Renal Revelations

A report agreed by the NKF Executive committee (29th November 2003) to encourage informed discussion and debate surrounding the publication of the Governments Renal National Service Framework.

It is hoped that this document will assist Kidney Patient Associations, and Kidney Patients themselves, to form views about renal provision which can then be used to judge the effectiveness of the NSF when published.

The information is for debate and discussion only and does not represent NKF policy.

29th November 2003

A service in crisis ?

At the time this report was prepared (November 2003) it had already become clear that

- Renal Failure treatment for the current 34,000 patients costs 2% of the National Health Service budget
- ESRF patient numbers are set to double in the next ten years
- The National Service Framework for renal services will not contain targets or costing
- Ring fenced funding for renal (and other therapy areas) has been removed
- Commissioning is in disarray with new commissioners failing to understand renal issues or being prepared to fully fund the existing service.
- The much vaunted (450 new dialysis stations over the past three year period) has not materialised – turning out to be a political promise of 450 new OR REPLACEMENT dialysis stations
- Dialysis units are overstretched or "full up" making new admissions problematic and "dialysis holidays" sessions impractical
- A series of "Nice" appraisals or guidelines has been set in motion by Government, Immunosuppressant drugs, Home versus Hospital Haemodialysis, Anaemia treatment, - all treatments which have huge cost implications to government.
- Despite clear announcements favouring an increase in Transplantation – Transplant surgeons are in short supply and the Government has begun a programme of rationalising down the number of Transplant centres
- The UKTransplant business plan to increase Transplant numbers appears to be starved of resource and failing to meet its own targets
- Both "Dialysis services" and "Transplantation services" rate amongst the poorest performers when compared to other European markers

Is it fair to ask whether Renal Services have been capped ?

There cannot be any doubt that renal patients are expensive to treat. 34,000 ESRF patients are not a large group by medical standards yet together they account for 2% of the NHS budget. Faced with a doubling of patient numbers over the next ten years it follows that renal will by 2013 swallow a full 4% of the NHS budget. Whilst nephrologists will argue that early detection and prevention might hold down the costs, politicians will know that preventative measures also have a cost. Although politicians would not admit to it, it is worth considering that faced with this runaway expenditure a decision may have been made to hold renal down to 2% of the NHS budget.

A 2% cap on existing patient numbers would mean that service provision will remain static, but on the growing patient numbers a 2% cap would have a devastating effect, meaning that either provision for patients would be halved or half of patients will not be treated.

Renal Patient Numbers

The following chart shows that the current proportion of Dialysis versus Transplant patients will not be maintained over the next ten years:-

Renal Patient Numbers - Growth and shortages

Year	ESRF Patients	Dialysis	Transplantation
2003	34000	15000	19000
2013	68000	30000	38000

However - UKTransplant agree that numbers likely to be Transplanted by 2013 are more likely to be around 24000

This leaves the table looking like this :-

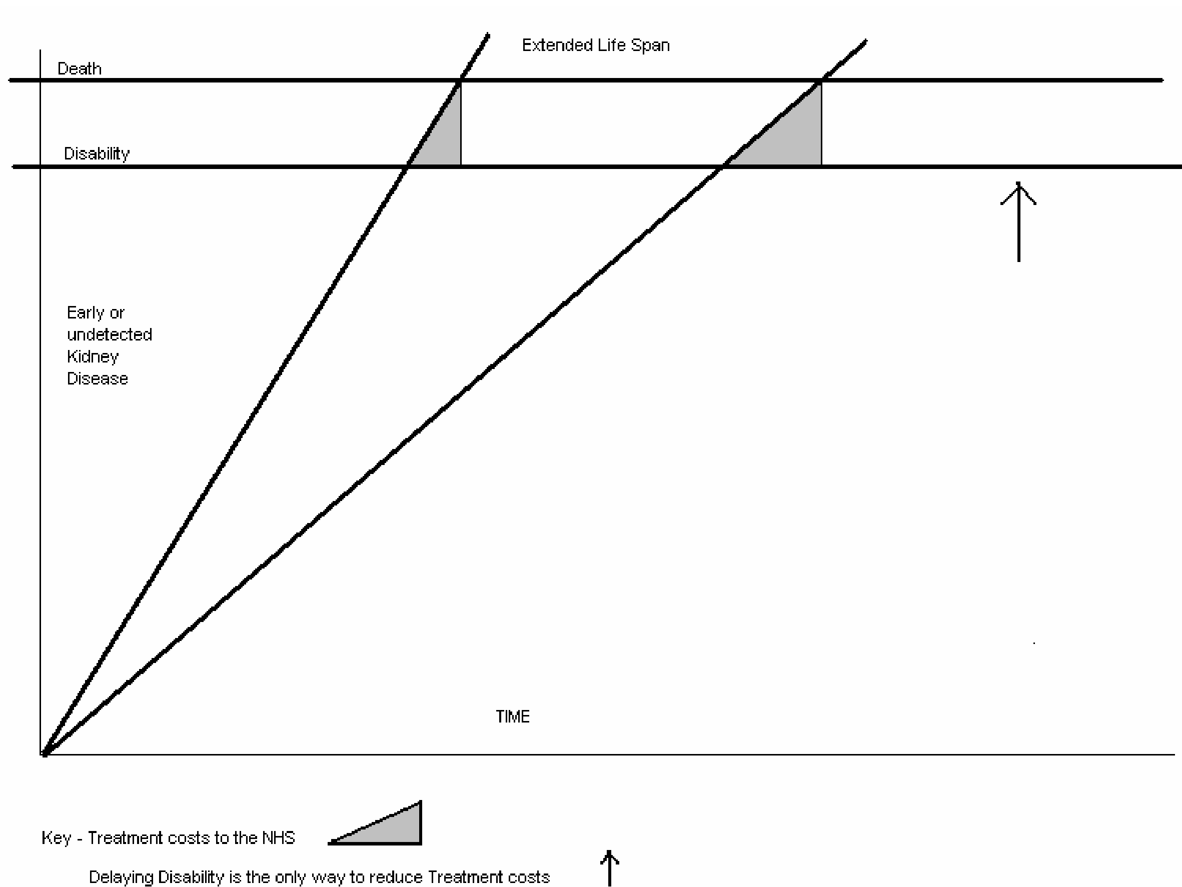
2013	**68000**	**44000**	**24000**

To Provide HaemoDialysis stations for the extra 29000 patients by 2013 would require Space, resource and staffing for a further 483 machines each and every year

How much does a renal patient cost ?

What a renal patient costs the NHS will depend on many variables, however what is very clear from the chart on the following page is that extending a renal patients life span increases the cost to the NHS. As can be seen from this chart – the cheapest patient is the patient who progresses in a vertical line from South to North without treatment. The more the treatment is successful, the longer the life span, the greater the cost to the NHS.

See over



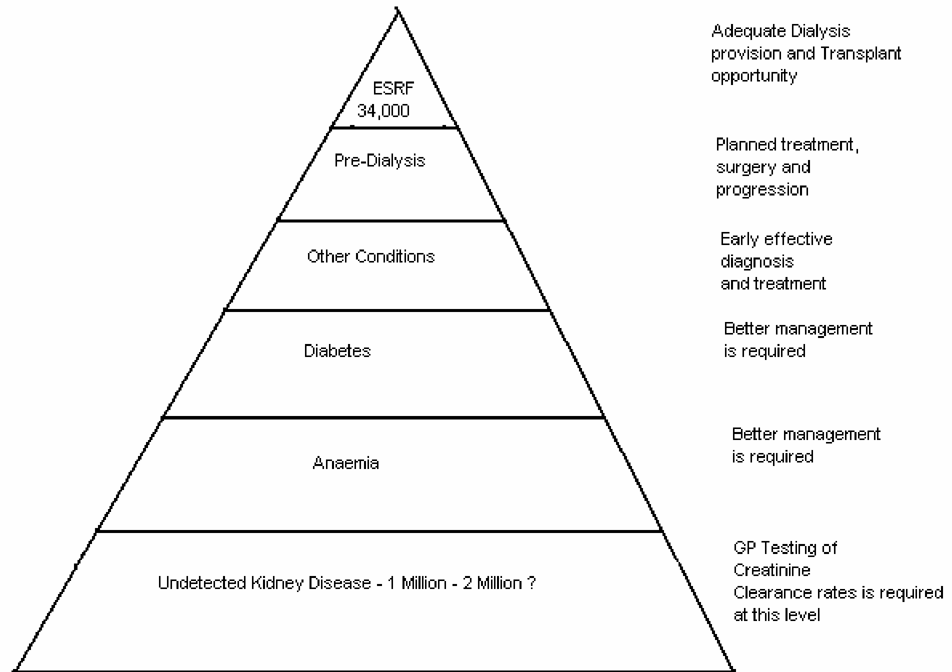
What becomes very evident from looking at this chart, is that the only cost effective way of treating a renal patient is to delay the onset of disability. The higher you can push the disability line, the smaller becomes the triangle of expenditure. Were this to be done it would have benefits in respect of patient quality of life and to the NHS budget.

Delaying Disability

It is evident looking at the above chart that any action to be taken should be in the large area below the disability line – but what is this area ? What is it comprised of and how many people are in it ? Can they be identified ?

The diagram that follows overleaf shows the "whole renal community" including all those that would appear in the above graph – only this time they have been roughly grouped. The graph also depicts the relative volumes of patients.

See over



Halting the Patient Journey

Each of the five sections shown in the graph (below ESRF) consist of a bodyof people gradually or speedily progressing upwards into the next tier. The pyramid is smaller at the top than it is at the bottom because many die on route. Nephrologists are right to argue that proper, better management of the groups in each segment can delay or prevent progression upwards through the pyramid.

It must be right to identify and then treat at an early stage all patients in each of the above segments. It also follows that patients in the lower segments may be unaware of their own condition; and the only answer to this is to involve G.P's in screening for creatinine clearance rates. Whilst as a nation we may not wish to embark on blanket screening of the population, there must be a case for screening those suffering from Anaemia, Diabetes, high blood pressure etc

THE NSF and the NKF

The NKF has since its inception only concerned itself with the top two layers of this pyramid, however it is hoped (indeed the NKF has argued for) that within the NSF attention will be given to early prevention and detection of renal disease. It can be argued that the time is now approaching, when the NKF must seriously consider whether or not it should position itself to become the spokesman for and champion of, all people with renal disease wherever they exist within this pyramid. Such a change of

emphasis cannot be undertaken lightly as the result would inevitably lead to a radically different organisation with different focus's to those that exist today. It may be that the new role would be too large an undertaking and that members would not like the dilution of effort to support ESRF patients, but the NKF Executive committee is duty bound to consider this matter under rule 3 of its constitution.

But what is to be done today ?

If we reconsider the first chart :-

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Most would accept that however much we campaign, we are not going to get the huge increases needed to cope with the dialysis population, and that only leaves one option – to dramatically increase the numbers of Transplants carried out each year.

The NKF has now had exploratory talks with UKTransplant and with representatives of renal industries at the highest level. It would appear that there may be grounds to believe that under the umbrella of the NKF these major players could be brought together, and that several initiatives could be undertaken that would have the one aim of improving transplantation in the UK and generating a large increase in the volume of Transplants undertaken.

National Kidney Federation, 6 Stanley Street, Worksop, Nottinghamshire, S81 7HX
Telephone – 01909 487795 Fax 01909 481723 Email nkf@kidney.org.uk