, responsibilities, and the NHS-wide values and principles. However, all the rights set out in the NHS Constitution are underpinned by law and are legally enforceable. Any new right must be

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<sup>1</sup> The NHS Constitution applies only to the NHS in England. The devolved administrations in Scotland, Wales and Northern Ireland are responsible for developing their own health policies.

separately established in law, for example by new legislation, if it is to be included in the NHS Constitution.

- 1.7 In addition, the provisions of the Health Bill, which is expected to receive Royal Assent by mid-November 2009, will require all providers of NHS care in England, from foundation trusts to the private and third sectors, to “have regard to” the NHS Constitution. This means that they will have to take it into account in all their actions and decisions, putting the NHS Constitution at the heart of everything the NHS does.
- 1.8 The publication of the NHS Constitution was only the first stage of the journey; the legislation will ensure that the NHS Constitution makes a lasting difference. It will require the Government to:
  - carry out a full review of the NHS Constitution at least every ten years, with consultation involving patients, the public, carers and staff. The Handbook must be reviewed at least every three years;
  - consult before making any changes to the NHS Constitution in the interim (any changes to the principles in the NHS Constitution must be made by regulations, subject to the scrutiny of Parliament); and
  - report every three years on the impact of the NHS Constitution.
- 1.9 This will secure an enduring future for the NHS Constitution, while at the same time providing flexibility for its contents to evolve over time. The NHS Constitution is designed to be a living document, and we intend to incorporate further rights and pledges as the NHS continues to improve.
- 1.10 We are intending to bring the duty to have regard to the NHS Constitution into force in January 2010. To help prepare for this, leading experts and stakeholders were invited to form a State of Readiness Group to assess the level of preparation in the health service for the NHS Constitution. The group was asked to make recommendations on how to embed the NHS Constitution within the NHS to ensure that it makes a real difference for patients, staff and the public. The Group’s report will be submitted to the NHS Management Board in November.

## From targets to rights/entitlements

- 1.11 *Building Britain's Future*, published in June 2009, signalled a new direction of travel for public services: moving from a system based largely on targets and central direction to one where individuals have clear entitlements over the services they receive, backed by clear and effective means of redress.<sup>2</sup>
- 1.12 That is not to say that targets have not played their part: waiting times in the NHS have improved dramatically in recent years as a result of targets based on what people said mattered to them. Previously it was not uncommon for patients to wait over 18 months. Over the last 12 years the NHS has improved to a point where patients can expect to be treated within a maximum of 18 weeks, and often much sooner.
- 1.13 It is precisely because those waiting time targets brought such significant improvements that we are now in a position to lock them in in the form of a binding commitment to patients.
- 1.14 The NHS Constitution gives us the foundation on which to build more ambitious entitlements. It already describes the rights that everyone – NHS staff, as well as patients and the public – has when it comes to NHS services. As *Building Britain's Future* set out, we are now proposing to establish new rights for patients and the public, and to enshrine those rights in the NHS Constitution. This consultation document asks for views on:
- a new right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers where this is not possible; and
  - the right to be offered a NHS Health Check every five years if you are aged 40–74.
- 1.15 We are also seeking views on a series of other potential new rights which we are seeking to put in place over the next five years around NHS dentistry, choosing to die at home, personal health budgets and diagnostic tests within maximum waiting times. Any detailed proposals for such new rights would be the subject of further consultation, but we are now seeking your views on whether these are areas that should be explored further.
- 1.16 The results of consultation on the draft NHS Constitution last year showed clearly that people want rights to be meaningful: they want to know that they can be depended on, and that we only call something a right if it can

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2 [www.hmg.gov.uk/media/27749/full\\_document.pdf](http://www.hmg.gov.uk/media/27749/full_document.pdf)

be delivered. That is why every right in the NHS Constitution has a legal underpinning.

- 1.17 This consultation follows the same approach: it only proposes rights that the NHS will be able to deliver. Where potential rights are put forward for the longer term, we are clear that the NHS is not in a position to deliver them immediately, but should be once further progress is made.

## How we reached our proposals

- 1.18 The key proposals in this consultation document have been tested through research and engagement with patients, the public and a wide range of NHS staff. We now want to hear the views of a wider audience and give everyone the chance to have their say on our proposals.

## 2. Patient entitlements

### Waiting times right

- 2.1 NHS waiting times are the shortest they have been since NHS records began. This has been driven by establishing clear expectations of areas for improvement and expected minimum levels of performance.
- 2.2 The use of carefully directed targets was necessary to turn around a system where too often patients were subject to unfair variations in their treatment. This postcode lottery meant that too many patients were waiting an unacceptable length of time, often for no reason other than where they lived. Such variations within a national service were not acceptable, and were a clear sign that the NHS was not living up to the expectations of patients or the public.
- 2.3 We listened to what patients and the public expected, and what they wanted from the NHS. Waiting times targets clearly communicated to the NHS what those expectations were. These targets are now being delivered across the NHS. Where previously they were challenging and aspirational, they now describe the minimum standard of delivery expected across the NHS.
- 2.4 The NHS has been meeting the 18 week waiting time standard at a national level since August 2008. The latest figures show that 93.6 per cent of admitted patients and 97.7 per cent of non-admitted patients were treated within 18 weeks. Many patients are treated much sooner, with an average wait of around eight weeks.<sup>3</sup>
- 2.5 The NHS is also successfully delivering access to a cancer specialist within two weeks of a GP's referral. The latest figures show that 94.1 per cent of all patients were seen within the two week waiting time, and we know that the majority of those not seen within two weeks have chosen to wait longer.
- 2.6 The NHS Constitution includes meeting the current waiting times standards as pledges to patients and the public. The pledge is "to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution" (the explanatory guide which sets out in more detail

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<sup>3</sup> [www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm)

what each right and pledge means). The Handbook states that: *“patients can expect to start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions unless they choose to wait longer or it is clinically appropriate that they do so”*. There should be no other reasons for patients waiting longer than 18 weeks. For patients with suspected cancer, the waiting time standard is *“a maximum two-week wait to see a specialist”* from GP referral, unless they choose, despite the urgency of the referral, to wait longer.

- 2.7 The NHS has delivered real improvements for patients in meeting these commitments. This is why we believe it is the right time to secure its achievements by turning these operational standards into enforceable rights for patients.
- 2.8 We are seeking to lock in these successes, as set out in *Building Britain's Future*, to ensure that the reductions in waiting times are preserved and protected for patients. We propose to do this by creating a legal right using the Secretary of State's power under the National Health Service Act 2006 to direct certain NHS bodies. The right would be included in a revised version of the NHS Constitution.
- 2.9 A legal right to treatment within a maximum of 18 weeks from referral and to be seen by a cancer specialist within 2 weeks (or, where this is not met, to be offered a range of alternative providers, wherever possible) would help patients and the public to know what they can expect from the NHS in terms of waiting times. Empowering patients in this way would mean that their demands, rather than top-down targets, will maintain improvements in waiting times, ensuring that the NHS continues to deliver high quality care in a prompt manner.
- 2.10 Converting these waiting times pledges into a right – a legal entitlement underpinned by law – would mean that for every patient the NHS would have a duty to provide treatment within the specified times or to take reasonable steps to offer a range of alternative providers, unless the patient chooses, or it is clinically appropriate, to wait longer.
- 2.11 Our focus is on getting it right for patients the first time. The system already works for the vast majority of people – but some patients do end up waiting inappropriately. This is about making sure fewer patients are delayed, and working towards all patients receiving their care within the appropriate time.

- 2.12 Recent successes show that the systems and incentives are already in place to ensure the NHS consistently delivers on waiting times, with systematic processes in place to intervene when this does not happen.
- 2.13 Patient empowerment will be key in providing further incentives for the system to continue improving. Choice of provider at the point of referral for a consultant-led outpatient appointment is already a powerful incentive for providers to improve their performance. Access to information, at the point of referral, on how providers are performing on a variety of factors – including waiting times – encourages providers to improve their performance or face patients choosing to be treated elsewhere.
- 2.14 However, more can be done so patients who do not choose to wait longer and whose treatment is not delayed for clinical reasons are seen or treated as soon as possible. Our proposals on redress, described later in this chapter, are designed as a further incentive for improvement, by placing more power in the hands of patients.

### What would the right look like?

- 2.15 We propose including a new right for patients and the public in a revised version of the NHS Constitution. The proposed right could read:
- 'You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.'*
- 2.16 The directions establishing the right would then describe the maximum waiting times that would apply. They would also be set out in the Handbook. We propose setting out the detail in directions and the Handbook, rather than on the face of the NHS Constitution, as the intention is that performance will improve over time, with the maximum waiting times continuing to decline. This means the right can be kept up to date with these improvements in performance without needing to change the NHS Constitution itself.

### How would the right work?

- 2.17 Subject to the outcome of this consultation, the right would come into force in April 2010. The NHS would be under a legal duty to ensure that all those providing NHS care continue to meet the operational standards for 18 week and 2 week waiting times. This duty would be created by issuing directions



to PCTs, requiring them to commission services to ensure that patients for whom they are responsible receive care within the relevant waiting times. If, despite their best efforts, a patient cannot be seen within the relevant time, the PCT would be required to take reasonable steps to find and offer a range of alternative providers. PCTs would need to make arrangements with their providers to ensure that waiting times were complied with.

- 2.18 Any right around waiting times would need to include certain exceptions: patients should be able to choose to wait longer; and in some cases delaying the start of treatment will be in a patient's best clinical interest.
- 2.19 It would also be unreasonable to place a legal obligation on the NHS to meet the waiting times in every individual case. This does not mean that we tolerate patients waiting unnecessarily. But we recognise that, in a very small proportion of cases and despite the best efforts of the NHS, it is not always possible to meet the waiting time limits. Rather than see the NHS dragged through the courts for this small minority of cases, we want to offer a meaningful form of redress for the patients who have not received what they are entitled to.
- 2.20 The proposed legal duty would oblige PCTs to ensure that the existing minimum operational standards on waiting times are met. Under our proposals, patients would have a right to be treated within the specified waiting times or for the NHS to take reasonable steps to offer a range of alternative providers where this does not happen. This form of redress would not apply to people who had originally chosen to wait longer or in whose case it is clinically appropriate to wait longer.

## Redress

- 2.21 For any patient who waits longer than the 18 week or 2 week waiting times without a legitimate reason, we expect the NHS to put things right as soon as possible. In the first instance, this should involve offering a quicker appointment at the original provider. If this is not possible, we propose that PCTs be under a legal obligation to take reasonable steps to find a range of alternative providers which can see the patient more quickly than the original provider, if this is what the patient wants. This means the NHS would take steps locally to ensure that the small number of patients who have an inappropriately long wait are treated or seen as quickly as possible. This would work alongside existing patient engagement processes and the NHS complaints procedure to ensure that any offer of redress is appropriate.

This is not about compensating people, but about putting things right for patients as soon as possible.

- 2.22 Under the proposed system, patients who are eligible for redress will be able to exercise their right by contacting their PCT. Patients will be given a point of contact so that they are clear exactly who to approach.
  
- 2.23 The PCT would then be under an obligation to take all reasonable steps to find a range of alternative providers to offer the patient a more timely appointment. This obligation would be established in the Directions to PCTs underpinning the right. Where possible, we would expect the range of alternative providers to include NHS providers or private providers which meet NHS standards and which can meet the NHS tariff.
  
- 2.24 In practice, providers may be best placed to make the arrangements on behalf of a patient's PCT, and we will look to include the same requirement in the NHS standard acute contract (the model contract used by PCTs to commission acute services). Providers know and understand their patients' cases and some already have systems in place to arrange for alternative providers. The PCT would retain responsibility for ensuring that the systems were working and that patients' expectations were being met. Where providers fail to meet these obligations, PCTs would be able to take action under the usual contractual arrangements (for example through reductions in contract payments or, in an extreme cases, terminating the contract and moving services to another provider).
  
- 2.25 It may not be possible to find a suitable alternative provider in every case, for example certain specialties may have very limited capacity nationally. This is why we are proposing that reasonable steps are taken to find an alternative.
  
- 2.26 NHS organisations would need to be satisfied that, if challenged, they could demonstrate they had done what could be reasonably expected of them. There are certain general principles which we would expect the NHS to observe, such as not paying for private care at above tariff costs at the expense of the taxpayer and not disadvantaging patients already on waiting lists by slotting in other patients of the same clinical priority ahead of them. We intend to issue guidance to PCTs on how to fulfil their legal obligations.
  
- 2.27 Ultimately, as with all other rights in the NHS Constitution, patients or their families would be able to seek to judicially review their PCT if they felt it was not complying with its legal duty in their case.

- 2.28 We expect the local NHS to continue to make every effort to ensure that patients are treated or seen within the expected waiting times. The proposed right to an offer of redress would not mean that providers could ignore their contractual obligations to meet existing waiting time standards. For example, working with the NHS, we would look to ensure that alternative providers treating patients would not be penalised for assuming responsibility for the patient's treatment.
- 2.29 As well as individual routes of redress, the Government has already created mechanisms for local communities to put pressure on services that are not performing, for example through the overview and scrutiny role of local government. The Government will also be exploring the role of the petitions duty, created by the Local Democracy, Economic Development and Construction Bill, in supporting local councillors to act on behalf of their communities where services are persistently failing to deliver entitlements and standards of service.

### Patient responsibilities

- 2.30 Of course, these obligations on the NHS need to be balanced with responsibilities on the patient's part. While the NHS should make every effort to treat patients within acceptable timescales, it is not possible to guarantee this if patients do not turn up for their agreed appointments or refuse treatment, for example.
- 2.31 The NHS Constitution already contains the following responsibility for patients and the public:
- "You should keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do."***
- 2.32 Under the proposed system, as is currently the case, the maximum waiting times would not apply to patients who failed to meet this responsibility where they had previously chosen their appointment from a set of reasonable options.<sup>4</sup>

### Better communication with patients

- 2.33 We know that better communication with patients around treatment within 18 weeks and 2 weeks will be central to ensuring that they understand their rights and responsibilities. Accurate knowledge of when their waiting time

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4 [www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/Rules-suite/](http://www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/Rules-suite/)

'clock' starts and stops, and what they need to do if they wait longer than expected waiting times, will be fundamental to putting patients themselves in control of driving improvements in waiting times.

- 2.34 We propose supporting the right with clear, simple communications to make sure patients understand what they can expect in their case. We are exploring how this will be best achieved. For example, we are looking at how best to support patients through developing materials such as 'Your Treatment Planner' (an easy access guide containing 18 week waiting times information in one place), or whether more can be done to support primary care staff to explain people's rights around waiting times, for example when using Choose and Book. The information provided will need to be appropriate for all groups of patients, for example to ensure that it is accessible for young patients, as well as for their parents and carers, who are likely to need to exercise their rights on their behalf.
- 2.35 The directions establishing the right would require PCTs to ensure that patients have details of who to contact if they have concerns about their length of wait. Who these contact points are will be most appropriately determined locally but, for illustrative purposes, they could be the booking manager or relevant medical secretary in a provider organisation, or the Constitution champion in the PCT. The role of Constitution champions is discussed more fully in Chapter 4.
- 2.36 We recognise that more needs to be done in relation to communication around two week cancer referrals in particular. In a number of cases, GPs choose not to explain why they are making an urgent referral. Given that most urgent referrals do not result in a cancer diagnosis, some GPs may be concerned about causing undue stress or worry. However, this means a number of patients are left unaware of the urgency of their referral, and may choose to delay their initial appointment with a specialist. This can impact on the outcome of their treatment pathway. We want to explore whether better communication with patients could change this.
- 2.37 It is, however, important to ensure that GPs are not discouraged from using the two week referral. There may be good reasons why a patient may not be informed that they are being referred for suspected cancer and we want to avoid introducing any new requirements that may discourage the use of this pathway. We would therefore welcome views on whether GPs or providers should be required to provide specific information to patients about their rights and what the two week waiting time means.

## Exceptions to the right

2.38 The NHS needs to retain the freedom to respond appropriately to crises. In certain extreme circumstances, it may not be possible, or desirable, for NHS resources to be focused on meeting waiting times rights for non-urgent elective patients, when the health needs of the population would need to be prioritised in other ways.

2.39 An example of this is an influenza pandemic, which carries the potential for a significant increase in the number of people accessing services and for placing an increased strain on NHS resources. To ensure that the NHS can continue to provide appropriate treatment based on clinical need, it may be necessary to temporarily suspend the right in certain circumstances. It is envisaged that such suspensions would be applied locally, depending on the impact of a pandemic or a similar event in a particular area. The decision to suspend the right would be taken by the Secretary of State for Health, who of course remains accountable to Parliament for any decision. Our current proposal, therefore, is that any suspension would be dealt with by further directions issued by the Secretary of State at the appropriate time.

2.40 The right would come back into effect as soon as the local NHS was no longer in a crisis situation.

## Consultation questions

**Should a right in respect of waiting times be established and included in a revised NHS Constitution?**

**If so, should the right include:**

- the current standard for treatment within 18 weeks?
- the current standard for urgent GP referrals for suspected cancer to be seen by a specialist within two weeks?

**Should GPs provide specified information to patients on their rights around a two week referral?**

## NHS Health Checks

2.41 The NHS Health Check programme is a prevention programme that assesses risk of heart disease, stroke, diabetes and kidney disease for those aged between 40 and 74 who have not been diagnosed with one of these conditions. The aim of a NHS Health Check is to identify an individual's

risk of these diseases earlier and support them to reduce their risk through lifestyle changes, such as smoking cessation or weight management, or clinical management, such as prescribing statins.

- 2.42 The programme is already under way; PCTs have been implementing it across the country from April this year and have begun to offer people a check. We believe that NHS Health Checks are an important part of preventing ill health, and want to go further by creating a legally binding commitment on the NHS to provide NHS Health Checks for those who are eligible.
- 2.43 The programme is currently being phased in and is due to be running fully from April 2012. We propose that a new right comes into effect in line with this timetable. This would mean that from April 2012 anyone eligible would have the right to be offered or to request a NHS Health Check once in the first five years and then once every five years after that. Making this a right would mean that we would guarantee that everyone who was eligible would have been offered their first NHS Health Check by April 2017 at the latest, whether they had been invited to participate in the programme or had requested a check themselves.
- 2.44 Within each PCT area there will be a range of different providers who have been commissioned to deliver the NHS Health Check programme. In the unlikely event that an individual approaches one of these and is then not offered a NHS Health Check, the PCT would be required to ensure that the individual had access to a NHS Health Check through another provider.
- 2.45 Our proposed timetable for bringing in the new right would allow time to ensure that appropriate services to manage and reduce risk of vascular disease, such as weight management programmes, are in place to meet the demand generated by the programme. It will also allow us to work with the NHS to put in place the necessary IT infrastructure to support the programme.
- 2.46 Our proposal is that directions under the National Health Service Act 2006 would place a legal duty on PCTs to ensure every eligible individual for whom they are responsible is offered a NHS Health Check, or is provided with one following a request, as part of the five year rolling programme. PCTs would be responsible for ensuring that people were offered their NHS Health Check, and for the commissioning of the services to provide the NHS Health Check.

2.47 The legal duty would mean that the public would have a right to be offered a NHS Health Check. People would then be free to choose whether or not to take up the offer. The provision of other NHS services would not be dependent on taking part in the NHS Health Check programme.

2.48 The new right could read as follows:

*'You have the right to a NHS Health Check every five years if you are eligible for one. If you are not offered one at the provider you approach, you have the right to see an alternative provider.'*

### Consultation question

**Do you agree that a right to a NHS Health Check every five years for those aged 40–74 should be established, with effect from April 2012, and be included in a revised NHS Constitution?**



# 3. Other opportunities for future patient entitlements

3.1 We have designed the NHS Constitution to be a living document which can be updated in line with rising public expectations. Besides the new entitlements that we propose to create as soon as possible, *Building Britain's Future* listed a number of further areas where we believe there is a case for introducing new entitlements over the longer term:

- evening and weekend access to GPs;
- access to NHS dentistry;
- personal health budgets; and
- choosing to die at home.

3.2 As we announced in September this year, we also believe that it is appropriate to introduce a right to key diagnostic tests within one week of seeing a GP, with an interim milestone of two weeks.

3.3 Any new rights in these areas would be incorporated in the NHS Constitution. As the proposals would be subject to full consultation and transparent debate at the time, this consultation document seeks views on the direction of travel.

## Evening and weekend access to GPs

3.4 The NHS Constitution sets out several patient rights in relation to access to GPs. For example, the *"right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons"* and the *"right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply."* In *Building Britain's Future*, we committed to going further and examining the possibilities of bringing forward a new right to evening and weekend access to a GP.

3.5 We have listened to patients and the public, and what they have told us is that more flexible and convenient GP access would make life much easier for them. Thanks to the hard work of GP practices and local NHS organisations, over three-quarters of GP practices across the country are now offering extended opening hours, and we expect this to continue to rise. On top of



this, by the end of the year we will have established around 135 GP health centres, open to any member of the public from 8am–8pm, 7 days a week.

- 3.6 We believe it is important for people to be able to see a GP at a time and place that is convenient for them. We are already committed to abolishing practice boundaries in order to allow people to choose which GP practice they register with, regardless of where they live. Building on that, we intend to create a right to choose a GP practice offering extended access to evening and weekend appointments. We will need to engage with the profession to work through the details and we will seek to introduce this right as soon as practically possible.
- 3.7 Until then we will continue to work with GP practices and the local NHS to encourage further progress in increasing the availability of GP consultations in the evenings and at weekends.

## NHS dentistry

- 3.8 Access to NHS dentistry is now growing again: over 700,000 more patients accessed NHS services in the 24 months ending June 2009 compared with the 24 months ending June 2008. In addition, NHS dentists are delivering more dental care, with 1.4 million more courses of treatment delivered in 2008/09 than in 2007/08.
- 3.9 However, even with these recent successes, we know there is more still to be done to ensure that everyone who needs to can access NHS dentistry. There have been problems with access to NHS dentistry since the early 1990s. Our 2006 dental reforms have given PCTs the power to contract dental services to meet local needs. In order to expand services wherever they are needed, we have set up a national dental access programme, headed by Dr Mike Warburton, an experienced clinician and manager, to support the NHS in further improving access. We have also accepted the recommendations made by the independent review of NHS dentistry led by Professor Jimmy Steele, published in June 2009, to improve access and quality further in the longer term.
- 3.10 Currently, PCTs have committed themselves to the goal of ensuring that by March 2011 anyone who is seeking NHS dentistry can get it. The Handbook to the NHS Constitution already includes this commitment. This is an ambitious pledge, but one that the NHS has set itself: a sign that it understands the importance of delivering access for all who seek it. Once this

commitment has been achieved, we think it would be sensible to translate it into a binding right of access to NHS dentistry.

## Personal health budgets

- 3.11 In line with the commitment in *High Quality Care For All*,<sup>5</sup> we have launched a pilot programme of personal health budgets in the NHS, learning from the experience in social care and other health systems. The aim is to deliver better quality services by letting people take more control over the way money is spent on their care.
- 3.12 Over 70 PCTs are developing plans for pilots, covering a range of conditions and services.
- 3.13 Initially, the budget itself will be held on behalf of the patient; but we will use powers in the Health Bill, which is expected to receive Royal Assent by mid-November 2009, to allow the additional option of direct payments to individuals in pilot sites.
- 3.14 The pilots, which are due to last until 2012, are supported by a robust and independent evaluation, to assess the impact of personal health budgets and help show how they can best be extended more widely.
- 3.15 In future we believe all patients who could benefit from a personal health budget should have a right to be offered one, just as there is a right to a direct payment in social care. We would like to develop this proposal further during the course of the pilots.

## Choosing to die at home

- 3.16 We believe that it is important to enable more people to die at home, if that is their wish. The *End of Life Care Strategy*,<sup>6</sup> published in 2008, sets out how services need to be developed to improve care for people at the end of life – including to support people to be cared for, and die, at home.

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5 Darzi, Lord (2008) *High Quality Care for All: NHS Next Stage Review Final Report*, London: Department of Health. [www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH\\_085825](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825)

6 Department of Health (2008) *End of Life Care Strategy: promoting high quality care for all adults at the end of life*, London: Department of Health. [www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086277](http://www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH_086277)

- 3.17 It may be possible in the future to go further for individuals who wish to die at home, perhaps by creating a legal right to certain medical care to support them in doing this.
- 3.18 However, any such right would need progress to be made first in implementing the *End of Life Care Strategy* itself. We want to be sure that the right services are in place to enable those who want to die at home to be supported to do so, before creating a right. Professionals, patients and their families and carers need this to be underpinned by the right systems for information, assessment and care planning. This includes advance care planning, which allows individuals to set out their wishes and preferences about treatments they would and would not wish to receive when they are not able to make decisions for themselves.
- 3.19 We are already making progress. For example, we have established the National Coalition, Dying Matters, to raise public awareness of the issues surrounding death, dying and bereavement. We have published a set of quality markers for all commissioners and providers of end-of-life care to help them benchmark and monitor progress locally. We have also published guidance for professionals and the public on advance care planning. By 2013, we should be in a position to review progress and explore the feasibility of establishing a right to choose to die at home.

## Waiting times for cancer diagnostics

- 3.20 As highlighted in Chapter 2, progress has been made in reducing waiting times, which is why we are in a position to consult on the introduction of patient rights in these areas. But the waiting times in this consultation are not the limit of our ambition and we intend to look into other areas where we believe patient entitlements can drive delivery on waiting times.
- 3.21 As we announced in September, we intend to give people the right to diagnostics and test results within one week of GP referral, with an interim step of two weeks. Referrals for diagnostic tests are often as a result of symptoms associated with minor or less serious conditions, where waiting times do not have a significant impact on outcomes. However, many symptoms of cancer are similar to or the same as the symptoms of these less serious illnesses.

- 3.22 From 2011/12, people will be able to expect access to the relevant diagnostics, and test results, associated with lung, colorectal and ovarian cancer within two weeks. Over the following five years the programme will be expanded so that all patients will be offered the relevant tests for all cancers within one week of GP referral.
- 3.23 In the small number of cases where diagnostic tests do reveal cancer, this rapid referral has potential to have a major impact on the chances of survival for those patients. Given the difference that this can make to individuals' lives, we intend to bring forward a proposal for a right to diagnostic tests, first within two weeks and then within one. We propose to consult on establishing this right and including it in the NHS Constitution once the NHS has made progress in delivering the tests within these timescales.

### Consultation question

**Do you agree we should explore potential future rights for patients and the public in the areas set out in Chapter 3?**

## 4. Constitution champion

- 4.1 Our vision is that, by moving away from top-down targets and towards patient entitlements, patients will be more empowered and will be able to drive improvements in services. It is therefore important that patients, staff and the public are able to understand their rights, and what to do if they are not met. Only by supporting the public and patients in understanding their rights will the NHS be responsive in meeting local needs and providing appropriate services. Through supporting staff in understanding their rights we can secure the commitment and dedication needed to meet the expectations of empowered patients.
- 4.2 Patients, staff and the public need to be aware of what support is available to them to understand and exercise their rights. There are already a number of services providing advice and advocacy. For example:
- Patient Advice and Liaison Services (PALS), available in most hospitals and PCTs, provide advice and information about the NHS, what people can expect and how to provide feedback or make complaints. PALS provide information about healthcare and the local NHS, helping patients to access services. They also listen to the experiences and concerns of patients and the public, identifying problems or gaps in services and reporting them.
  - Local Involvement Networks (LINKs) have been in place in every local authority area since April 2008. By giving everyone in the local community a chance to have their say in ways that suit them, LINKs are providing an important channel to ensure that the suggestions and concerns of those communities are heard by commissioners and providers of services. Health and social care organisations are required to respond to LINK reports and recommendations within set time limits. LINKs help local communities to have influence over, and drive improvement in services in, a way that is most suitable for the needs of the local population.
- 4.3 *Building Britain's Future* announced the commitment to build on the advocacy and redress systems, so that every PCT has a 'Constitution champion' to uphold the NHS Constitution locally.

## The nature of the role

4.4 The Constitution champion role should not supplant or cut across systems of patient advocacy and empowerment, or staff representation, that are already in place but should build on them. There are many ways in which a Constitution champion could add value for patients, the public and staff. We do not intend to be prescriptive about the precise functions of the role because each local area will have its own needs, which might best be met in a variety of ways. Finding the right local fit will be key to the success of the role and we expect PCTs to work with their stakeholders to determine what works best for them.

4.5 For example, the Constitution champion could take a lead on:

- ensuring the organisation has the right systems and processes in place to meet people's rights and to live up to the NHS Constitution's pledges;
- working with staff groups to ensure that the NHS Constitution is being considered as part of their objectives, development and general conduct;
- ensuring that patients, their representatives and carers, the public and staff are aware of their rights, responsibilities, and what services are available to provide advice and support;
- co-ordinating feedback from patients, the public and staff to the PCT board on the impact of the NHS Constitution locally, and what more needs to be done; and
- supporting the local health economy to meet its legal obligation to take the NHS Constitution into account in all that it does.

4.6 It may make most sense in some areas to incorporate the role into existing functions; for example, it could sit with an existing non-executive director or a senior executive. Other areas may wish to create a new post or allow different aspects of the role to be fulfilled by different people. For example, a PCT could choose to have one champion for patient and public elements of the NHS Constitution and another for staff elements. Trusts may also wish to consider the role in line with broader patient and public empowerment functions, and other patient champion campaigns, for issues such as dignity, patient safety and equality.

- 4.7 However the role is designed, the Constitution champion will need to be a leader and a role model for the NHS Constitution. They will have an important part to play in ensuring that the NHS Constitution is embedded across the NHS.

### Consultation questions

**Do you agree the role of the Constitution champion should be determined locally by PCTs?**

**Do you think there are any particularly important aspects of the role?**

## 5. Summary of consultation questions

Should a right in respect of waiting times be established and included in a revised NHS Constitution?

If so, should the right include:

- the current standard for treatment within 18 weeks?
- the current standard for urgent referrals of suspected cancer to be seen by a specialist within two weeks?

Should GPs provide specified information to patients on their rights around a two week referral?

Do you agree that a right to a NHS Health Check every five years for those aged 40–74 should be established, with effect from April 2012, and be included in a revised NHS Constitution?

Do you agree we should explore potential future rights for patients and the public in the areas set out in Chapter 3?

Do you agree the role of the Constitution champion should be determined locally by PCTs?

Do you think there are any particularly important aspects of the role?



# 6. The consultation process

## The consultation process: next steps

- 6.1 The Government wishes to engage everyone in the debate on the NHS Constitution; this is because the NHS belongs to all of us.
- 6.2 We will be encouraging ongoing web-based consultation via the NHS Constitution's website: [www.dh.gov.uk/nhsconstitution](http://www.dh.gov.uk/nhsconstitution). Information about the NHS Constitution can also be found on the NHS Choices website ([www.nhs.uk](http://www.nhs.uk)).
- 6.3 As with the consultation on the draft NHS Constitution, carried out from June to October 2008, there will be a strong local focus to the consultation, with all strategic health authorities and PCTs playing their part in engaging with local people and staff. The Department of Health will bring together what people tell us nationally and locally to produce a formal government response to the consultation process.
- 6.4 You can comment:
- by email to [NHSConstitution@dh.gsi.gov.uk](mailto:NHSConstitution@dh.gsi.gov.uk)
  - online
- or
- by post to  
NHS Constitution Consultation Response  
Richmond House 601  
79 Whitehall,  
London SW1A 2NS
- 6.5 Responses should be submitted by 5 February 2010.

## Criteria for consultation

- 6.6 This consultation follows the Cabinet Office Code of Practice. In particular, we aim to:
- consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy;

- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses;
- ensure that our consultation is clear, concise and widely accessible;
- ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy;
- monitor our effectiveness at consultation, including through the use of a designated consultation co-ordinator; and
- ensure that our consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full text of the code of practice is available at:  
[www.berr.gov.uk/files/file47158.pdf](http://www.berr.gov.uk/files/file47158.pdf)

## Confidentiality of information

- 6.7 Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
- 6.8 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.
- 6.9 The Department of Health will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Comments on the consultation process itself

6.10 If you have concerns or comments which you would like to make relating specifically to the consultation process itself, please contact:

Consultations Co-ordinator

Department of Health

3E58, Quarry House

Leeds LS2 7UE

Email: [consultations.coordinator@dh.gsi.gov.uk](mailto:consultations.coordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**



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# Developing renal dialysis services for people in the east of England

Full consultation document



## Your chance to have your say

Deadline for feedback March 8, 2010

Published December 14, 2009

East of England Specialised Commissioning Group

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# 1. INTRODUCTION

## 1.1 What is the East of England Specialised Commissioning Group (SCG)?

The East of England SCG purchases (commissions) services on behalf of all 14 Primary Care Trusts (PCTs) in Essex, Bedfordshire, Hertfordshire, Norfolk, Suffolk and Cambridgeshire.

It was established to commission high cost/low volume services that are either very expensive in terms of treatment costs or are for rare conditions with very low numbers of cases.

These 'specialised services' include: rarer cancers, burn care, medical genetics, some mental health services, specialised services for children, renal services, morbid obesity and cardiac surgery, amongst others.

## 1.2 Developing services for the future

The East of England SCG is asking for your views about services for adults with chronic renal failure in the region.

The document describes:

- *What renal failure and dialysis is*
- *What services are currently available*
- *Why services need to develop*
- *Our proposals for services in the future, and*
- *How you can have your say on the proposals*

Any changes will affect patients, their families and carers and NHS staff working in this area of healthcare in the east of England.

Your ideas will help us decide how best to develop these services for the people involved across the region.

The way we have developed our proposals, and the way we will reach a decision on them, is being overseen by the Joint Health Overview and Scrutiny Committee (JHOSC), which is made up of representatives from local authorities in the east of England.

## 2. BACKGROUND

### 2.1 What is kidney disease?

Under normal circumstances, the kidneys work continuously to keep you alive and well. They act as filters and remove waste products from the blood and excess water from the body. In addition the kidneys help influence haemoglobin production, blood pressure and bone formation.

Four conditions are needed for the kidney to be able to work properly:

- 1. A supply of blood that needs to be cleaned*
- 2. A cleaning or filtration system to clean the blood*
- 3. A way for the cleaned blood to return to the rest of the body*
- 4. Excess water and waste needs to be able to leave the kidney and then the body*

If any of the above do not work as they should, then the kidney is unable to produce urine and therefore waste cannot be removed from the body properly. If these problems persist, then it is possible that kidney disease will be the result.

**Renal failure** is the general term used when the kidneys fail to function properly. For some patients renal failure can develop over the course of months, even years, but for others it can occur very quickly.

**Chronic Kidney Disease (CKD)** is defined as the presence of kidney damage, or a decreased level of kidney function, for a period of three months or more. CKD can be divided into five stages, depending on severity. The final stage of this is known as 'End-Stage Renal Failure' (ERF), which requires ongoing dialysis. People with renal failure will need some form of treatment for the rest of their life. For most people, the treatment they receive can be tailored to suit their lifestyle.

### 2.2 What causes chronic kidney disease?

Some kidney diseases are inherited and others develop as we grow older. Often kidney disease is associated with other medical conditions including diabetes, hypertension and heart disease. In addition, members of certain ethnic groups are also at higher risk because of the greater incidence of diabetes and high blood pressure. These include people of Aboriginal, Asian, south Asian, Pacific Island, African/Caribbean and Hispanic origin.

The exact cause of many types of kidney disease is not yet well understood. However, over the last 40 years there have been significant advances in the ability to treat CKD, enabling people to survive much longer.



## 2.3 How renal failure affects people

ERF is an irreversible, long term condition for which regular dialysis treatment or transplantation is required. Since the introduction of modern treatment methods many people have enjoyed a near normal life span. Nevertheless, the rigours of treatment are considerable. For example, four hours a day, three days a week are normally devoted to the renal dialysis process in hospital.

Treatment presents social, financial and practical problems for the whole family. As well as the time spent on renal dialysis, there is considerable travelling time to and from the dialysis unit, and often additional time spent waiting to be treated or for transport home. Additional time will also be needed for other clinical appointments.

Many people with renal failure consider a kidney transplant the best treatment. However, not everyone can benefit from a transplant, and there is also an increasing proportion of patients starting dialysis who are not clinically eligible or may not be healthy enough to have a transplant.

## 2.4 What is renal dialysis (Renal Replacement Therapy)?

Renal Replacement Therapy (RRT) is a term used to encompass life-supporting treatments for renal failure.

Clinicians and nurses have been working over the past few months to develop a future strategy for commissioning renal services in the region that cover three treatments.

We are asking for your views on the provision and expansion of these three types of renal dialysis services in the region:

- *Haemodialysis (cleaning the blood through a machine)*
- *Peritoneal dialysis (a process by which fluid is introduced into the abdomen to clean the blood - can be conducted in a unit or through home therapy)*
- *Home therapies (patients receive treatment at home when clinically suitable)*

The terms 'renal dialysis' or 'renal dialysis services' in this document therefore refer to all three types of treatment.

## 2.5 Home therapies – a closer look

NICE (National Institute for Health and Clinical Excellence) produced guidance on home therapy in 2002, which was subsequently supported by both the renal National Service Framework (NSF) in 2004 and the Department of Health Operating Framework 2008/09.

NICE estimated that between ten and 15 per cent of patients would prefer home therapy, if offered a choice. This percentage has been met (and exceeded) in certain places (including Manchester). However, in the rest of England less than two per cent of renal dialysis patients are currently self-caring at home.

The East of England SCG has been carrying out work to explore the rejuvenation of home therapies, adding to that already carried out for this consultation. There has been some success and new mobile dialysis technology has been piloted.

The aspiration is to have ten per cent of renal dialysis patients in the east of England self-caring by 2015.

Patient groups are strongly supportive of choice in renal services – including choice of home therapies if clinically suitable.

Clinicians and nurses have established that the provision of renal services needs to be expanded in order to meet future need, but also to improve the experience of existing patients.



## 2.6 What renal dialysis services are available now?

Renal dialysis services in the east of England are provided by eight 'principal' units and nine 'satellite' units. Patients are also treated outside of the region.

The table below shows the current provision of renal dialysis services (haemodialysis and peritoneal) available in healthcare settings but not home therapy provision.

Provider	Number of existing dialysis stations	Number of existing patients
<b>Principal Units</b>		
Addenbrooke's Hospital, Cambridge	35	129
Basildon & Thurrock Hospital	26	149
Broomfield Hospital, Chelmsford	24	115
Colchester Hospital	20	120
Ipswich Hospital	19	94
Lister Hospital (East & North Hertfordshire Hospitals)	20	122
Norfolk and Norwich Hospitals	28	165
Southend Hospital	28	168
<b>Satellite Units (and their principal units)</b>		
Aldeburgh (Ipswich Hospital)	5	10
Cromer (Norfolk & Norwich Hospital)	8	47
Huntingdon (Addenbrooke's Hospital)	14	45
James Paget Hospital (Norfolk & Norwich Hospital)	18	95
Kings Lynn (Addenbrooke's Hospital)	14	83
Luton & Dunstable (East & North Hertfordshire Hospitals)	23	145
Peterborough (Leicester)	16	90
St Albans (East & North Hertfordshire Hospitals)	16	104
West Suffolk (Addenbrooke's Hospital)	13	56
Watford (with north west London satellite)	22	150
<b>Principal units providing treatment outside east of England area</b>		
Barts & The London Hospital		56**
Royal Free Hospital and satellites		66*
Oxford (with Milton Keynes satellite)		17***

\* Predominantly east and north Hertfordshire residents, Essex and a small number from Bedfordshire

\*\* Predominately Essex residents

\*\*\* Bedfordshire residents

'Principal' units are those at hospitals. These are supported by one or more 'satellite' units that are closer to patients' homes.

## 2.7 What needs to change and why?

In January 2004, the first part of the renal NSF was published with the aim of recognising the need for significant expansion of services for patients with chronic renal failure. The NSF suggested that between 2004 and 2014 the number of patients needing RRT would double.

Although transplantation rates are planned to increase, it is expected that the most significant service pressure will relate to renal dialysis services, with growth of five per cent per annum until 2030, and possibly beyond.

Therefore it is predicted that the number of patients will rise from 1,769 in 2008 to 2,143 in 2015 and to 2,868 in 2020.

An assessment that was developed by clinicians, nurses and commissioners from across the region predicted a rise in the demand for dialysis services up to 2014. This forecast was based on population growth, current inequality in access to services and was also designed to meet national policy guidelines.





## 2.8 What has national policy said about renal care?

The key national policy documents in relation to future dialysis requirements are:

- *The Renal National Service Framework (NSF) (2004 and 2005)*
- *National Institute for Health and Clinical Excellence (NICE) guidance (home dialysis) (2002)*
- *'Saving Lives, Valuing Donors' – Organ Donation Taskforce report (2003)*
- *'Organs for Transplants' – Organ Donation Taskforce report (2008)*
- *Department of Health Operating Framework 2008/09*

### The renal NSF

The renal NSF published in January 2004 encompasses issues relating to dialysis and transplantation. The NSF requires the NHS to:

- *Use national data to support planning and to identify local priorities, including the needs of black and minority ethnic groups*
- *Continue to expand renal dialysis capacity*
- *Join the UK registry of the Renal Association and take part in a national comparison*
- *Implement the NICE guidelines on home therapies*
- *Implement the NICE appraisal of immunosuppressive therapy*

### NICE guidance

NICE has recommended that all patients who are suitable for home therapies should be offered the choice of receiving therapies in this way, provided they are clinically suitable.

#### *'Saving Lives, Valuing Donors' – Organ Donation Taskforce report*

This report sets out key aims for organ and tissue transplantation over the next ten years and identifies good practice.

#### *'Organs for Transplant' – Organ Donation Taskforce Report*

This report made a series of recommendations relating mainly to reorganisation, which have been accepted by the Department of Health.

#### *Department of Health Operating Framework 2008/09*

This framework includes guidance relating to RRT growth and reinforces NICE guidance in relation to the provision of home dialysis:

***'Demand for Renal Replacement Therapy (dialysis and transplantation) is projected to rise by around five per cent per year until at least 2030. SCGs [Specialised Commissioning Groups] will wish to consider options for expanding the provision of satellite dialysis centres and offering more people the option of home dialysis, as well as expanding traditional acute dialysis units'.***

## 3. VISION

### 3.1 Our vision for renal dialysis services

Taking into account national policy and feedback from patient groups, the vision of the East of England SCG is to provide:

A service which where possible actively encourages enhanced and independent dialysis. It provides sufficient renal dialysis capacity to appropriate quality standards for those patients who choose renal dialysis or for whom home dialysis or peritoneal dialysis is not an option. Service provision across the region will be equal, based on patient need. The standards and markers of good practice stated in the renal NSF will form the basis of all future service development plans.

## 3.2 Supporting this vision

The planning assumptions to support this vision and guide our proposals are based on:

- *Six per cent growth in haemodialysis need*
- *Ten per cent of patients receiving home therapies by 2015*
- *Peritoneal dialysis at national average of 10.7 per cent by 2015*

The planning assumptions are set out below:

Vision	Planning assumption
Encouragement and support of the self care approach (where possible)	Choice of type of treatment for patients (where clinically appropriate) with support to make an informed choice.  Home therapy to be offered to all patients where clinically appropriate.
Sufficient renal dialysis capacity	Expansion of renal dialysis capacity, including satellite unit provision to improve access with effective transport services.  Expansion of renal dialysis capacity to take account of increase in home therapy and transplantation rate.  Patients on hospital/satellite dialysis to receive dialysis three times per week.  Renal dialysis facilities to be offered within 30 minutes travel time for the majority of patients.
Standard of dialysis facilities	New and current facilities to be developed and improved in line with specified requirements of size and cost efficiency.
Equality of services	Taking into account population age, deprivation and ethnicity to ensure fair access based on need.
Renal NSF standards and markers of good practice to form basis of future planning	Ensuring the relevant standards and markers have been reflected.  Standards beyond the scope of this plan will be taken forward by nurses, clinicians and individual PCTs.

### 3.3 Financial implications

Each of the 14 PCTs have already agreed to set aside £22 million to improve renal services in the region, so that if the proposals are approved the money is available to support the changes.

### 3.4 Service specification

Clinicians and nurses have been working over the summer to develop a clinical service specification so that any new renal dialysis unit providers will meet quality standards, if the proposals are approved.

As part of the service specification we also need input from you telling us what you want to see as part of service development across the east of England.

The feedback from this consultation will form part of the service specification which will be used to secure new, and improve existing, services.





## 4. PROPOSALS AND CONSULTATION

### 4.1 Our proposal

To expand renal dialysis services across the east of England region with a focus on areas of greatest need, including hospitals, satellite units and home therapies.

The aims of our proposals are to:

- *Improve equality of access to services, based on population need*
- *Improve the experience of patients by expanding patient choice where clinically appropriate*
- *Improve the balance of geographic access to services, including shorter travel times for patients, so that the majority are no longer than 30 minutes away from a unit*
- *Ensure that renal dialysis units are the right size and therefore provide cost-effective services*

No services are to be taken away, and existing patients will not be forced to move to another place for treatment.

## 4.2 What do renal dialysis patients value?

Informal consultation with patient groups and members of the public showed the key issues to be:

Treatment standards and patient choice	Patients value choices about their treatment and care.
Location of services	Patients value services that are closer to home, that are also co-located with other services they use.
Specification and design of units	Patients have helped to develop national specifications covering main renal units, satellite units and transplant units.
Patient transport	Transport is particularly important to renal patients, due to the frequency of hospital/satellite unit attendances. In relation to transport, parking cost and provision is also a key factor.
Holistic care	Patients have identified a range of services required to support them in the management of their condition. In particular these include psycho-social support, cultural needs and considerations, advice and information, excellence in staff communication, dietetics support, support to go on holiday, finance/benefits counselling and employment support.
Dignity and privacy	The need to be treated with dignity when undergoing treatment and having privacy when necessary.
Communication with health professionals	Patients and their carers value clear communication with staff caring for them and need to feel that they can ask questions.

## Patient representation

We appreciate the enormous value of working with patients and public representatives in the early stages of service development and planning, so we have incorporated a representative onto our Renal Project Board.

### Fiona Loud

Chair of The Kidney Alliance, a local Kidney Patient Association and East of England Renal Project Board member

*“The East of England SCG recognises that dialysis services need to grow in line with increasing demand and that patients value choice and high quality in their care. Having had dialysis treatment in our area for five years, I know how important it is that the services are there to meet our needs.*

*This is your chance to influence the way in which services are developed. Your involvement is important to ensure you get the service you need.”*

## Specialist medical representation

Having kidney specialists on the Renal Project Board allows us to tailor our plans, so that we can improve the quality of care for patients and receive a greater insight into how services work on a local level.

### Dr Alex Heaton

Nephrologist, Norfolk & Norwich University Hospitals NHS Foundation Trust and East of England Renal Project Board Member

*“The East of England SCG will be listening carefully to what people say and will take account of those views to ensure future service provision meets the needs of patients and their families.*

*This is an opportunity to expand renal dialysis services in a way which makes them more accessible to the people who need them now and in the future.”*

### 4.3 Locations for expansion of renal services

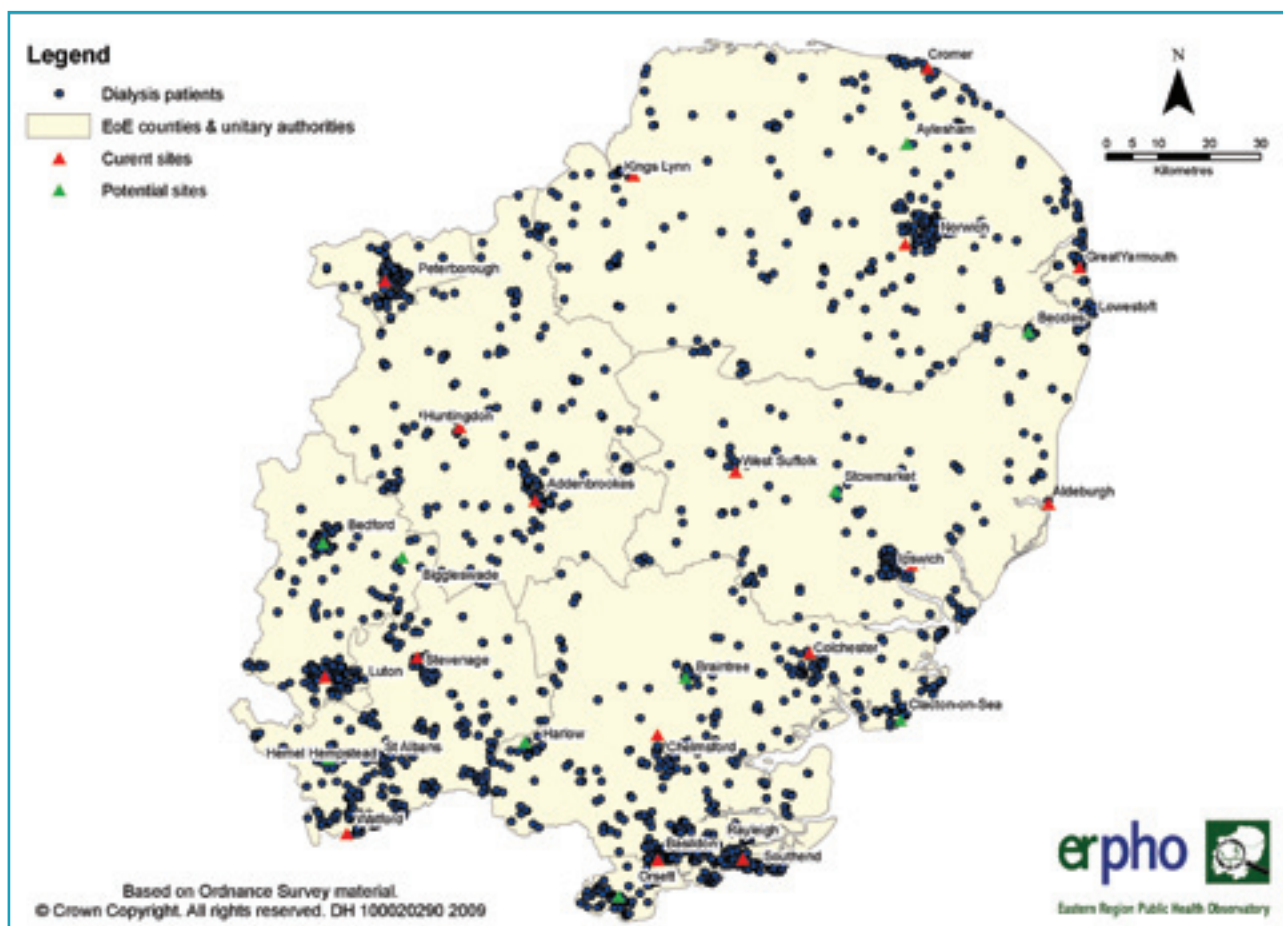
During the summer of 2009, clinicians were consulted about current services, capacity and future growth.

The factors that they identified as key to the improvement of renal dialysis services in the region are:

- *To release pressure on existing units when provision in areas close by may not be adequate*
- *Journey times to units (based on 30 minutes for the majority of patients), taking into account the rural locations of some existing and future patients*
- *Accessibility of new units (close to main roads or on existing hospital sites)*
- *Areas where there are more patients will need better service provision*
- *Proposed sites need to have the capacity to expand as patient numbers increase*
- *Build quality of new and existing units needs to meet national NHS standards*

Taking into account these factors, the proposed sites were identified by each PCT and are shown on the map below:

#### Current and proposed sites



### Proposed sites (table)

Primary Care Trust	Location	Number of new dialysis stations
West Essex/ East & North Hertfordshire	M11 corridor (eg Harlow, Bishop's Stortford) (or within a 30 minute radius)	Minimum 22 stations (with room for further expansion)
Bedfordshire	Bedford (or within a 30 minute radius)	Minimum 20 stations (with further room for expansion)
	Biggleswade (or within a 30 minute radius)	Minimum 8 stations (with further room for expansion)
North East Essex	Colchester (or within a 30 minute radius)	Minimum 8 stations (with room for further expansion)
Great Yarmouth & Waveney	Beccles or Bungay (or within a 30 minute radius)	Minimum 5 stations (with further room for expansion)
Norfolk	Aylsham (or within a 30 minute radius)	Minimum 6 stations (with room for further expansion)
Suffolk	A14 corridor (eg Stowmarket) (or within a 30 minute radius)	Minimum 5 stations (with room for further expansion)

### Other areas in the east of England

The East of England SCG is responsible for commissioning renal dialysis services throughout the east of England region.

We are constantly reviewing all of our renal dialysis services and during this consultation are inviting the views of patients, the public and staff right across the region – including the PCT areas not specified above.

## 4.4 Key Questions for Consultation

We would like to hear the views of patients, their families, carers and the staff working in this area of healthcare.

We are asking:

- 1. Do you agree that renal dialysis services within the region need to be expanded?*
- 2. Do you agree with the proposed locations for expansion of renal dialysis services?*
- 3. Do you agree with the numbers of stations in each location?*
- 4. What benefits or concerns do you see regarding the proposed developments for patients, families, carers and staff?*
- 5. Are there any aspects of renal dialysis service provision you feel should be taken into account to ensure a positive experience for renal dialysis patients?*
- 6. If you are a patient and are clinically eligible, would you consider home therapies?*

*Please see the feedback form inserted into this document to give us your views.*

## Evaluation of responses to the consultation

There will be an independent evaluation of all the responses to the consultation, including all written responses and outcomes of discussions from the consultation meetings.

This evaluation will then be fed into the final decision-making process, where your views will be taken into account by the Renal Strategy Board.

## 4.5 Decision-making process

### Key dates for consultation

December 14, 2009	Start of public consultation, including consultation with local Health Overview and Scrutiny Committees, patient groups and NHS staff.  Consultation documentation and public information available to view.
December 14, 2009 – March 8 , 2010	Consultation meetings and collation of feedback.
March 8, 2010	Deadline for consultation feedback.
March 9, 2010	Analysis of consultation outcome.
March 24, 2010	Recommendations from the Renal Strategy Board to the East of England SCG Board for a final decision.
April 2010	Final outcome document published.

## 5. HOW TO HAVE YOUR SAY

### 5.1 Responses in writing

There are many ways in which you can feedback your views on the proposals to us:

- 1. Fill in the form at the back of this document and return it to us by post using the envelope provided (no stamp is required)*
- 2. Write us a letter and return it to us using the envelope provided (no stamp is required)*
- 3. Log on to [www.eoescg.nhs.uk](http://www.eoescg.nhs.uk) and complete our form online*
- 4. Scan and email your completed feedback form to [renaldialysis@eoescg.nhs.uk](mailto:renaldialysis@eoescg.nhs.uk)*
- 5. Fax the form to us on 01279 666982*

If there is not a FREEPOST envelope enclosed in this document, simply send your feedback form or letter to:

FREEPOST RSEL-JKTR-LLCE  
East of England Specialised Commissioning Group  
Endeavour House  
Coopers End Lane  
Stansted  
Essex  
CM24 1SJ

### **The deadline for all feedback is March 8, 2010**

### 5.2 Come along to one of our consultation meetings

We are looking to speak with patients, families, carers, experts, staff and anyone with an interest in working with us on plans to develop renal dialysis services.

We are running a series of consultation meetings at the venues listed on the back page of this document. You will have the opportunity to listen to a presentation given by one of our commissioners, find out more about the proposed developments to renal services, talk informally with professionals and patients, participate in discussions and give us your views.

## Appendix A – Further information

### Organisations

#### Kidney Care Matters Online

The e-communications tool from NHS Kidney Care that aims to keep you informed and aware of what is happening across England to ensure successful consistent implementation of the renal National Services Framework

<http://www.kidneycare.nhs.uk/Default.aspx>

#### The Kidney Alliance

Organisation bringing together patients' voices and professionals committed to renal medicine to promote prevention and early identification of kidney disease, and high quality treatment for all patients at risk from, or identified with, kidney failure on an equal and uniform basis throughout the UK.

<http://www.kidneyalliance.org/>

#### UK National Kidney Federation (NKF)

UK national charity run by kidney patients to promote both the best renal medical practice and treatment, and the health of persons suffering from CKD or ERF. The NKF also supports the related needs of relatives and friends who care for kidney patients.

<http://www.kidney.org.uk/>

#### The East of England Specialised Commissioning Group (SCG)

Information about the East of England SCG and further documentation behind the renal project  
[www.eoescg.nhs.uk](http://www.eoescg.nhs.uk)

#### The Department of Health

[www.dh.gov.uk](http://www.dh.gov.uk)

#### NHS Direct

[www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)

### Documentation

#### The Renal National Service Framework (NSF)

[http://www.dh.gov.uk/en/Healthcare/Renal/DH\\_234](http://www.dh.gov.uk/en/Healthcare/Renal/DH_234)

#### Department of Health Operating Framework for 2008/09

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

#### Guidance on home therapies from the National Institute for Health and Clinical Excellence (NICE)

<http://www.nice.org.uk/TA048>

#### 'Organs for Transplant' - Organ Donation Taskforce report

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082122](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082122)

#### 'Saving Lives, Valuing Donors' – Organ Donation Taskforce report

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4090217](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090217)



## Appendix B – Key stakeholders

### Service user networks and voluntary sector

We are aware of the existence of the following service user groups, but would be delighted to hear from your group if you would like to have a say on renal dialysis services in the east of England

### Patient and public involvement groups linked to PCTs and other Trusts in the East of England

Addenbrooke's Kidney Patient Association  
United Norwich Kidney Patient Association  
Southend Hospital Association for Renal Patients  
Lister Kidney Foundation  
Family carers associations  
Councils for voluntary services  
Local Involvement Networks (LINKs)  
Racial Equality Councils  
Age Concern  
Diabetes UK  
National Kidney Federation  
British Kidney Patient Association  
Kidney Alliance  
Kidney Research UK  
British Renal Society  
UK Renal Registry

### Government and public representatives

Health Overview and Scrutiny Committees  
County councils and unitary authorities  
District councils  
Local MPs  
All Party Parliamentary Kidney Group

### Health and social care sector

The Renal Association  
The Renal Pharmacy Group  
NHS Kidney Care  
NHS hospitals  
Primary Care Trusts  
Local authority adult services  
GP practices and practice-based commissioning groups  
Local medical committees  
Local pharmaceutical committees  
Staff-side and union representatives  
Department of Health

### East of England Specialised Commissioning Group

## Appendix C – The team for this project

### Renal Advisory Group Chair:

Andrew Morgan, Chief Executive, NHS Bedfordshire

### Senior Responsible Owner:

Trevor Myers, Interim Chief Operating Officer, East of England Specialised Commissioning Group

### Senior Renal Commissioner:

Catherine Turner, East of England Specialised Commissioning Group

### Communications

Tina Starling, Senior Communications Manager, East of England Specialised Commissioning Group

Lucy Dominy, Communications Assistant, East of England Specialised Commissioning Group

# Appendix D

## Glossary of terms

**CKD** (Chronic Kidney Disease)

**ERF** (End-Stage Renal Failure)

**RRT** (Renal Replacement Therapy)

**NSF** (renal National Service Framework)

**NICE** (National Institute for Clinical Excellence)

**PCT** (Primary Care Trust)

**SCG** (Specialised Commissioning Group)

### **Immunosuppressive therapy**

Therapy used to decrease the body's immune responses, such as drugs given to prevent transplant rejection

### **Home therapy**

Renal dialysis in the home

### **Joint Health Overview and Scrutiny Committee**

Contains representatives from all local authorities in the East of England

### **Renal Strategy Board**

Established to assess the status of renal dialysis services in the East of England and create the strategy for improving it

### **Renal Project Board**

Manages the overall planning and consists of clinicians, patient representatives, members of East of England Specialised Commissioning Group and a representative from a PCT that will make the final decision on the future of renal services following the feedback received from the public consultation

### **Renal Advisory Group**

The Renal Advisory Group advises the Renal Project Board on the implementation of the renal dialysis services strategy



# Feedback

The East of England Specialised Commissioning Group is keen to receive your feedback on the proposals for renal services for people in the east of England.

We invite you to complete the following questions – you may answer as few or as many as you wish.

## Confidentiality

If you provide us with your details they will only be used as part of the public consultation and not be disclosed except as may be required by law. We would be grateful if you could provide personal information, as it will enable us to check we have received responses from a representative group of people and identify trends.

All consultation responses will be fully taken into account when decisions are made, irrespective of whether or not you provided personal details.

## Questions

1. Do you agree that renal dialysis services within the region need to be expanded? ☐ Yes ☐ No

Why is this?

2. Do you agree with the proposed locations for expansion of renal dialysis services? (see pages 13 and 14) ☐ Yes ☐ No

Why is this?

Please continue on a separate sheet if necessary.



3. Do you agree with the numbers of stations in each location? ☐ Yes ☐ No

Why is this?

4. What benefits or disadvantages do you see regarding the proposed developments for renal services for patients, families, carers and staff?

5. Are there any aspects of renal dialysis service provision you feel should be taken into account to ensure a positive experience for renal dialysis patients?

6. If you are a patient and are clinically eligible, would you consider home therapies? ☐ Yes ☐ No

Why is this?

Please continue on a separate sheet if necessary.



1. Are you (please tick):

- ☐ a) Providing your own response  
or  
☐ b) Submitting your response on behalf of an organisation or patient group  
(Go to question 8)

2. How old are you? (please tick)

- ☐ Under 25      ☐ 25-34      ☐ 35-44      ☐ 45-54  
☐ 55-64      ☐ 65 or over      ☐ Prefer not to say

3. Are you (please tick):

- ☐ Male      ☐ Female      ☐ Prefer not to say

4. Which ethnic group do you consider you belong to? (please tick)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> White: British               | <input type="checkbox"/> White: Irish                     | <input type="checkbox"/> White: other                     |
| <input type="checkbox"/> Asian/Asian British: Indian  | <input type="checkbox"/> Asian/Asian British: Pakistani   | <input type="checkbox"/> Asian/Asian British: Bangladeshi |
| <input type="checkbox"/> Asian/Asian British: other   | <input type="checkbox"/> Mixed: white and black Caribbean | <input type="checkbox"/> Mixed: white and Black African   |
| <input type="checkbox"/> Mixed: white and Asian       | <input type="checkbox"/> Mixed: other mixed background    | <input type="checkbox"/> Black/black British: Caribbean   |
| <input type="checkbox"/> Black/black British: African | <input type="checkbox"/> Black/black British: Other       | <input type="checkbox"/> Chinese                          |
| <input type="checkbox"/> Other                        | <input type="checkbox"/> Prefer not to say                |   |

5. Do you consider that you have a disability? (please tick)

- ☐ Yes      ☐ No      ☐ Prefer not to say

6. Please can you give your full Postcode below. This will help us to monitor whether we are receiving responses from across the region.

7. Are you employed by the NHS? (please tick)

- ☐ Yes      ☐ No      ☐ Prefer not to say

8. Please complete the following section if you are responding on behalf of an organisation or patient group.

Name of the organisation or patient group you are submitting this response on behalf of:

Please tell us who the organisation patient group represents (patients, staff etc) and, where applicable, how you assembled the views of the members.

There are many ways in which you can feedback your views on the proposals to us:

1. Fill in and return this form to us by post using the envelope provided (no stamp is required)
2. Write us a letter and return it to us using the envelope provided (no stamp is required)
3. Log on to [www.eoescg.nhs.uk](http://www.eoescg.nhs.uk) and complete our online form
4. Scan and email your completed feedback form to [renaldialysis@eoescg.nhs.uk](mailto:renaldialysis@eoescg.nhs.uk)
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FREEPOST RSEL-JKTR-LLCE  
East of England Specialised Commissioning Group  
Endeavour House  
Coopers End Lane  
Stansted  
Essex  
CM24 1SJ

**The deadline for all feedback is March 8, 2010**

If you would like to see a copy of the outcome summary from the consultation after the decision has been made in March 2010, please complete your details below to tell us how you would like to receive it (please tick)

☐ Post

Name.....

Address .....

.....

.....

☐ Email

Name.....

Email address.....

Thank you for taking the time to give us your views on our proposals for changes to renal services in the region.



## Notes

## Notes

## Dates and locations of consultation meetings in 2010:

Date	Area	Location
Thursday, January 7 10am – 12pm	Great Yarmouth	Celebration Suite – James Paget Hospital, Burrage Centre, Lowestoft Road, Gorleston, Great Yarmouth, NR31 6LA.
Thursday, January 7 2pm – 4pm	Norwich	Benjamin Gooch Lecture Theatre, Norwich and Norfolk Hospital, Colney Lane, Norwich, NR4 7UY.
Tuesday, January 12 2pm – 4pm	Stowmarket	Civic Offices, Council Chambers, Milton House, Milton Road South, Stowmarket, Suffolk, IP14 1EZ.
Thursday, January 14 11am – 1pm	Peterborough	Thorpe Lodge Hotel, 83-85 Thorpe Road, Peterborough, PE3 6JQ.
Friday, January 15 2pm – 4pm	Cambridge	Addenbrooke's Hospital Clinical School, Seminar room five, Hills Road, Cambridge, CB2 2SP.
Monday, January 18 10am – 12pm	Rayleigh	Mill Hall, Bellingham Lane, Rayleigh, SS6 7ED.
Thursday, January 21 10am – 12pm	Luton	The Board Room, Old Ward Block, Luton and Dunstable Hospital, Lewsey Road, Luton, LU4 0DZ.
Thursday, January 21 2.10pm – 4pm	Bedford	Medical Institute, Postgraduate Centre, Bedford Hospital, Kempston Road, Bedford, MK42 9DJ.
Friday, January 22 10am – 12pm	Stevenage	Lister Hospital, Corey's Mill Lane, Stevenage, SG1 4AB.
Friday, January 22 2pm – 4pm	Harlow	Latton Bush Centre, Southern Way, Harlow, CM18 7BL.
Monday, February 1 2pm – 4pm	Colchester	Lecture theatre, Postgraduate Centre, Colchester Hospital, Turner Road, Colchester, CO4 5JL.

## Request a consultation meeting

If you are involved in a patient or community group and would like a separate consultation meeting, please contact:

## East of England Specialised Commissioning Group Communications team

Email: [renaldialysis@eoescg.nhs.uk](mailto:renaldialysis@eoescg.nhs.uk)

Tel: 01279 666388

This consultation document is produced on behalf of the 14 Primary Care Trusts (PCTs) in the east of England:

NHS Great Yarmouth and Waveney  
NHS Peterborough  
NHS Cambridgeshire  
NHS Norfolk  
NHS Suffolk  
NHS Mid Essex  
NHS North East Essex  
NHS South East Essex  
NHS South West Essex  
NHS West Essex  
NHS East and North Hertfordshire  
NHS West Hertfordshire  
NHS Bedfordshire  
NHS Luton

The document is also available from [www.eoescg.nhs.uk](http://www.eoescg.nhs.uk)

If you would like information in another language or format, please ask us.

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھیے۔

যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

यदि आपको सूचना किसी अन्य भाषा या अन्य रूप में चाहिये तो कृपया हमसे कहे

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Jezeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.

Se deseja obter informação noutro idioma ou formato, diga-nos.

Türkçe bilgi almak istiyorsanız, bize başvurabilirsiniz.

Если вы хотели бы получить информацию на другом языке или в другом формате, просим обращаться в администрацию.

如欲索取以另一语文印制或另一格式制作的资料，请与我们联系。

## Renal Consultation

East of England Specialised Commissioning Group  
Tel: 01279 666388  
Email: [renaldialysis@eoescg.nhs.uk](mailto:renaldialysis@eoescg.nhs.uk)

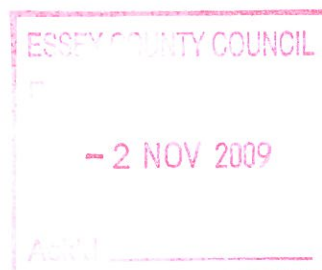
Our ref: CP/vg  
Direct Line: 01279 827080  
[Chris.pocklington@pah.nhs.uk](mailto:Chris.pocklington@pah.nhs.uk)

Princess Alexandra Hospital  
Hamstel Road  
Harlow  
Essex  
CM20 1QX

27 October 2009

Tel: 01279 444455

Mr David Moses  
Head of Member Support & Governance  
Essex County Council  
PO Box 11, County Hall  
Chelmsford  
Essex. CM1 1LX



Dear Mr Moses

## Health/NHS Overview and Scrutiny: Review of the Dialysis Services for the residents of Essex

Thank you for your letter of the 16<sup>th</sup> September 2009 and the final report with regards to the above.

The Trust Board at the Princess Alexandra Hospital NHS Trust recognises the comparative lack of renal services in the West Essex and East Herts area. The Trust has recently made some progress in rectifying this by developing weekly nephrology clinics in Harlow, in conjunction with Mid Essex Hospital. This pilot began in summer 09 and we hope to work in partnership to expand this service in the future.

Our Executive Director of Delivery – Darren Leech is a member of the East of England Specialist Commissioning Renal Advisory Group and he advised that many of the recommendations in your review are indeed part of the plans of that group.

We would be pleased to discuss this matter with you at any point in the future and in the meantime we will continue to work with the Renal Group and West Essex PCT to further improve access to renal services for the population we serve.

Yours sincerely,

  
**Chris Pocklington**  
Chief Executive

Cc Trevor Myers  
Chief Operating Officer  
EoE Specialist Commissioning Group  
3<sup>rd</sup> Floor Endeavour House  
Stansted Airport  
Essex.

Cc Darren Leech – Executive Director of Delivery – TPAHT

Mr David Moses,  
Head of Member Support and Governance,  
Essex County Council,  
PO Box 11, County Hall,  
Chelmsford,  
Essex, CM1 1LX,

Wellington House  
133-155 Waterloo Road  
LONDON  
SE1 8UG

Tel: 020 7972 2000  
Direct Line: 020 7972

8 December 2009

Dear David,

Thank you for your letters to Donal O'Donoghue and myself of 16 September about the Health/NHS Overview and Scrutiny Review of the Dialysis Services for the residents of Essex. I am very sorry for the long delay in replying.

As you may know, we have offered help to facilitate the East of England Development Programme and NHS Kidney Care, our service implementation arm, has funded a post through the East of England Specialised Commissioning Group to focus on the provision of home haemodialysis. This post has been in place for about 18 months and will be reviewed at the end of the year.

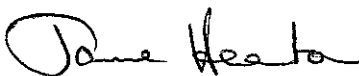
You asked us to comment on recommendation 15 about free prescriptions. The Government agrees that it is vitally important that people get the medicines they need and that we need a fairer system of prescription charging in England. The Prime Minister announced important new proposals for prescription charges in England on 23 September 2008 with the announcement that patients with cancer would be exempted from prescription charges from 2009, and that in time patients with long-term conditions would be exempted from charges.

Prescription charges for cancer patients were abolished from 1 April 2009. Patients undergoing treatment for cancer, including the effects of cancer or the effects of current or previous cancer treatment, can apply for a certificate that will give them exemption.

Professor Ian Gilmore President of the Royal College of Physicians, has now submitted his report on the prescription charges review to the Department of Health. The Department is considering the recommendations. We intend to publish the review's report and a response to the recommendations in due course.

I hope this is helpful.

Yours sincerely,



Jane Heaton  
Renal and Vascular Policy Manager  
Vascular Programme