SPECIAL MEETING OF THE LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: **FRIDAY, 28 SEPTEMBER 2018**
TIME: **2:00 pm**
PLACE: **Meeting Rooms G.01 and G.02 - City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Cutkelvin (Chair of the Committee)
Councillor Chaplin
Councillor Cleaver
Councillor Fonseca
Councillor Dr Moore
Councillor Pantling
Councillor Dr Sangster

Leicestershire County Council

Dr R.K.A.Feltham CC (Vice-Chair of the Committee)
Mrs A Hack CC
Mr D Harrison CC
Dr S Hill CC
Mr T Barkley. CC
Mrs J Richards CC
Mrs M Wright CC

Rutland County Council

Councillor G Conde
Councillor Miss G Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Julie Harget**, Democratic Support on (0116) 454 6357 or email Julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HWLL	Healthwatch Leicester and Leicestershire
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
RSE	Relationship and Sex Education
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. THE CONSOLIDATION OF LEVEL 3 INTENSIVE CARE **Appendix A (Pages 1 - 78)**

Members will continue their consideration of a report from the University Hospitals of Leicester (UHL) relating to the Consolidation of Level 3 Intensive Care. The report and associated documentation was considered as an item of any other urgent business at a meeting of the Leicestershire, Leicester and Rutland (LLR) Joint Health Scrutiny Committee on 4 September and due to time factors, Members agreed to reconvene to enable all members of the committee to contribute to the discussion.

The report and supporting documentation considered at the meeting on 4 September 2018 are attached at Appendix A as follows, along with a draft minute extract from that meeting.

Draft Minute Extract from the meeting of the LLR Joint Health Scrutiny

Committee held 4 September 2018 (**Appendix A1)**

Questions submitted at the meeting of the Leicester City Council Health and Wellbeing Scrutiny Commission held 23 August 2018 and the meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee held 4 September 2018 (**Appendix A2)**

The Consolidation of Level 3 Intensive Care – Report from the UHL. **(Appendix A3)**

Leicestershire County Council

Minute extract of the meeting of the Health Overview and Scrutiny Committee – 22 February 2015 **(Appendix A4)**

The Future of Intensive Care at UHL. Report submitted to the meeting held 22 February 2015. **(Appendix A5**)

Leicester City Council

Minute extract of the meeting of the Health and Wellbeing Scrutiny Commission held 25 March 2015. **(Appendix A6)**

The future of Intensive Care at UHL. Report submitted to the meeting held 25 March 2015**.(Appendix A7)**

Rutland County Council

Minute extract of the meeting of the Adult and Health Scrutiny Panel held 5 April 2018**. (Appendix A8)**

Presentation to the meeting of the Adult and Health Scrutiny Panel held 5 April 2018. **(Appendix A9)**

Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: TUESDAY, 4 SEPTEMBER 2018 at 10.00am

P R E S E N T :

Councillor Cutkelvin – Chair of the Committee
Dr R.K.A.Feltham CC – Vice Chair of the Committee

Leicester City Council

Councillor Chaplin
Councillor Dr Moore

Councillor Pantling

Leicestershire County Council

Mr T Barkley CC
Mrs A Hack CC
Mr D Harrison
Dr S Hill CC
Mrs J Richards CC
Mrs M Wright CC

Rutland County Council

Councillor Conde
Councillor Miss G Waller

In attendance

Micheal Smith – Manager of Healthwatch Leicester and Leicestershire
Dr Janet Underwood – Healthwatch Rutland
Harsha Kotecha – Chair of Healthwatch Leicester and Leicestershire

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cleaver, Fonseca and Dr Sangster.

2. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business on the agenda.

Dr Feltham, C.C. declared that he worked for the NHS in Northamptonshire.

Dr Janet Underwood declared that she had made a representation to Leicester City Council, that was independent to her position in Healthwatch Rutland. The representation related to the consolidation of the Level 3 Intensive Care Units. It was agreed that this did not constitute a declaration of interest that meant she could not continue with the upcoming debate.

7. ANY OTHER URGENT BUSINESS

The Chair agreed to take the following item of Any Other Urgent Business in accordance with the Scrutiny Procedure Rules Rule 14 (Part 4E) of the Council's Constitution.

The Consolidation of Level 3 Intensive Care

The Chair agreed to take the report as urgent on the grounds that it needed to be considered before the next meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee.

8. THE CONSOLIDATION OF LEVEL 3 INTENSIVE CARE

The Chair invited the following members of the public to read out their questions which had all been received in accordance with the Scrutiny Procedure Rules Rule 10 (Part 4E) of the constitution.

Ms Jean Burbridge

"The law requires commissioners and providers to involve the public when making changes to the provision of NHS healthcare. NHS bodies discharge this duty by carrying out consultations. There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services, usually involving a change to the range of services available and/or the geographical location from which services are delivered. Not only is a change in service location being proposed in UHL's full business case, but it is a change in the location of a **core** service, that is, one on which numerous other service depend and one where change has significant ramifications for the rest of the hospital. **Why did UHL consider it possible to proceed without a full public consultation and will the committee ensure that this omission is rectified and recommend that full public consultation takes**

place?"

Giuliana Foster

"Why has UHL been planning to close level 3 intensive care at the Leicester General Hospital since at least 2015 and yet still not consulted the public?"

Ms E Brenda Worrall

“Given the recent ruling by The High Court (HHJ Jarman QC sitting as a High Court Judge) in quashing a decision by the Corby Clinical Commissioning Group over failure to undertake public consultation, is there a danger that the local NHS could find itself on the wrong side of the law if it proceeds to remove services as important as level 3 intensive care from Leicester General Hospital without full public consultation? A legal challenge will be costly in time, money and reputation. I therefore urge you to recommend full public consultation”.

Ms Warrington

"Why is the NHS undertaking to consult the public on ‘our plans for acute reconfiguration’ (Next Steps to Better Care in Leicester, Leicestershire and Rutland, August 2018 p40) but is not consulting the public on the reconfiguration of intensive care and other services such as kidney services now?"

Mr A Ross

“Although the scrutiny committee does not have the right to impose its views on the local NHS, will it state its desire to see a full public consultation take place in relation to the closure of level 3 intensive care and the consequent downgrading of the Leicester General Hospital?”

The Chair also referred Members to the questions relating to this issue, that had been brought to the meeting of the Leicester City Council Health and Wellbeing Scrutiny Commission on 23 August 2018. These were circulated for reference. The Chair thanked the members of the public for their questions and invited representatives of University Hospital Leicester (UHL) to respond to the issues raised.

Mark Wightman, Director of Strategy and Communications UHL, explained that with regards to the consultation, their response and the clinical risk remained the same as it did in 2015.

The Chair explained that following the article in the Mercury in March 2018, members of the public had understandably interpreted the move of the ICU as closure of the Leicester General Hospital by stealth. Whilst she did not believe that this was the intention of UHL, she sympathised with the public’s concern of this as the conversation had not been held in the public domain since 2015 and time had moved on since then. There was now the question of whether an argument of urgency can still be applied three and a half years later. Given this,

there needs to be a conversation about what the current situation is and if the legal position would require UHL to go out to consult.

Andrew Furlong, Medical Director, UHL explained that there were three Intensive Care Units in Leicester providing level 3 and level 2 services and the pressures were such that 2014 it was considered that it was no longer possible to sustain safe level 3 services at the LGH. The training status of the unit had been downgraded at LGH because it wasn't seeing the complexity of work going through and trainees could not get the training they required to become intensive care clinicians. A number of consultants were due to retire and multiple efforts to recruit were unsuccessful because of the loss of training status and because it was a very poor environment to work in due to the facilities. There were also considerable problems in maintaining ICU nursing levels. These pressures meant that it was not safe to keep the services at LGH open long term. Numerous reviews had been carried out to say that the services were not sustainable.

The move of the level 3 ICU from LGH would affect some services such as renal transplant surgery but there would still be a level 2 ICU and High Dependency Unit, and number of other services such as orthopaedics would remain at the LGH. The move of the ICU did not mean that all services would move from the LGH as a formality.

John Adler, Chief Executive, UHL stated that they would have liked to have proceeded quicker but were prevented by a lack of capital funding. There was also a need to move the Congenital Heart Unit from the Glenfield to the LRI by 2020 and they had to ensure there was sufficient capital for that work. Members heard that the money for the ICU had been allocated in 2017. The outline business case had been recently approved and the final business case was due to be approved soon. The Chief Executive stated that if the UHL went out to consultation, the delay could impact on the funding as it had not yet been received. He added that the UHL had been open about the strategy and the ultimate plan to move acute services from LGH, which was part of 'Better Care Together' and that would be out for consultation when the funding position was clear.

Rakesh Vaja, consultant in ICU added that the critical care services in Leicester had been chronically underfunded, but he believed that the UHL were as close as they had ever been to getting that investment. The services were isolated across the three sites and it was not possible to access the expertise immediately when the patient needed it when clinicians were on different sites.

The Chair stated that she had met with senior management at the NHS. She believed they felt they had fulfilled their duty to consult by going to the various scrutiny meetings, including scrutiny at Leicester City and Leicestershire County Council in 2015 and more recently at Rutland County Council in April 2018. The Chair agreed that the plans for the consolidation of Level 3 ICUs had been in the public domain and that now the funding was available there was a strong argument for wanting to make that investment. However, she expressed disappointment that the report did not address the matter of urgency

as fully as she had hoped.

The Chair stated that despite the urgency of the move, the UHL had managed to mitigate the situation with the ICU at the LGH for the last three years and although far from ideal, a public consultation would only require them to continue to manage the situation for a further three months.

The Chair expressed some disappointment that when the UHL took the issue to the Adults and Health Scrutiny Panel at Rutland County Council in April, they misrepresented the views of the Leicester City Council (LCC) Health and Wellbeing Scrutiny Commission where the issue was considered in March 2015. Rutland County Council had been informed that the Leicester City Commission had agreed that for safety and welfare reasons, the consultation was unwarranted, where in fact they had simply noted the position. This concern was also reiterated by other Members, including Members from Rutland.

Dr Feltham CC stated that his view had not changed since 2015 and now that it was known that the funding would be received, the same level of urgency still applied. The UHL had managed extremely well in keeping the Level 3 ICU operational across the three sites. Dr Feltham added that it was only Level 3 that would be moving from the LGH and he referred to the logistical problems in getting all the clinical specialists together across the three sites. He was willing to listen to the arguments but he was of the view that the reasons for urgency still applied.

Members raised concerns about the process and the lack of consultation and clarification of the legal position was sought. Views were expressed that this was not so much about clinical need, but the process and that people had the right to have their say on the issue. Concerns were also expressed that there was a lack of transparency regarding Better Care Together and the future of the LGH. Comments were also made that there appeared to be a breakdown of trust and that the public were being denied their say in the way the NHS was run.

Concerns were expressed about the impact the removal of the Level 3 ICU would have on the LGH, and a comment was made that it was disingenuous to argue that it would not affect the future of that hospital.

The Director of Strategy and Communications explained that when the issue was discussed in April at Rutland, the UHL had explained that they had been told they could not hold a consultation until the capital investment was confirmed. In relation to urgency, they had been working extremely hard to keep the ICU open, and the level of risk had not diminished. In relation to the consultation, a basic premise was that consultations took place where there were options, but on this issue, it was considered that there were no options. The Chair responded that the City Council ran a large number of consultations with limited options, the point being to allow people to express their opinions and concerns.

In response to a question about the cost of holding a consultation, the Director responded that he did not know but he believed that the cost should not be a factor in whether a consultation took place.

The Chair asked Members, in view of the time factor, with some Members yet to speak and with four items of business on the agenda, another meeting should be arranged to continue the discussion. The Chair recommended that the Committee note the report and note that the UHL had put forward a clinical case, but they were not in a position to make any suggestions as to whether or not the UHL should consult; and that a further meeting would be reconvened to continue the debate. Upon being put to the vote, this was agreed.

The Healthwatch Rutland representative wished it to be noted that she had not had the opportunity to speak during the debate and the Chair assured her that she would have the opportunity at the reconvened meeting.

AGREED:

1) that the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee note the report and note that the University Hospitals Leicester had put forward a clinical case, but they are not in a position to make any suggestions as to whether or not the UHL should consult; and

2) that the further meeting be reconvened to continue the debate.

The following questions were received at the meeting of the Leicestershire, Leicester and Rutland (LLR) Joint Health Scrutiny Committee held 4 September 2018, under agenda Item 5: Questions, Representations and Statements of Case.

Question 1 from Ms Jean Burbridge

The law requires commissioners and providers to involve the public when making changes to the provision of NHS healthcare. NHS bodies discharge this duty by carrying out consultations. There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services, usually involving a change to the range of services available and/or the geographical location from which services are delivered. Not only is a change in service location being proposed in UHL's full business case, but it is a change in the location of a **core** service, that is, one on which numerous other service depend and one where change has significant ramifications for the rest of the hospital. **Why did UHL consider it possible to proceed without a full public consultation and will the committee ensure that this omission is rectified and recommend that full public consultation takes place?**

Question 2 from Giuliana Foster

"Why has UHL been planning to close level 3 intensive care at the Leicester General Hospital since at least 2015 and yet still not consulted the public?"

Question 3 from Ms E Brenda Worrall

Given the recent ruling by The High Court (HHJ Jarman QC sitting as a High Court Judge) in quashing a decision by the Corby Clinical Commissioning Group over failure to undertake public consultation, is there a danger that the local NHS could find itself on the wrong side of the law if it proceeds to remove services as important as level 3 intensive care from Leicester General Hospital without full public consultation? A legal challenge will be costly in time, money and reputation.
I therefore urge you to recommend full public consultation.

Question 4 from Ms Warrington

"Why is the NHS undertaking to consult the public on 'our plans for acute reconfiguration' (Next Steps to Better Care in Leicester, Leicestershire and Rutland, August 2018 p40) but is not consulting the public on the reconfiguration of intensive care and other services such as kidney services now?"

Question 5 from Mr A Ross

Although the scrutiny committee does not have the right to impose its views on the local NHS, will it state its desire to see a full public consultation take place in relation to the closure of level 3 intensive care and the consequent downgrading of the Leicester General Hospital?

The following questions were received at the meeting of the Leicester City Council Health and Wellbeing Scrutiny Commission held 23 August 2018, under agenda Item 5: Questions, Representations and Statements of Case and were referred to the LLR Joint Health Scrutiny Committee on 4 September 2018 for noting.

Question from Mr Robert Ball:

Moving the Intensive Care Unit from the Leicester General Hospital to the LRI

University Hospital Leicester (UHL) presented a case to the Scrutiny Commission stating that the intensive care unit (ICU) needed to be closed down at the Leicester General Hospital and moved to the Leicester Royal Infirmary and Glenfield Hospital. Because this was considered an urgent matter with closure required within months for reasons of patient safety, the scrutiny commission at the time approved the move without public consultation.

Clearly, however, closure was not urgent nor required in 2015 as the ICU at the General Hospital continues in place. As its governing body's approval of the full business case indicates (Ref 1), UHL appear to be assuming they can proceed three years later (commencement of construction by October 2018) with no public consultation, despite the fact that this represents a major change in service delivery.

This is a question for the Health and Wellbeing Scrutiny Commission: what action will the scrutiny commission be taking to ensure this does not occur?

The effective closure of ICU at LGH will require the removal of other services, making the long-promised STP consultation on the three to two strategy virtually a meaningless exercise.

Question from Mr Stephen Score:

University hospitals of Leicester want to close the General as an acute hospital and concentrate their services onto two sites only (the Royal Infirmary and the Glenfield). However, there has been no public consultation on this. Despite that, they are planning to move ITU out of the General, which will make it very difficult to keep other services there. Effectively they are moving from three to two hospitals by stealth and without public consultation. Will the Scrutiny Commission ensure consultation happens?

Question from Mr Peter Worrall:

It's my understanding the Scrutiny Committee approved the closure of intensive care at the General Hospital in 2015 without formal public consultation because it was informed by University Hospitals of Leicester that the matter was urgent and needed to be dealt with swiftly for patient safety reasons. As ITU still functions at the General can we assume that formal consultation will now be required? And furthermore will the Scrutiny Committee make clear whether it **wishes** to see proper consultation now take place?

Report to Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

4th September 2018

The Consolidation of Level 3 Intensive Care

Report by: Andrew Furlong, Medical Director, and Mark Wightman, Director of Strategy and Communications, University Hospitals of Leicester NHS Trust

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What is the background to the proposed service moves?

University Hospitals of Leicester NHS Trust was formed in the year 2000 by the merger of the Royal Infirmary, (LRI) the General, (LGH) and the Glenfield Hospitals, (GH). Although the merger was successful in many ways, one fundamental issue remains unresolved to this day: the current clinical configuration of the hospitals is still more an accident of history rather than design. This means that services are duplicated and triplicated across the three sites which in turn means that clinical expertise is spread too thinly, expensive equipment has to be bought and maintained two or three times over and patients are too often transferred between the hospitals for different elements of their care.

The first attempt to solve these issues ended with the cancellation of what was known as the 'Pathway' scheme in 2007… a circa £850m capital plan to reconfigure the hospitals. The collapse of Pathway meant that from 2000 until the opening of the new (£48m) A&E in 2017 Leicester's Hospitals had no significant capital investment for almost 20 years. This is in stark contrast to the rest of the NHS, which saw well over 100 major hospital investment schemes completed during this period.

This has to change. Leicester's Hospitals are one of the biggest NHS organisations in England with many clinical services that rank amongst the best in country (vascular, diabetes, renal, cardiac surgery, ECMO, respiratory, to name but a few) but the Trust risks being left behind as a consequence of old estate and a clinical configuration that no longer makes sense in terms of modern medicine and surgery.

Within this overall picture, the foremost issue is Intensive Care.

Executive Summary: Intensive Care Unit (ICU) Consolidation,

UHL has 3 Intensive Care Units, one on each site - this triplication of services is unsustainable & inefficient; the biggest risk is the lack of suitably qualified clinicians to maintain safe Level 3 ICU services (Level 3 is the highest level of Critical Care for the sickest patients) across the three sites. This is compounded by the fact that nationally and locally patients are becoming older, sicker and more complex, requiring more ICU capacity but without the doctors in training to staff that capacity.

For some considerable time the Intensive Care Unit (ICU) at the Leicester General Hospital (LGH) site has faced significant operational difficulties. This came to a head in 2014 when senior medical and nursing staff told us that maintaining safe high quality Intensive care at the LGH had reached a tipping point due to:

- Changes in the way that medical training for intensive care staff was structured had led to the removal of training designation status at the LGH unit
- The imminent retirement of a number of experienced consultants
- Recruitment to substantive posts at the LGH had failed repeatedly owing largely to the loss of training designation and the reduction in patient acuity making LGH posts an unattractive proposition for applicants
- A national shortage of experienced critical care nursing and medical staff compounding recruitment problems

At this point the Trust had to act and so having considered all other options, we developed an interim plan to consolidate level 3 intensive care at the LRI and GH. The intention was to have enacted that plan by the end of 2015. Given the clinical imperative of the consolidation of ICU the Trust asked that the local HOSCs support the plan without the requirement for consultation, which they did.

Between 2015 and 2017 there was essentially no national capital available for major new schemes and the Trust was only able to maintain the level 3 service at the LGH as a consequence of staff going above and beyond on a daily basis to cover rotas. Following the release of some capital in the Spring Budget 2017, the government specifically allocated £30.8m of Sustainability and Transformation Capital Funding to this scheme and as such the much needed ICU consolidation could progress.

As of now, the full business case for the ICU consolidation is awaiting approval by the central NHS team and building work is due to start in a matter of weeks.

The interim ICU consolidation is not part of the Trust's major reconfiguration bid for £367m of capital investment to fundamentally transform Leicester's Hospitals. That scheme is progressing well, including an even more substantial improvement to ICU which will see a doubling of capacity. *This major hospital reconfiguration will be subject to full public consultation but that consultation is not permitted to start until the £367m capital investment has been approved in principle by government.*

The interim ICU consolidation has recently been characterised as a management device to undermine the sustainability of the General Hospital as an acute site. That is not the case; it was and remains still, a *clinically led* response to the unacceptable risks that are inherent in trying to maintain three viable ICUs in the context of too few staff and increasing demand.

The fact that the funding for the scheme has now been secured and that work starts in a matter of weeks is a reason for optimism, not least amongst those clinical teams who have worked so hard to keep the service safe. As such we would not want to create more delay than there already has been by reconsidering the rationale for ICU consolidation.

The rest of this short paper will explain this in more detail.

What is the Clinical necessity to transfer Level 3 ICU Beds from LGH site?

In November 2014 the scale of the risk to the Level 3 services at LGH was first highlighted and escalated within the Trust by the clinical team. The department had experienced medical staff recruitment and retention issues across all grades which meant that the future was bleak in terms of maintaining the level of ICU service provision, driven by:

- A reduced dependency level for the sickest patients at LGH. This restricted opportunities for critical care staff to maintain their skills in providing care for the most critically ill patients
- Due to the lower acuity of patients the middle grade doctor rota at the unit at LGH could no longer be filled with suitable trainee posts
- Changes in the way medical training for intensive care staff was structured led to the distribution of training posts to other units to ensure that they are exposed to sufficiently complex patients to meet their training requirements
- Recruitment to substantive intensivist posts at LGH had been attempted on multiple occasions but had failed, largely due to the loss of training designation and the reduction in patients' acuity

At the same time an external report commissioned in 2014 concluded that there would be substantial benefits to merging the units to create centralised larger units and that the extent of these benefits could not be overstated.

More recently Care Quality Commission Inspection reports for the 3 hospital sites were published in January 2017 incorporating inspection of the critical care units on all 3 sites. Critical care units at GH and LRI were rated as "good" across the board, whilst the LGH rated as "requires improvement" for the "safe" domain.

The report referenced some key factors particularly in relation to the quality of the environment within the LGH critical care unit:

- A cramped layout and lack of clinical space
- An inability to prepare drugs away from the bedside, in accordance with best practice,
- Side rooms that are used for the isolation of patients have no gowning lobbies
- There is limited space around bed areas
- There are no bathroom, shower or toilet facilities for patients on the unit
- There is a lack of storage space on the unit

Why did the service moves not happen in accordance with the original timescales?

In response to these concerns, in December 2015 the Trust Board approved the internal Full Business Cases which supported the transfer of Level 3 ICU & associated clinical services from LGH to GH and LRI.

The transfer of vascular services from LRI to GH to create a 'cardiovascular centre of excellence' was identified as a key enabler to delivering this scheme as it released both bed and theatre capacity at LRI, to facilitate the subsequent service moves. The vascular move was to create a cutting edge and comprehensive centre for cardiovascular medicine and research on a single site, transform the scope and quality of vascular service for patients and staff and support the on-going recognition of UHL as a level 1 regional centre for complex endovascular services.

The vascular development at GH was commenced in August 2015 but became delayed in December 2015 when access to national capital funds was suspended. The construction recommenced in April 2016 prioritised from within Trust's own internal capital resources and the vascular service moved, with the creation of a new hybrid operating theatre at GH, in May 2017.

The case for ICU was not able to progress further due to the lack of capital funds nationally, although this Business Case had been approved by the Trust Board. The first subsequent opportunity the Trust has had to progress this scheme since 2015 was with the submission of a Sustainability and

Transformation Partnership, (STP) capital bid in April 2017. It was confirmed by the Trust and its commissioners, as part of the bid submission process, that this scheme remained clinically urgent and was the Trust's (and the wider system's) highest clinical priority to deliver.

If the need to move Level 3 ICU from LGH was urgent in 2014, how has the service been sustained since?

To ensure the continued safe service provision at LGH during the period since the issue was raised in 2014, a series of temporary actions were put in place:

- Recruiting to substantive and locum non-trainee middle grade Doctor posts to support safe provision of the level 3 service
- Changes in consultant anaesthetist job descriptions to support more flexible working
- The appointment of internal locums to cover consultant vacancies
- Consultants acting down on shifts to cover junior doctor rota deficits
- The use of bank or agency staff for junior doctor or nursing vacancies
- On-going dialogue and engagement with clinicians over long term strategic plans for intensive care

Above all, the service has been maintained over this challenging period because the staff have gone beyond what could reasonably be expected of them to make sure that the unit remains open until the Level 3 service moves can be enacted.

Why is this need still determined as clinically urgent?

Whilst the actions outlined above have helped to ensure the continued delivery of a safe service at LGH for the time being, the service remains fundamentally unsustainable in the long term. The discretionary effort displayed daily by staff cannot and should not be counted on any longer than is absolutely necessary. The daily risk is that any additional loss of key clinical staff would further destabilise the unit.

Conversely, the benefits of the planned consolidation of level 3 ICU will improve the workforce experience for all staff. Specifically for the medical staff and the ICU consultants it will mean they are no longer trying to cover three units with too few people; this in turn will give trainee intensivists better access to their educators, and will help support recruitment & retention in what is a very competitive market for ICU clinicians. Further, the transfer of level 3 ICU and associated services from LGH will also improve the Trust's ability to accommodate demand and reduce elective cancellations by increasing the total number of ICU beds and separating emergency from elective work via the consolidation of day case activity at the LGH site, as a function of this case.

What will happen if these service moves do not take place?

If there are further losses of key clinical staff at LGH and the Trust is unable to conceive of further actions to continue to deliver Level 3 ICU services then the Trust will cease to provide a surgical service to the population of patients who need access to this facility. As currently configured the activity could not be absorbed at either the LRI or GH because these ICUs are already operating at capacity and approximately 1,800 patients would therefore need to travel to acute Trusts outside of Leicestershire for their surgery. Aside from the obvious inconvenience to patients and their families, this would mean a loss of £15m to the Trust's income. There is also not the spare capacity at other centres to absorb this volume of patients.

How do these proposals link with the longer term proposals to invest in the hospitals?

The Trust is on a reconfiguration journey, which has been well articulated and widely reported over a number of years, (this link will take Scrutiny members to the online brochures which describe the plan, https://www.leicestershospitals.nhs.uk/aboutus/our-purpose-strategy-and-values/our-5-yearstrategy/). Members will note that the plan was first published in 2015 and updated in 2016/17.

The central component of the plan is to address those fundamental issues mentioned in the introduction to this paper around: first, the duplication and triplication of services; second, the fact that many of the clinical services are not currently in the right location, and third to separate emergency and elective care so that when emergency demand is high elective patients do not suffer cancellations to their planned surgery.

The total investment required to realise this ambition is £367m and though there is still some way to go in terms of the assurance process with NHS England / Department of Health and Social Care and HM Treasury, the feedback on our case thus far has been overwhelmingly positive.

The key schemes to deliver this include:

- A new A&E and Assessment unit at the LRI (£48m COMPLETE)
- A new maternity hospital at LRI (£83m)
- A new standalone children's hospital at LRI (£35m)
- A new daycase hospital at GH providing adult outpatient and daycase surgery. (£136m)

Progress is being made: the new Emergency Floor was completed in May 2018, with phase 1, the Emergency Department, having been opened in April 2017. Vascular services moved from LRI to GH in May 2017 to create the cardiovascular centre of excellence and the transfer of Level 3 ICU and associated dependent services from LGH to GH and LRI is now planned for March 2020.

The ICU investment unlocks some of our reconfiguration ambitions, but it is important to note that it is separate to the further reconfiguration proposals which will be subject to full public consultation once we have received the go ahead and funding from government.

It is crucial to note that the Trust is not allowed to consult on the major reconfiguration plans until there has been central government agreement in principle that the plans will be funded. To do otherwise would mean that we risked building up people's hopes for major investment without any certainty that we could make it happen.

The key point to bear in mind is that regardless of the ultimate success of the major capital funding decision, level 3 ICU remains a clinical risk and must be addressed.

Why is it not necessary to undertake Public Consultation for the ICU scheme?

In February and March 2015, the Trust presented a paper to the Health Overview and Scrutiny Committees of both Leicestershire County and Leicester City Councils. The paper set out the Trust's concerns regarding ICU and sought the committees' approval to enact the plan to reconfigure ICU.

The County Council was satisfied that the plan would improve patient experience and outcomes and, in view of this, agreed that it would not be in the interest of the people of Leicestershire for it to insist upon formal consultation as this would divert resources away from the project team charged with the delivery of these necessary changes, and therefore waived its right to be formally consulted.

The City Council noted the guidance issued to Local Authorities, ('Guidance to Support Local Authorities and their Partners to Deliver Effective Health Scrutiny', published in June 2014), which set out certain proposals on which consultation is not required; specifically, "Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this".

At that time the Rutland HOSC was not consulted on the proposal which was a mistake on the Trust's part. This has since been rectified and the Rutland HOSC has also now supported the approach.

It is the strong assertion of the Trust's clinicians that the risk remains and if anything has increased and that the decisions taken in 2015 re: consultation should therefore still be the case. There remains a significant risk that if there are further losses of key staff at LGH, or other changes, that the continued provision of a Level 3 ICU service at this site becomes unviable. A safe service is only currently being provided with a series of supporting actions in place, and with considerable goodwill from staff members… that goodwill only maintains on the basis that staff believe there is a solution within our grasp and, critically, within a defined timescale.

What is the timeline for this project?

The timeline is complex and contains a number of interdependencies.

The original Full Business Cases were approved by UHL Trust Board in December 2015, but were not progressed due to the inability to access capital funds.

Following the announcement of a successful outcome (July 2017) from the bid for £30.8m of STP capital an Outline Business Case, (OBC) was developed.

The OBC was approved by Trust Board & CCG Boards in November 2017 and national approval followed in April and July 2018 from NHSI National Resource Committee and the Department of Health and Social Care.

The Full Business Case was developed during the period January to June 2018 and was approved by the Trust Board and Clinical Commissioning Group Boards in public in July 2018. It is due to be received by the NHS Improvement, (NHSI), National Resource Committee at their September meeting and approval will then be sought from the Department of Health and Social Care to proceed. These final approval stages should be straightforward as the Outline Business Case has already been approved at all levels.

Assuming that nothing derails this, the construction is due to commence in October / November2018 with completion in April 2020 at which point we can return ICU to a sustainable footing.

Are there interdependencies between this project and others?

First and most obviously those clinical services at the LGH which require Level 3 ICU provision will move at the same time as the consolidation takes place in 2020. The diagram below shows those services and their future locations.

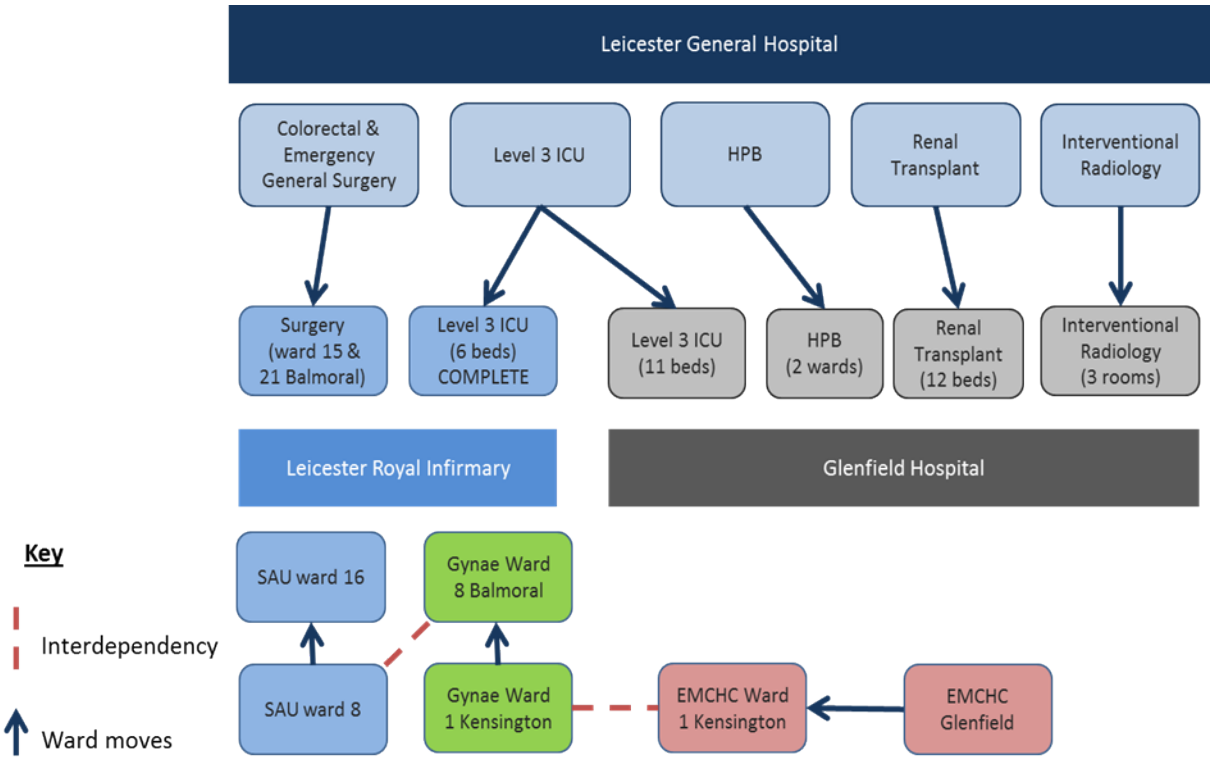
Of more concern is a key interdependency between the ICU project and the transfer of children's heart services, (EMCHC) from GH to the LRI by March 2020. Members will recall that a key clinical

standard set by NHS England for any centre wishing to maintain children's heart surgery was the colocation of all children's services on one site by March 2020.

The agreed plan is for Childrens heart services to be located in the Kensington building (which will ultimately become the new standalone children's hospital when major reconfiguration takes place). For this to happen we will move gynaecology services, which are currently in the Kensington Building, to a ward currently occupied by surgical services; these will then be moving to create a single surgery emergency unit when emergency surgery is moved from the LGH to the Royal's Balmoral building.

The service moves are complicated but the shorthand is that any delay to the ICU plan will delay the move of children's heart services to the LRI and thus risk undermining the enormous effort which went into the successful campaign to save the service. If the ICU plan is not just delayed and instead shelved, we will have to go back to the drawing board in terms of location for the children's heart service which will create further delay and further risk on the basis that we will not meet the colocation standard by the agreed deadline.

The diagram below outlines in detail the totality of the ICU moves together with the interdependency for the delivery of the children's congenital heart service move.



The table below summarises the timeline associated with the interdependent service moves for the EMCHC and ICU Projects outlined above.

Date	Milestone
Oct 2018 to April 2019	ICU project refurbishes wards 15 & 16, LRI Balmoral
April 2019	SAU LRI (Ward 8 Balmoral) moves to ward 16
April to July 2019	EMCHC 'enabling' project refurbishes ward 8, Balmoral
July 2019	Gynaecology moves from Ward 1 Kensington, LRI to Ward 8 Balmoral
August 2019 to March 2020	EMCHC Project refurbishes Ward 1 Kensington
March 2020	EMCHC moves from GH to Ward 1 Kensington

April 2020	Services relocate from LGH to GH and LRI including the move of LGH SAU to Ward 15 LRI creating an Emergency Surgical Unit on Wards 15 and 16.
April 2020	The ICU reconfiguration is completed with the opening of the 11 bed ICU extension at GH and the 6 bed ICU annex at LRI. The LGH will continue to care for Level 2 patients.

Summary and Conclusion from Andrew Furlong, Medical Director.

The Trust recognises the public interest regarding the proposed long term investment and major reconfiguration of our hospital sites and as such with the CCGs will lead a robust public consultation as soon as we have the approval from NHS England to do so.

However, after years of under investment in Leicester's Hospitals there is surely reason for optimism; the new A&E, the new assessment units and the funding for ICU already totals nearly £80m of new funding. Moreover the process to secure the £367m which will finally help us create modern health facilities that patients and staff can be proud of, is progressing well and fittingly on the day of the 70th anniversary of the NHS received the backing of the East Midlands Clinical Senate, a key stage in the approval process.

In the meantime we cannot stand still; the delivery of the scheme to transfer Level 3 ICU from LGH is a function of the risk of on-going clinical unsustainability first raised by our clinicians in 2014 but still valid today. We are within weeks of ending that uncertainty and starting to make ICU viable in the long term meaning that fewer patients suffer cancellations for their surgery and our excellent clinical teams no longer have to try and be in three places at once.

There is of course also the collateral damage of failure to progress the scheme. Long before I became the Medical Director my colleagues at the East Midland Congenital Heart Centre, were already many years into their work to convince other NHS colleagues that the clinical case for maintaining children's heart surgery in Leicester was sustainable; the fact that they achieved that against the odds is remarkable… to jeopardise that would be unthinkable.

In certain quarters the Trust's pursuit of this project has been branded as 'underhand'. More recently the clinical reasoning has been questioned, though not by anyone who practices in Intensive Care. The reality is that the Trust's vision for Leicester's Hospitals has been in the public domain for years; covered by the media as far back as 2014 and in 2017, when we received news of the investment for ICU it was hailed as a "£30m boost for our hospitals" by our local paper.

With all that in mind, the only meaningful conclusion I can offer you is that we, by which I mean me and my clinical colleagues think that the ICU consolidation is the right thing to do for patients and staff and we would ask that the Joint Scrutiny Committee support the plan. Any delay at this stage would be extremely damaging and put at risk the stability of this crucial service.

MINUTE EXTRACT

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 25 February 2015.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. J. A. Dickinson CC	Mr. J. Miah CC
Dr. T. Eynon CC	Mr. M. T. Mullaney CC
Dr. R. K. A. Feltham CC	Mr. J. P. O'Shea CC
Mr. W. Liquorish JP CC	Mr. R. J. Shepherd CC

In attendance

Mr E F White CC, Cabinet Lead Member for Health
Rick Moore, Chairman of Healthwatch Leicestershire
Kate Allardyce, Performance Manager, GEM Commissioning Support Unit (minute 67)
Kate Shields, Director of Strategy, UHL (minute 69)
Mary Barber, Better Care Together Programme Director (minute 70)

69. The Future of Intensive Care at University Hospitals of Leicester.

The Committee considered a report from the University Hospitals of Leicester NHS Trust (UHL) which set out plans for all level three intensive care services to be provided by the Leicester Royal Infirmary and Glenfield Hospital and for intensive care at the General Hospital to become a High Dependency Unit (level two service). A copy of the report marked 'Agenda Item 10' is filed with these minutes.

The Chairman welcomed Kate Shields, Director of Strategy at UHL, to the meeting for this item.

Arising from discussion the following points were raised:-

(i) The development of a regional intensive care transport service would build on the extracorporeal membrane oxygenation (ECMO) service at the Glenfield Hospital.

(ii) It was not expected that the overall number of intensive care beds would need to increase.

(iii) It was hoped that the Glenfield Hospital would become a centre of excellence for cardiac, vascular, thoracic and respiratory services. The intensive care unit would therefore be focused on this cohort of patients whereas the unit at the Leicester Royal Infirmary would respond to issues arising from acute hospital presentations.

MINUTE EXTRACT

RESOLVED:

(a) That the future of Intensive Care Services, as aligned to the blueprint for Health and Social Care in Leicestershire, Leicester and Rutland 2014-19 be noted;

(b) That this Committee is of the view that the proposals to consolidate level 3 Intensive Care Services at the Leicester Royal Infirmary and the Glenfield Hospital are significant and as such constitute a 'substantial variation' which would normally need to be the subject of formal consultation;

(c) That this Committee, having considered the outline of the proposals set out in (a) above is of the view that such changes would, if fully implemented as described, improve patient experiences and outcomes and, in view of this, agrees that it would not be in the interest of people of Leicestershire for it to insist upon formal consultation as this would divert resources away from the project team charged with the delivery of these necessary changes, therefore waives its right to be formally consulted on condition that the UHL Trust undertakes to:-

    (i) provide the Committee with a detailed project plan for the relocation of services;

    (ii) provide regular updates on the progress of works and any variations to the plans; and

    (iii) to meet with the Committee or its representatives if there are any concerns raised by members of the Committee about the implementation of the proposals.

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 10TH SEPTEMBER 2014

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

THE FUTURE OF INTENSIVE CARE AT UNIVERSITY HOSPITALS OF LEICESTER

Executive Summary

Introduction:

1. The Trust is about to commit to a significant investment in intensive care services, which will ultimately see intensive care for the sickest patients consolidated at the Royal Infirmary and Glenfield hospitals. The £3.2m programme will involve the creation of two 'super' Intensive Care Units (ICU) a doubling of level 3 capacity, (level 3 is where we care for the 'sickest of the sick') and the development of the largest ICU transport service outside the nation's capital.

2. The plan is part of the Trust's overall vision, which was shared with Health Overview and Scrutiny colleagues in 2012, to become smaller and more specialised as more patients are treated out of hospital and is a major building block in the £320m development of Leicester's hospitals.

Current status:

3. Currently, there are three ICUs, one at each hospital site; however there is not enough capacity at the Leicester Royal Infirmary and the Glenfield Hospital, where the highest number of the sickest patients is to be found, whilst there is overcapacity at the General.

4. Allied to this is the fact that in Leicester and across the NHS, experienced ICU staff are few and far between meaning that the Trust is increasingly spreading its ICU expertise too thinly. This combined with the fact that the ICU at the General looks after less sick patients has resulted in the General's status as a unit for training the next generation of intensivists (Intensive Care Consultants) being revoked.

The future:

5. The transfer of level 3 ICU beds at the General to the Leicester Royal Infirmary and the Glenfield Hospital will bring a number of important benefits.

   a) Fewer cancelled operations as a result of the scarcity of ICU beds on the emergency sites.

   b) Faster access to theatre and ICU for emergency cases

c) 24/7 consultant cover in both ICUs

d) More attractive to the next generation of intensivist (Intensive Care Consultants) in training

e) Better access to diagnostics, physiotherapy, imaging and pharmacy.

f) The capacity to create a regional intensive care transport service for the East Midlands.

6. In short, the plan will deliver extra ICU capacity; better clinical outcomes, shorter waits and units, which are attractive to new doctors and nurses.

Timing:

7. By December 2015 all level 3 ICU beds will be consolidated at the Leicester Royal Infirmary and the Glenfield Hospital. In the interim, the current ICU at the General would become a High Dependency Unit (Level 2). In other words, it would be more specialised than a normal ward, but not as specialised as an ICU.

Engagement and involvement:

8. The project team are undertaking the necessary analysis of patient flows, transport and equality impact of this plan. The numbers of patients directly affected by this move (circa 320 per year) is small but the team recognise that it is nonetheless important to engage during the creation of two super ICUs.

Recommendations:

9. The Trust's intensivists (Intensive Care Consultants) would like the support of the Health Overview and Scrutiny Committee to proceed with this plan. They recognise that this is a significant change to the service, albeit one that was shared in the 2012 vision. With the necessary checks and balances referred to above, the team are convinced that clinically this is the right plan to deliver a new and better future for intensive care in Leicester.

Officer to contact:

Kate Shields, Director of Strategy

Appendices:

The full report is attached as Appendix 1.

APPENDIX 1

THE FUTURE OF INTENSIVE CARE AT UNIVERSITY HOSPITALS OF LEICESTER

Context

1. The Intensive Care Unit (ICU) at the Leicester General Hospital (LGH) site will face significant operational difficulties within the next 12 months in maintaining a safe and high quality service for patients requiring level 3 (the most acute level) intensive care; reasons for this include:

    - The opportunities for critical care staff to gain adequate experience in providing care for the most ill patients is being affected by a reduction in the number of level 3 patients cared for at the LGH site.
    - Changes in the way medical training for intensive care staff is structured has led to the removal of training designation status at the LGH unit
    - The retirement of experienced consultant grade staff.
    - Recruitment to substantive posts at the LGH has failed repeatedly owing largely to the loss of training designation and the reduction in patient acuity is making posts an unattractive proposition for applicants.
    - A national shortage of experienced critical care nursing and medical staff compounding recruitment problems.

2. This means that towards the end of 2015 the level 3 ICU service at the General Hospital will not be clinically sustainable.

Background

3. A report completed by external experts in November 2014 has shown that the LGH does not treat a sufficient number of critically unwell patients to safely maintain a level 3 critical care service on the site, in terms of both emergency and elective work. The report is based on national clinical standards and recommended the merging of units across the Trust into two larger units to improve quality, governance and efficiency. Previous reviews by the Critical Care Network showed environmental and quality issues across University Hospitals of Leicester (UHL) critical care services.

4. The Trust Board has agreed that providing level 3 and level 2 activity in two large critical care units on the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) sites appears to provide the most flexible, efficient and viable option to meet national standards for critical care units. Addressing the immediate issue of unsustainable level 3 critical care cover at the LGH site is the first step in delivering this.

5. In summary, even if the current service was clinically sustainable, it would still need to undergo change to ensure modernisation of its ICU infrastructure and capacity.

Governance and Project Framework

6. An ICU reconfiguration steering group has been established which meets bi-weekly and reports into existing UHL governance structures through the UHL Bed Programme Board.

7. The steering group oversees the work of three implementation groups established to address the following areas:

    - Surgical services moving to and from the LRI;
    - Surgical services moving to and from the GH;
    - The creation of a retrievals pathway to transfer patients who require level 3 care post operation (where this could not reasonably have been anticipated) from the LGH to LRI and GH units.

8. The implementation groups are chaired by clinicians and include representation from all affected Clinical Management Groups (CMG). Expertise from the East Midlands Ambulance Service (EMAS) informs the work of the retrieval pathway.

9. The working groups meet weekly and each have been charged with producing:

    - A business case which sets out the potential options for changes to services on each site and a reasoned and justified rationale for selection of a preferred option;
    - A detailed implementation plan which will deliver the required consolidation of level 3 ICU capacity on two sites.

10. A number of options are being considered, that range from the do-minimum through to moving some or all of the high volumes specialties from the LGH site. Any option selected will have an impact on a number of different clinical services. A request for an estate feasibility study was approved by the UHL Capital Investment Committee on the 16th January. This will help scope the likely capital consequences of the options being considered.

11. Of these specialties General Surgery, Hepatobiliary, Nephrology, Urology, Neurology, Obstetrics and Gynaecology draw most heavily upon Level 3 critical care services. The project will assess the most suitable method to enable the delivery of these services in the immediate future, through either re-location to GH or the LRI sites or continued provision on the LGH site, supported by the establishment of a robust retrievals service.

Timeline

12. A full project plan has been compiled that sets out the key milestones and deliverables for the project:-

    - Options appraisals, assessing each potential site solution, to be carried out in February 2015 with the preferred way forward to be sanctioned by the ICU reconfiguration steering group;
    - Feasibility study currently being undertaken by the estates team to ensure full visibility of site utilisation options;
    - Outline Business cases and granular implementation plans to be produced by each workstream for submission to the UHL Bed Programme Board in March 2015;
    - Outline business cases, once authorised to progress through Better Care Together (BCT) UHL Programme Board and Leicester, Leicestershire and Rutland Bed Reconfiguration Board for executive approval;
    - Implementation of agreed action plans enabling a period of shadow running from 1st October 2015;

- New model of level 3 ICU provision to be fully operational by 18th December 2015.

Benefits

13. The remodelling of level 3 service provision across UHL will bring a number of important benefits:

    - The ability for UHL to continue to provide specialist surgical activity for patients in Leicester, Leicestershire and Rutland;
    - Contribution to the rationalisation of ICU beds in UHL to two sites improving quality, safety and sustainability of care;
    - Improved patient experience and quality of care through maintenance of critical skills for the most acute patient;
    - Sustainable 24/7 consultant cover;
    - Better recruitment and retention, providing a more attractive proposition for the next generation of intensivists (Intensive Care Consultants) in training;
    - Better access to diagnostics, physiotherapy, imaging and pharmacy, by having more ICU beds on the two sites;
    - The potential to create a regional intensive care transport service for the East Midlands. This clearly is a longer term benefit and would require a separate business case and planned benefits realisation;
    - The plan will deliver more appropriate ICU capacity where it is most needed, better clinical outcomes, shorter waits and units, which are attractive to new doctors and nurses.

Risks and Issues

14. Failure to secure sustainable level 3 facilities will mean that consideration will need to be given to either transferring patients requiring ICU support across sites, transferring their care to another Trust or alternatively stopping the dependent service. All clearly have very significant clinical, financial and reputational risks associated with them which is why delivery of this business case is so important.

Engagement and communications

15. A communication and engagement plan has been developed and will form part of the overarching messaging within the Better Care Together communication plan. The Director of Communications and Marketing is leading on this and discussions are at an advanced stage around recruiting a communications specialist to work with the reconfiguration team.

16. Members of staff have been involved agree the current issues and what the future state should look like. Weekly meetings with staff are planned for the next two months and the project engagement is supported by human resources representation co-opted onto the steering group.

17. Staff meetings with ICU and theatre staff at the LGH have been taking place since November 2014 and will continue throughout January and February 2015.

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Leicester City Council

MINUTE EXTRACT

Minutes of the Meeting of the HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 25 MARCH 2015 at 5:30 pm

P R E S E N T :

Councillor Cooke (Chair) Councillor Cutkelvin (Vice Chair)

Councillor Chaplin Councillor Sangster

* * * * * * * * *

103. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bajaj, Glover and Singh.

108. IMPROVEMENTS TO INTENSIVE CARE PROVISION

Kate Shields, Director of Strategy University Hospitals of Leicester NHS Trust (UHL) attended the meeting to discuss the issue of the future provision of Intensive Care Units (ICUs) at UHL. A background briefing paper was circulated at the meeting and a copy is attached to these minutes.

Before considering the briefing paper, the Chair circulated and extract from the 'Guidance to support Local Authorities and their partners to deliver effective health scrutiny, published in June 2014'. This is reproduced below:-

Local Authority Health Scrutiny - Extract from page 24 & 25

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is not required.

These are:

a) Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

b) Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.

c) Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

Following consideration of the guidance, the Chair commented that the Commission's role was not to approve the proposals, but to understand them and to fulfil their obligations under the guidance, particularly those relating to paragraph a) above.

The briefing paper outlined the proposal to reduce the current three ICUs at each of the three hospital sites into two 'super' ICUs at the Royal Infirmary and Glenfield Hospital. There was not enough capacity at the Royal Infirmary and Glenfield Hospital to provide level 3 care, whilst there was over capacity at the General Hospital. Difficulties in recruiting staff for level 3 care had been difficult as the trust was no longer able to provide training and the volume and mix of cases at each site was not attractive to potential staff. In addition, 3 consultants had given notice to retire in the near future. The details of the proposal were being subjected to external review to validate that the proposal was safe and sustainable. It was intended to have the two level 3 care units in place by December 2015. The General Hospital would become a High Dependency Unit providing a higher level of care than a ward but not as specialised as a level 3 care ward (ICU).

In response to members' questions the following responses were noted:-

a) Transport arrangements would be put in place to ensure that any patient requiring level 3 support on the three hospital sites would have access to them.

b) A plan would be required to ensure that the level 2 care facility at the General Hospital could be maintained in the future.

c) It was estimated that there would be 150 bed activity at the Royal Infirmary and Glenfield Hospital and this was currently undergoing a "confirm and challenge" process.

d) Plans were also being currently developed to free up surgical beds through efficiency measures. This included day case patients not being admitted before operations and being discharged earlier. Discussions were also taking place with Leicestershire Partnership Trust as part of the process of freeing up surgical bed availability.

e) The proposal was not associated with delivering the Better Care Together Programme, but was concerned with continuing to provide a service. A level 3 care ward was necessary to support multiple organ support and ventilation and, if this level of ICU was not available, then surgical operations involving renal care, kidney transplants, gall bladder and liver conditions would need to cease shortly after December 2015. Whilst the current proposal may not be ideal, it was nevertheless considered safe and sustainable for the foreseeable future.

f) There would be 2 units of 6 beds close to each other at the Royal Infirmary.

RESOLVED:

1) That it be noted that the University Hospitals of Leicester NHS Trust (UHL) had determined that it was necessary to proceed with the proposal without engaging in a full public consultation exercise, as they felt this was in the best interests of patients in order to provide ICU facilities after December 2015.

2) That UHL continue to present periodic updates on the progress with the proposal and the consequence of the changes.

The future of Intensive Care at University Hospitals of Leicester

Executive Summary

Introduction:

The Trust is about to commit to a significant investment in intensive care services, which will ultimately see intensive care for the sickest patients consolidated at the Royal Infirmary and Glenfield hospitals. The £3.2m programme will involve the creation of two 'super' Intensive Care Units (ICU) a doubling of level 3 capacity, (level 3 is where we care for the 'sickest of the sick') and the development of the largest ICU transport service outside the nation's capital.

The plan is part of the Trust's overall vision, which was shared with OSC colleagues in 2012, to become smaller and more specialised as more patients are treated out of hospital and is a major building block in the £320m development of Leicester's hospitals.

Current status:

Currently, there are three ICUs, one at each hospital site; however there is not enough capacity at the Royal and the Glenfield, where the highest number of the sickest patients are to be found, whilst there is overcapacity at the General.

Allied to this is the fact that in Leicester and across the NHS, experienced ICU staff are few and far between meaning that we are increasingly spreading our ICU expertise too thinly. This combined with the fact that the ICU at the General looks after less sick patients has resulted in the General's status as a unit for training the next generation of intensivists (Intensive Care Consultant) being revoked.

The future:

The transfer of level 3 ICU beds at the General to the Royal and the Glenfield will bring a number of important benefits.

1. Fewer cancelled operations as a result of the scarcity of ICU beds on the emergency sites.
2. Faster access to theatre and ICU for emergency cases
3. 24/7 consultant cover in both ICUs
4. More attractive to the next generation of intensivist (Intensive Care Consultant) in training
5. Better access to diagnostics, physio, imaging and pharmacy.
6. The capacity to create a regional intensive care transport service for the East Midlands.

In short, the plan will deliver extra ICU capacity; better clinical outcomes, shorter waits and units, which are attractive to new doctors and nurses.

Timing:

By December 2015 all level 3 ICU beds will be consolidated at the Royal and the Glenfield. In the interim, the current ICU at the General would become a High Dependency Unit (Level 2). In other words more specialised than a normal ward, but not as specialised as an ICU.

Engagement and involvement:

The project team are undertaking the necessary analysis of patient flows, transport and equality impact of this plan. The numbers of patients directly affected by this move (Circa 320 per year) is small but the team recognise that it is nonetheless important to engage during the creation of two super ICUs.

Recommendations:

The Trust's intensivists (Intensive Care Consultant) would like the OSC's support to proceed with this plan. They recognise that this is a significant change to the service, albeit one that was shared in the 2012 vision. With the necessary checks and balances referred to above, the team are convinced that clinically this is the right plan to deliver a new and better future for intensive care in Leicester.

The future of Intensive Care at University Hospitals of Leicester

Context

The Intensive Care Unit (ICU) at the Leicester General Hospital (LGH) site will face significant operational difficulties within the next 12 months in maintaining a safe and high quality service for patients requiring level 3 (the most acute level) intensive care; reasons for this include:

- The opportunities for critical care staff to gain adequate experience in providing care for the most ill patients is being affected by a reduction in the number of level 3 patients cared for at the LGH site
- Changes in the way medical training for intensive care staffis structured has led to the removal of training designation status at the LGH unit
- The retirement of experienced consultant grade staff.
- Recruitment to substantive posts at the LGH has failed repeatedly owing largely to the loss of training designation and the reduction in patient acuity is making posts an unattractive proposition for applicants.
- A national shortage of experienced critical care nursing and medical staff compounding recruitment problems.

This means that towards the end of 2015 the level 3 ICU service at the General Hospital will not be clinically sustainable.

Background

A report completed by external experts in November 2014 has shown that the LGH does not treat a sufficient number of critically unwell patients to safely maintain a level 3 critical care service on the site, in terms of both emergency and elective work. The report is based on national clinical standards and recommended the merging of units across the Trust into two larger units to improve quality, governance and efficiency. Previous reviews by the Critical Care Network showed environmental and quality issues across University Hospitals of Leicester (UHL) critical care services.

The Trust Board has agreed that providing level 3 and level 2 activity in two large critical care units on the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) sites appears to provide the most flexible, efficient and viable option to meet national standards for critical care units. Addressing the immediate issue of unsustainable level 3 critical care cover at the LGH site is the first step in delivering this.

In summary, even if the current service was clinically sustainable, it would still need to undergo change to ensure modernisation of its ICU infrastructure and capacity.

Governance and Project Framework

An ICU reconfiguration steering group has been established which meets bi-weekly and reports into existing UHL governance structures through the UHL Bed Programme Board.

The steering group oversees the work of three implementation groups established to address the following areas:

- Surgical services moving to and from the LRI
- Surgical services moving to and from the GH
- The creation of a retrievals pathway to transfer patients who require level 3care post operation (where this could not reasonably have been anticipated) from the LGH to LRI and GH units

The implementation groups are chaired by clinicians and include representation from all affected Clinical Management Groups (CMG). Expertise from the East Midlands Ambulance Service (EMAS) informs the work of the retrieval pathway.

The working groups meet weekly and each have been charged with producing:

- A business case which sets out the potential options for changes to services on each site and a reasoned and justified rationale for selection of a preferred option
- A detailed implementation plan which will deliver the required consolidation of level 3 ICU capacity on two sites

A number of options are being considered, that range from the do-minimum through to moving some or all of the high volumes specialties from the LGH site. Any option selected will have an impact on a number of different clinical services. A request for an estate feasibility study was approved by the UHL Capital Investment Committee on the 16th January. This will help scope the likely capital consequences of the options being considered.

Of these specialties General Surgery, Hepatobiliary, Nephrology, Urology, Neurology, Obstetrics and Gynaecology draw most heavily upon Level 3 critical care services. The project will assess the most suitable method to enable the delivery of these services in the immediate future, through either re-location to GH or the LRI sites or continued provision on the LGH site, supported by the establishment of a robust retrievals service.

Timeline

A full project plan has been compiled that sets out the key milestones and deliverables for the project;

- Options appraisals, assessing each potential site solution, to be carried out in February 2015 with the preferred way forward to be sanctioned by the ICU reconfiguration steering group
- Feasibility study currently being undertaken by the estates team to ensure full visibility of site utilisation options
- Outline Business cases and granular implementation plans to be produced by each workstream for submission to the UHL Bed Programme Board in March 2015

- Outline business cases, once authorised to progress through Better Care Together (BCT) UHL Programme Board and LLR Bed reconfiguration Board for executive approval
- Implementation of agreed action plans enabling a period of shadow running from 1st October 2015

- New model of level 3 ICU provision to be fully operational by 18th December 2015

Benefits

The remodelling of level 3 service provision across UHL will bring a number of important benefits:

- The ability for UHL to continue to provide specialist surgical activity for patients in Leicester, Leicestershire & Rutland
- Contribution to the rationalisation of ICU beds in UHL to two sites improving quality, safety and sustainability of care
- Improved patient experience and quality of care through maintenance of critical skills for the most acute patient
- Sustainable 24/7 consultant cover
- Better recruitment and retention, providing a more attractive proposition for the next generation of intensivists (Intensive Care Consultant) in training
- Better access to diagnostics, physiotherapy, imaging and pharmacy, by having more ICU beds on the two sites
- The potential to create a regional intensive care transport service for the East Midlands. This clearly is a longer term benefit and would require a separate business case and planned benefits realisation
- The plan will deliver more appropriate ICU capacity where it is most needed, better clinical outcomes, shorter waits and units, which are attractive to new doctors and nurses.

Risks and Issues

Failure to secure sustainable level 3 facilities will mean that consideration will need to be given to either transferring patients requiring ICU support across sites, transferring their care to another Trust or alternatively stopping the dependent service. All clearly have very significant clinical, financial and reputational risks associated with them which is why delivery of this business case is so important.

Engagement and communications

A communication and engagement plan has been developed and will form part of the overarching messaging within the Better Care Together communication plan. The Director of Communications and Marketing is leading on this and discussions are at an advanced stage around recruiting a communications specialist to work with the reconfiguration team.

Members of staff have been involved agree the current issues and what the future state should look like. Weekly meetings with staff are planned for the next two months and the project engagement is supported by human resources representation co-opted onto the steering group.

Staff meetings with ICU and theatre staff at the LGH have been taking place since November 2014 and will continue throughout January and February 2015.

MINUTE EXTRACT Appendix A8

Rutland County Council

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Oakham

Minutes of the **MEETING of the ADULTS AND HEALTH SCRUTINY PANEL** held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on Thursday, 5th April, 2018 at 7.00 pm

Present:	Mrs L Stephenson (Chair)	Miss R Burkitt
	Mr G Conde	Mr W Cross
	Mrs J Fox	Miss G Waller

Officers present:	Mr M Andrews	Deputy Director for People
	Ms K Kibblewhite	Head of Commissioning
	Ms S Newton	Commissioning Officer
	Mrs K Sorsky	Service Manager
	Mrs N Taylor	Governance Manager

In attendance:	Mr A Walters	Portfolio Holder for Adult Social Care and Health
	Paul Traynor	Chief Financial Officer UHL
	Nicky Topham	Reconfiguration Programme Director UHL
	John Jameson	Deputy Medical Director UHL
	Rakesh Vaja	Head of Service Critical Care UHL
	Tammy Thurley	Community Support Services Team Manager
	Joanne Carter	MICARE Community Support Coordinator
	Carol Taggart	MICARE Community Support Coordinator
	Tracey Taylor	MICARE Community Support Coordinator
	Gaynor Poole	MICARE Community Support Coordinator
	Mrs J Musson	Service User
	Mrs A Moore	Admiral Nurse

718 APOLOGIES FOR ABSENCE

No apologies were received.

719 CONSOLIDATION OF INTENSIVE TREATMENT UNITS

A presentation (appended to the minutes) was received from University Hospitals Leicester. The presentation was provided by Paul Traynor – Chief Financial Officer; Nicky Topham – Reconfiguration Programme Director; John Jameson – Deputy Medical Director and Rakesh Vaja – Head of Service Critical Care.

The purpose of the presentation was to provide members with information and background regarding the plan for the relocation of Intensive Care capacity and associated specialties from the Leicester General site.

During discussion the following points were noted:

i. The current situation was not sustainable due to the lack of a suitably qualified clinicians to maintain safe Level 3 Intensive Care Unit (ICU) services across the three sites and the fact that the Leicester General did not treat a sufficient number of critically unwell patients to safely maintain Level 3 ICU services;

ii. The £31 million investment was designated to this project only and was not reliant on or connected with other proposals for sustainability through the Sustainability and Transformation Plan;

iii. It was confirmed that clinicians advised the project team, members were reassured that Doctors and Consultants working within the system were involved in developing proposals. The Chief Finance Officer was also important to maintain oversight of budgets and the capital programme;

iv. Members asked for reassurance that this would not lead to further reduction in services at the General, especially as many Rutland Residents already opted to go to Peterborough Hospital as it was easier to access. It was confirmed that this business case stood alone, but that there may be other projects and schemes to centralise services in order to ensure future sustainability; and

v. Leicester General was still a teaching hospital, but the full range of intensive care teaching could no longer be achieved at the General.

AGREED:

The Panel endorsed the plan to consolidate ICU at the Royal and Glenfield.

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

The relocation of Intensive Care capacity and associated specialties from the Leicester General site

Rutland Adult and Health Scrutiny Panel

Thursday 5th April

Paul Traynor – Chief Financial Officer
Nicky Topham – Reconfiguration Programme Director
John Jameson – Deputy Medical Director
Rakesh Vaja – Head of Service Critical Care

One team shared values

Appendix A9

Background

The current configuration of ICUs / the whole Trust is an accident of history not an act of design

The need to consolidate ICU became urgent in 2014 – Business Cases were approved internally by the Trust in 2015, but were not progressed due to the national lack of capital for NHS developments.

The Trust was then successful in its bid for £30.8 million to consolidate ICU at the Royal and Glenfield in the 2017 Spring Budget.

The OBC was supported by the Trust and CCG Boards in November 2017 and is currently with NHSI for approval.

The FBC is due to be taken to Trust & CCG Boards in June 2018 for support.

Why is this important?

Historically 3 ICUs, one on each site - this triplication of services is unsustainable & inefficient; the biggest risk is the lack of a suitably qualified clinicians to maintain safe Level 3 ICU services across the three sites.

The Leicester General does not treat a sufficient number of critically unwell patients to safely maintain Level 3 ICU services.

Sticking plasters have been put in place to provide interim safe service provision – the service however remains clinically unsustainable in the longer term.

Factors requiring change

The opportunities for critical care staff to gain experience in providing care for the most ill patients was affected by a reduction in the number of level 3 patients cared for at the General.
Changes in in the way medical training for critical care staff is structured led to the removal of training status at the General
The retirement of experienced consultant grade staff
Recruitment to posts failed repeatedly largely due to the loss of training status and reduction in patient acuity.
A national shortage of experienced critical care nursing and medical staff compounding recruitment problems.

Summary: Qualified staff are in short supply nationally, the ones that are available can pick and choose and they choose the bigger centres with sicker patients and designated training. We need to compete.

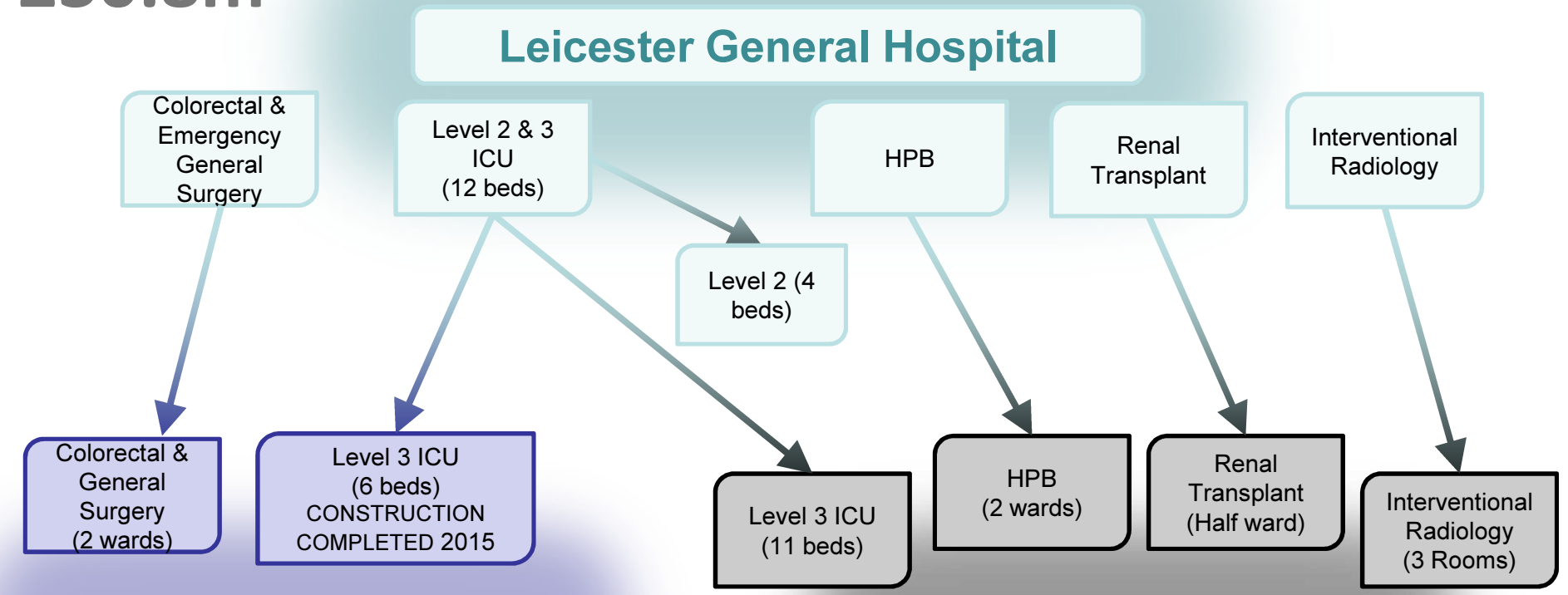
Engagement

In February and March 2015 the issue was shared with Leicester City and Leicestershire County Health Scrutiny Committees; both understood the clinical priority and supported the plan with the County waiving the option of public consultation and City noting that for safety and welfare reasons consultation was unwarranted.

A presentation was not made to the Rutland committee at this time and we are here to make amends.

As part of the national Outline Business Case approval process CCGs have reaffirmed support for these service changes.

The creation of 2 super ICUs: £30.8m



One team shared values

Summary

1. The current configuration of the hospitals / ITU is an accident of history, not a design.
2. Trying to run 3 ITUs for the size of population across Leicestershire and Rutland makes no sense and stretches clinical teams beyond what can reasonably be expected… not to mention the cost of triplication.
3. We have too little ICU capacity at Glenfield / Royal and too much at General, meaning we're cancelling sick patients for want of ICU beds
4. The clinical team have been brilliant and tolerant but getting by on goodwill alone is not sustainable
5. The £31m investment means we can finally fix this, consolidate clinical talent and resources and start to get the right clinical services next to one another.
6. We'd like your approval please.

One team shared values