1. INTRODUCTION

1.1 I was appointed as External Visiting Transplant Advisor to work with the Renal Unit to set and monitor standards and raise its profile. I began work in November 2002 and have visited Portsmouth on a weekly basis since then. I have worked closely with all members of the Renal Unit staff including surgeons, nephrologists, nurses, transplant co-ordinators and administrators. I have also worked closely with members of the Trust Executive, particularly the Director of Nursing, Medical Director and the Director of the Surgical Division. I have made been made welcome by all and received excellent levels of co-operation.

1.2 I have regularly attended the monthly meetings of the Trust Board Renal and Transplant Sub Committee. I have attended academic and clinical meetings in the Unit as well as meetings with patients' representatives. I have had regular meetings with most Renal Unit staff in groups and as individuals. I have assisted the Unit in producing new rotas, protocols and new collaborative working arrangements.

1.3 I believe I now have objective insight into most areas of activity within the Renal Unit and have an appreciation of the many difficulties that have faced the Trust in its attempt to bring about significant change.

2. ACHIEVEMENTS

2.1. I propose to outline my view of the progress made by the Unit and the Trust in achieving the targets set by the Review Body. I will not comment on all recommendations but will focus on the most important (to me) and controversial.

2.2 The Renal Unit moved to new facilities at the Queen Alexander Hospital in autumn 2002. These are purpose built and of a high standard. This move has produced a significant improvement in moral throughout the Unit.

2.3 Transplant surgeons job plans were reviewed and individual appraisals carried out. It was recognised that there was a need for more than 1.75 full time equivalents to provide surgical services to the Renal Unit particularly with the proposed changes in working arrangements. New rotas were drawn up by the Clinical Director of the Surgical Division, Mr Graham Sutton, with the full agreement of the surgeons involved. These changes required more sessional commitment to the Renal Unit and this was rewarded by extra sessional payment on a short term basis.

2.4 It was agreed by the Trust that at least a further 0.5 WTE of transplant surgical service was required within the Unit and a business case was submitted to that effect. Funding has been obtained in fact for a 1.0 whole time equivalent post and the job description has been produced and submitted for approval.

2.5 An internal audit showed that the use of surgical lists for dialysis access procedures and related surgery was not being used with optimal efficiency. This has been addressed in the short term by the appointment of an associate specialist dedicated to access surgery and is likely to be greatly assisted by the work of the Dialysis Access Nurse who will work with surgeons to optimise the efficiency of the system.

The plans to appoint full time transplant and access surgeons will also improve the commitment to improving the efficiency of access provision.

Increasing transplant activity will be more difficult but one significant step forward has been taken by the appointment of a Live Donor Co-ordinator in March 2003 and a plan to double live donor transplantation to approximately 25 per year.

There is also a plan to begin to utilise certain types of non heart beating kidney donors.

2.6 The appointment of a whole time transplant surgeon will give a total of 2.75 whole time equivalent produced by five surgeons and there is no doubt in my mind that this is adequate for a unit of this size.

2.7 The concept of daily multidisciplinary transplant ward rounds attended by physicians, surgeons and nurses was accepted and put into practice early in 2003 and was seen to be working well. Evidence based written protocols were developed for immunosuppressive therapy and treatment of rejection and gained the agreement of all teams.

The idea was that surgeons and physicians should share care according to their expertise on a daily basis. This required a physician and surgeon of the week and this itself required considerable manipulation of medical and surgical rotas. For both teams this produced much better discipline on the wards and avoided the previous problem of multiple conflicting inputs on any particular day. It became clear to the nursing staff and junior doctors that there was a surgeon and physician of the week and difficult decisions could be discussed in an inter-disciplinary manner. This was a very large step for both physicians and surgeons to take and both groups took time to adjust.

2.8 In May there was, unfortunately, a breakdown of relationships between surgeons and physicians which occurred as a result of problems with working in a collaborative way on ward rounds. It became clear to me that it was difficult if not impossible for some surgeons to trust the judgement of their medical colleagues and there was the threat of a return to the previous dangerous practice of conflicting opinions at the bedside. Attempts were made by the Trust, with my assistance, to discuss these operational problems as a group but it became clear during these discussions that compromise was not possible. I have discussed this in more detail in Section 3.

2.9 The nephrologists made significant changes in their management of inpatients by instigating a system of paired nephrologists on call for (a) transplantation and (b) end stage renal failure and nephrology. The physician responsible for transplantation worked closely with the surgeon responsible for transplantation.

2.10 There was great discussion about multidisciplinary clinics and clinicians were encouraged to visit other renal units. Dr John Scoble visited the Unit to discuss different ways of working within the Unit. The concept of multidisciplinary clinics was agreed and pairs of nephrologists are now working together in low clearance clinics with some crossover between consultants and this has been a greatly assisted by the appointment of the Low Clearance Nurse Specialist. The clinicians realise that further changes to this multidisciplinary working will evolve in the future.

2.11 Professional accountability of the transplant surgeons was transferred to the Surgical Division and this proved very popular with some of the transplant surgeons. My feeling is that this did not go far enough and there was a clear agenda that there should be a Surgical Director of the Transplant Unit and this Unit should be outwith the Directorate of the Renal Unit. It was also felt that management of the renal transplant budget by the surgeons would give them much more of a stake in the running of the Unit and command respect from their nephrological colleagues. A renal budget has been identified thanks to the efforts of Steve Williamson, the new Renal Unit Manager, and once this has been fine tuned there is no reason why management of the transplantation budget cannot be transferred to the Head of Transplantation whether this person works within the Renal Unit or within the Surgical Division.

2.12 I have been most impressed with the commitment of Trust Board Members to the future success of the Renal and Transplant Unit. The, Director of Nursing and the Medical Director have both worked tirelessly to facilitate change, support staff and to provide resources where necessary. I do not believe the Trust could have done more to promote transplantation in the Trust.

2.13 The Renal and Transplant Clinical Governance Group has been successfully set up and has been working well.

3. UNRESOLVED PROBLEMS

3.1 At this stage I wish to draw attention to an internal investigation which has been taking place within the Trust during 2002-2003. I believe the Review Panel were made aware of this at their last visit. There was a series of complaints by one surgeon against two of his surgical colleagues invoking, amongst other things, bullying and racial discrimination. This investigation has taken place over the last nine months and although the report has been finally produced, to my knowledge its findings have not yet been made known to the clinicians involved. This process has created an exceptionally stressful atmosphere within the Unit and has made collaborative working difficult if not impossible.

3.2 It is my belief that this investigation and the longstanding reasons which led to its instigation have undermined the relationships between surgeons and physicians as well as surgeons and surgeons within the Unit

3.3 Currently none of the four consultant surgeons who make up this permanent establishment are working within the Renal and Transplant Unit. Mr Kamal Abusin is undergoing assessment and professional development at Guy's and St Thomas' Transplant and Breast Units. This year-long attachment commenced in August 2003 although he was actually on leave from the Portsmouth Trust from April this year. He is still employed by the Trust and may return to duties in 2004.

3.4 Mr Sami Sadek and Ms MaritiaWalters have been on sick leave from the Renal Unit since May this year although they continue to perform their general surgical duties within the Trust. They have made it clear to me that the stress of working on the Renal and Transplant Unit has led directly to this course of action and that they do not intend to return to the Unit under any circumstances.

3.5 Mr Martin Wise decided in June this year, on the basis of medical advice, to step down from the Unit although he does still fulfil his other surgical duties within the Trust. I believe that he has found the out of hours commitments of the Unit as well as the interpersonal problems between other members of the team highly stressful and he has indicated that it is unlikely that he will return to active duty on the Renal and Transplant Unit in the future.

3.6 The timing of the loss of surgical support for the Unit is interesting. With the temporary departure of Mr Abusin in April the three remaining surgeons initially agreed to a more onerous one in three rota and it appeared that the Unit was still on course to achieve the targets set by the Review Panel.

3.7 The flashpoint which caused Mr Sadek to step down from the Unit, soon to be followed by his other two colleagues, was a problem with joint ward rounds for transplant patients. It proved impossible to resolve the issue of collaborative working at the bedside and to me this clearly indicated the deep-seated nature of the mistrust and dislike between some physicians and surgeons.

3.8 The surgical duties within the Unit are now being performed on a locum basis by Professor Van Wyk, Mr Pandy and Mr Lewis. The Transplant Programme which was transferred to Oxford during June this year is now fully active again.

3.9 Funding for a new full time transplant surgeon has been obtained and a job description submitted to the Royal College of Surgeons for approval.

4. CONCLUSIONS

4.1 The many achievements described above show determination both by the Trust and the staff of the Renal and Transplant Unit to improve standards and working relationships. My feeling is that the current surgical staffing problems are temporary and can be resolved over the next six to twelve months. Furthermore I believe that the change in surgical staffing of the Unit is a prerequisite for collaborative working in the future and it is easy to detect an improved, more friendly working environment within the Unit in the last three months.

4.2 I would like to see the new full time Transplant Surgeon appointed in the next three months, a return to duty for Mr Kamal Abusin and the renewal of two of the part time transplant posts shared with general surgery.

4.3 I believe that the environment and infrastructure within the Unit and the change in attitude of the staff means that the Unit is a much more supportive and friendly environment in which surgeons and other staff can practice. I would therefore recommend an extension of a further twelve months to enable these plans to come to fruition and a re-inspection thereafter.