Public questions received on the UHL Reconfiguration item

For the 16th December 2020: City Health & Wellbeing Scrutiny Commission

1. Robert Ball

With regards to the UHL Reconfiguration Plan. The questions following are for the Leicester City Health and Wellbeing Scrutiny Commission ahead of its meeting on 16th December.

a) Why are the risks of placing all 11,000 births in one maternity building not on the risk register? What do you think these risks are and how will you address them?

At the UHL Board Trust meeting, 2pm 3rd September 2020, Paper B states:

"Sustainability is clearly going to be mandated. The expected brief has been shared with us, which includes the need to ensure new buildings are carbon neutral. Since our design assumptions are at a high level, we need to employ expert advisors to work with us to determine how this can be delivered, and at what cost. It is recognised that this requirement will impact on capital, so further discussions are required on the extent of delivery."

In addition, the Preconsultation Business Case states: "...the highest level of BREEAM performance rating and stars as **practicable**."

Answer:

The proposals we are making to improve maternity services represent the culmination of extensive work over a number of years across many national, regional and local stakeholders. We believe they represent the most sustainable configuration of maternity service for the entire population of Leicester, Leicestershire and Rutland - delivering both equity of service and access.

Our proposals include creating a new dedicated maternity hospital to be located at the Leicester Royal Infirmary. It would provide a safe and sustainable environment for maternity and neonatal services with more personalised care provided by a named midwife.

This would allow obstetric-led births (specialist care of women during pregnancy, labour and after birth) and a co-located midwife-led unit to be with neonatal services (care for premature or ill babies) all in the same building.

We believe that this proposal is about reducing risks that have been highlighted in a number of maternity reviews. It was noted in NHS RightCare data for Leicester, Leicestershire and Rutland. Although outcomes in our early years pathway are promising the trends for maternity show that there is considerable room for improvement.

One of the key drivers of reconfiguration of the maternity model of care is to enable these clinical factors to be managed in the most effective way possible. For example, increasing the presence of consultant obstetricians in delivery suites has been shown to reduce caesarean section rates and complications of deliveries. Unfortunately UHL struggle to deliver this on the current multiple site model but would be able to if it was to move to the proposed reconfigured state.

With continuous oversight and scrutiny from our LLR Local Maternity and Neonatal System, the current Maternity Transformation Programme (Better Births) has seen significant work undertaken

locally in relation to improving and maintaining quality to ensure a safe and sustainable maternity service. This has resulted in investment in midwifery, neonatal and obstetric services. However, services still face demographic challenges, especially in Leicester City, in relation to the capacity of services to cope with increasing complexity. The current split-site working has caused difficulties for both neonatal and obstetric services, sometimes leading to temporary unit closures and we know that this is unsustainable.

In addition, clinical safety issues potentially could arise as a consequence of multiple site provision as seen in various neonatal services where service reviews over time have highlighted that there remains a significant risk that a baby will come to harm should consultant presence be required simultaneously on both units. This risk is compounded by significant rota gaps in junior doctor rotas, highlighted by both the East Midlands Operational Delivery Neonatal Network and the Care Quality Commission (CQC).

Inefficiencies are also reported in specialities such as Gynaecology as a consequence of split site working. Geography adds further to these clinical challenges. Currently there is an inefficient configuration of Gynaecology services e.g. day case activity is undertaken in main theatres, geographically separated from the ward base. There is also a conflict between Gynaecology emergency theatre use and the elective Obstetric pathway.

The maternity facilities in UHL were designed to cater for approximately 8,500 deliveries per year but deliveries now total approximately 9,895 (revised 2019). The local health community agreed as far back as 2010, through the Next Stage Review, that the solution would be to have a single site maternity and neonatal service based at the LRI site, with the option of community birthing facilities. However, due to financial constraints at that time, an interim solution was adopted. The interim solution has been successful at maintaining the current provision, but progression to the single site option is imperative to sustain the safety of maternity services.

b) **Will UHL please confirm the new buildings will be designed and built to the highest of the five BREEAM ratings available to the 'Outstanding' rating Star 5 and the capital funding is available to achieve this?**

Answer:

Any buildings that are new build will be designed to BREEAM excellent rating. This will be delivered within the capital funding allocated.

2. Brenda Worrall

Your proposals dramatically reduce choice for expectant mothers. Why won't you commit to the provision of a free-standing midwifery unit for low risk mothers? Offering one is part of NICE's quality statement but you are offering only a possible 12 month trial of a free-standing midwifery unit on the site of the General Hospital, with no associated capital investment. Requiring 300-500 births (the numbers keep changing) in a 12 month period, the trial looks as if it is set up to fail.

Answer:

Our priority for women and families across Leicester, Leicestershire and Rutland is to provide maximum choice of 'place of birth'. This includes options such as a home birth as well as shared care arrangements between an obstetric-led unit (co-located with neonatal services) alongside a midwifery-led unit at the Leicester Royal Infirmary. In addition, the option of a birth in a standalone midwifery-led unit is also proposed.

We are proposing to relocate the existing midwife-led unit from St Mary's hospital in Melton Mowbray to the Leicester General Hospital. The existing facility is significantly underused, with fewer than three births taking place there a week which isn't clinically or financially sustainable. We believe that moving it to Leicester would make it accessible to many more women.

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead we are looking for evidence that a clear trajectory for 500 births in subsequent years is likely to be achieved.

If the consultation shows that there is support for the Midwifery Led Unit at Leicester General Hospital then we are fully committed to developing this service and making it work, as we believe that it is a good option for mums. If the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL.

3. Jean Burbridge

Some risks of cost overruns are present in the risk register but some of them are not. Recent tenders have come in at higher than expected cost. Also, the proposals were costed before the pandemic so altering hospital design to allow for the greater space and flexibility needed in pandemic planning may also push costs up. Why is the possibility of cost overruns because of higher than expected construction and project management costs not reflected in your risk register?

Answer:

The budget costs identified in the Pre-consultation Business Case at the stage we are at are based on our recent experience of letting schemes in UHL – for example the emergency floor scheme, the East Midlands Congenital Heart Centre scheme and the interim Incentive Care Unit scheme. These costs have been validated by the estates team at NHS England and Improvement. The risk register in the Pre-consultation Business Case is at a point in time. It is a live document that is continually updated and validated, with mitigations identified to help prevent the risk coming to fruition. The current risk register has been updated and is presented to the UHL Trust board on a monthly basis.

With regards to pandemic proofing, the current proposal will respond to a future pandemic. For example, this includes:

- a doubling of Intensive Care Unit capacity. During the peak of the Covid 19 pandemic we had to use some theatres and move children's heart intensive care to Birmingham for a period of time. We needed in excess of 70 Intensive Care beds at the peak; our scheme will provide over 100 Incentive Care beds.
- In addition, the development of the new treatment centre allows us to split a lot of planned care from the emergency care. This means that at times of peak emergency pressure we can maintain our planned activity.
- New buildings also have a more generous footprint. This will make it easier to separate flows of people and goods around the new buildings.

Will the Department of Health cover additional costs for pandemic planning and how will you address cost overruns from higher than planned construction costs?

Answer:

We are working with our professional advisors and design team to ensure we deliver our scheme within the £450million budget allocated.

However, vacated land and buildings at Leicester General Hospital would be freed up and sold for affordable housing developments. This money from the sale of the land and buildings which would be over and above the £450million, would be reinvested into the hospitals.

4. Jill Friedman

In response to public questions NHS leads have spoken about the removal of services from the Royal Infirmary to Glenfield as an example of how traffic on the LRI site will reduce. However, it has not spoken about how the new services on the LRI site, including a Maternity Hospital supporting 11,000 births, will affect traffic within the site and parking. Can it be more specific? Also it has ignored the issue of the congested nature of the roads around LRI and the impact that will have on access to LRI. Are there plans to improve traffic flow in the area?

Answer:

The new maternity centre would be created at Leicester Royal Infirmary, bringing together the existing units there and at Leicester General Hospital. But to make way for these, more than half a million outpatient appointments and 100,000 day case procedures would be done differently – reducing expected traffic and footfall at the site by approximately 45%. This would include reducing the amount of first referrals and follow-up visits by an anticipated 30%. Technology would help to provide certain aspect of care differently in the future. This could include telephone conversations, Skype calls or other forms of virtual online appointments if it was appropriate. It would also involve having more appointments, where appropriate to the condition, in community settings close to home.

Travel, transport and access are important issues for us. We have commissioned a specialist company called Go Travel Solutions to work with us. They are taking all the insights collected through the consultation and working with a range of partners including the local authority and Healthwatch organisations to develop a travel plan to improve traffic flow and access and develop long term sustainable solutions.

5. Indira Nath

What happens after 2024? A £450m capital expenditure on hospital services is a long-term investment, so what is the long-term plan for hospital expansion after 2024? I appreciate that bed modelling is difficult, but population increases are a certainty, so a plan for expansion is unavoidable. 2025 is not far off and at the least, we should see a plan till 2036, including where the funding for that plan is going to come from.

Answer:

Our ambitious plans for investing £450million in modernising and improving Leicester's hospitals is about much more than simply creating additional beds. Had it not have been it is unlikely our bid for Government funding would have been successful.

Instead our proposals are about correcting decades of capital under-investment in our hospitals. They address some of the clinical adjacency and co-location issues that all too often hinder our ability to deliver the kind of care and experiences we want for our patients.

Simply put services are currently organised in a way that is a legacy of history rather than design, often in buildings and facilities that are outdated and not fit for the delivery of modern healthcare.

If further capital developments are needed to meet growth in population or health need after 2024, then we do have flexibility in our existing estate to develop. We retain 33 acres of developable land – the equivalent to approximately 22 football pitches. This is located at the Glenfield Hospital. More than 25 acres of this land is already empty space.

If future developments are needed they would likely be funded from the Trust's own capital budgets and, working with local NHS and local government partners, through access to section 106 funding and the community infrastructure levy to support services when housing growth puts pressure on them.

We will also continue to maximise space at the Leicester Royal Infirmary, with appropriate planning consent if necessary. We appreciate that it is essential to consider travel, access and car park when considering what services are provided on this site.

6. Elizabeth Moles

How can the public be expected to give an informed assessment of the proposals without details of the community services which, we are told, will be picking up more health care through new patient pathways? The interdependence of community and hospital services is well established in whole systems thinking but community services have been bracketed off from this consultation.

Answer:

The plans to build better hospitals for the future for Leicester, Leicestershire and Rutland stand independently of other proposals. Even if we were planning to do nothing to improve and expand on the services provided in the community closer to where people live, these plans are the right ones and the reason why we have undertaken the consultation at this time.

However, during 2018 and 2019 we undertook separate engagement to understand what matters most to people about community services. The feedback from this work aligns with the central tenet of our overall clinical strategy for health and care services which is delivering as much care as we can as close to where patients live as is practically possible.

We have already started discussions in some local areas as the first step to developing plans for what local health and care services should look in communities across Leicester, Leicestershire and Rutland. These plans would include discussions relating to GP provision and the usage of local infrastructure, such as the community hospital, to deliver a greater range of services locally.

We are committed to continuing these conversations over the coming months. Our focus will be on working with the local community to identify services that can and should be delivered locally.

7. Tom Barker

You state in the PCBC and in your response to an October 2020 JHOSC representation that the consultation does not include proposals for community services. You then make proposals for

community services on the site of the Leicester General Hospital and consult the public on these, despite the fact that, as you admit, they are not funded in the £450m scheme. Do you agree that consulting the public on these possible, one-day-in-the-future 'potential' services alongside services you are committed to retaining on the site of the General Hospital is likely to confuse the public? I note that one of the prominent images on the website, in the brochures and in videos circulated on Twitter is an image of 'The Leicester General Hospital Community Hub' – which is unfunded - sometimes alongside the planned Treatment Centre and the planned Maternity Hospital - both of which are funded.

Answer:

The consultation is about the three acute hospital sites in Leicester and the services that will be provided from these in the future It also covers the future of the midwife-led unit at St Mary's in Melton Mowbray. It is therefore entirely appropriate that the consultation should ask for views about what services could be provided from at the Leicester General Hospital campus given its proposed changed remit.

8. Sally Ruane

In the light of:

- the absence of details on community services making an informed assessment of the adequacy of the proposed hospital changes virtually impossible,
- the confusion surrounding the inclusion of unfunded 'potential' community services on the site of the Leicester General Hospital in the consultation,
- the failure of the consultation to reach what appears to be thousands of people in Leicester, Leicestershire and Rutland,
- the restrictions imposed by the pandemic, including full lockdown,
- the requirement to engage online in order to find out what is happening and to ask questions about it,

How likely do you think it is that the Building Better Hospitals consultation will fulfil the requirements of a lawful public consultation?

Answer:

With regard to the opinions expressed above, these have been responded to in previous reports and communications.

The Better Hospitals consultation has fulfilled the statutory duties and common law obligations placed on the CCGs.

The consultation provides sufficient information to understand what is being proposed from acute and maternity services provided by UHL.

It has been accepted that additional work will always be required after any consultation to understand what services could replace those moved from a particular NHS site. Ideas are being generated by people who are responding to this Better Hospitals consultation. It is normal in those instances to seek to co-produce future service provision with the relevant communities and that is all that is being proposed. This we feel further supports the fact that the CCGs are undertaking an open and transparent process which meets their statutory duties and common law obligations.

Consulting during a pandemic has shown us how technology can be used to involve and engage the public on a range of issues. In the context of health service reconfiguration, we adapted and adopted new ways of working to exercise our statutory functions.

The use of technology to hold meetings, share information and recordings of meetings, and enable a wider reach across communities has provided additional methods and opportunities to consult or provide information to individuals to whom the services are being or may be provided.

This is in addition to off-line communications and engagement activities in order to reach people who may not be digitally enabled or active.

The only restricting factor experienced during the consultation has been the inability to undertake public face-to face events and public outreach. However, the public face-to-face events have been replaced by many more virtual online events than would have been practically possible using off-line mechanisms.

We have undertaken extensive online and offline activities which we are able to measure confidently. This demonstrates that the vast majority of adults across Leicester, Leicestershire and Rutland will have had the opportunity to be aware of the proposals, often through multiple channels and participate in the consultation process if they wish.

Questions from Member

9. Councillor Patrick Kitterick

<u>Issues around consultation</u>

a) There is reference to Independent Legal Analysis of the validity of the PCBC consultation - is that available in complete or redacted form?

Answer:

The legal advice which the CCGs have received is legally privileged and, as the Committee will appreciate from each constituent Council's own legal dealings, it would not be appropriate to disclose that advice. However, the CCGs have been advised throughout this process by Gerard Hanratty of Browne Jacobson, who is a solicitor specialising in public law and service reconfiguration advice for the NHS. He has also supported the preparation of the answers to these and other queries, in which he has confirmed the CCGs have complied with their statutory duties and common law obligations, including the Gunning Principles.

b) A door to door leaflet drop was promised what percentage was delivered and how was this verified (lots of reports of no leaflet having been received) what was the cost of this exercise?

Answer:

We have undertaken a solus door drops of an A5 information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland receive a leaflet via Royal Mail as solus was not an option.

Whilst many people have told us that they have received this leaflet, we are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors including the recall of delivery, particularly if when posted through letter boxes it has become combined with other promotional items.

We have raised this with our delivery partners who have provided us with GPS tracking information for their agents, as well as feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery.

However, the door-drop is only one small part of the overall awareness activities we have undertaken. We have undertaken extensive online and offline activities which we are able to measure confidently. This demonstrates that the vast majority of adults across Leicester, Leicestershire and Rutland will have had the opportunity to be aware of the proposals, often through multiple channels and participate in the consultation process if they wish.

c) **Can we have a breakdown of consultation responses with where the response originated from, when will this breakdown be supplied?**

Answer:

All the consultation responses we receive from the consultation will be independently analysed and evaluated by Midlands and Lancashire Commissioning Support Unit (CSU).

The responses provided by the public are anonymous. However, the questionnaire does ask people to provide socio-demographic and equality data. This is optional. Where people have provided this information, the CSU will include a full breakdown of this data in their Consultation Report.

The final Consultation Report of Findings will be received by the three CCG governing bodies and discussed in a public meeting in the first half of 2021. The public consultation feedback will be considered and taken into account in any decisions they make.

The papers for this meeting will be publicly available including the Consultation Report of Findings. We will promote the governing body meetings to enable people to attend and hear the discussions. All decisions will be made public after the governing board meetings and further engagement work will commence with people who use services provided by UHL. This work will include communicating the decision via local newspapers, social and broadcast media. We would also expect to present this information to Scrutiny Committee.

Actual Number of Beds

d) **Can a detail description of how the change of 28 Hampton Suite beds to other uses will be handled?**

Answer

As part of winter and Covid-19 there was an urgent clinical need to convert the Hampton Suite to an acute medical ward from the beginning of November. Therefore, there was a need to pull forward proposed changes because of the operational changes result from Covid-19.

Patients that would previously have gone to Hampton Suite, if at all possible, go home with Home First care. If they need tests at the hospital this is done whilst on a medical ward. They then either go to a community bed if they need inpatient rehabilitation or they go home with Home First care for continued rehabilitation.

In line with its change of role over the winter we have increased funding to increase medical and nursing cover to the same level of an acute medical ward. We had set up a system to monitor the

outcome for this to be pulled from nerve centre to assess with this change should be maintained in the long term.

e) 70 Capital Resource Limit funding has been discussed (if needed) what is the current official position on this?

Answer:

UHL has assumed that it will receive a total of £450 million Public Dividend Capital (PDC) between 2019/20 and 2026/27. PDC is a form of long-term government finance. The drawing down of this funding is described in detail in 8.2 of the Pre-Consultation Business Case.

UHL also has other capital developments which it assumes will not be counted against its Capital Resource Limit (CRL). These reflect investment in car parks and Welcome Centres at Leicester Royal Infirmary and Glenfield Hospital.

Loss of Leicester General Hospital

f) How does the loss of Leicester General Hospital impact the city and counties resilience in terms of "Clean Sites" during the current or future pandemics.

Answer:

The change of use of Leicester General Hospital will not impact on the availability of clean sites within UHL. Leicester General Hospital was not a clean site in the current pandemic; it had less COVID cases than the other 2 sites but that was/is a reflection of the case mix admitted there – there are no emergency medical or respiratory patient admissions to that site, only surgical and urological patients. The new build on the Glenfield Hospital site essentially provides us with a "hospital within a hospital" which will cater for elective work and that will be our "clean site", putting us in a far better position than we are in now.

g) Could the General Hospital be used to address the backlog of operations created by COVID19?

Answer:

As part of our Phase 3 plans we are using all available capacity to support Restoration and Recovery of services – this includes all 3 Leicester hospital sites, the Independent Sector, Community Hospitals and some GP surgeries.

h) BCT Page 138-141 – Financial Pages – Are these affected by £46 million financial adjustment currently under investigation by auditors

Answer:

These plans are not affected by the £46 million financial adjustment.

i) BCT Page 156 What land is due to be sold at the Glenfield Hospital site and can a full map of the land left at both the Glenfield and LRI site?

Answer:

No land will be sold at the Glenfield Hospital site. UHL still has 33 acres of developable land at the Glenfield Hospital site should it be needed in the future.

Some land would be sold at the existing Leicester General hospital site to create essential affordable housing for key workers including nurses and other healthcare staff. Money from the sale would be reinvested into hospital services.

We know from our discussions with the local council that affordable housing in this area is badly needed and we are working closely with them on for this for the benefit of the local community. We will make a full map available on our consultation website.

j) BCT Page 327 Financials, is a sale of land required to fund the PCBC?

Answer:

No, the land sale is not required to fund the proposals as set out in the PCBC.

k) BCT Page 328 & 329 What roles does the £46 million financial adjustment play in these figures?

Answer:

These plans are not affected by the £46 million financial adjustment.

<u>DELIVERY BY PRIMARY CARE</u>

l) BCT Page 121 – Talks about delivery by Primary Care, is there a plan that we can see that describes how this formerly delivered hospital care will be delivered by primary care. This is especially important considering the difficulties in Primary Care provision in the city.

Answer:

The world has changed over the last 9 months. We are now working in a different environment and therefore we need to revisit our plans including the Primary Care Plan. This will ensure that they are still appropriate given the learning of the NHS during the pandemic.

<u>MATERNITY SERVICES</u>

m) BCT Page 127 – Offer to look at Midwife Led Unit – Offer of 500 births to take place in a short time or total close. What is the thinking behind 500 births and the time scale? Is there any flexibility on this?

Answer:

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. However, to be clear, this is not a hard target that must be achieved in year one. Instead we are looking for evidence that a clear trajectory of approximately 500 births per year can be achieved in subsequent years.

If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL.

n) **BCT Page 180 & 181 Reference to drop off at LRI being key to moving births, how confident are UHL about traffic management around the LRI site?**

Answer:

The Trust is working with Go Travel solutions on plans to make all forms of alternative transport available to a site users. We recognise that using an alternative is not always possible but feel that if we can try to encourage people to recognise that the car is not the only option all of the time it will help with traffic flow.

As well as the above work that is ongoing with regards to the use of alternatives there are plans to look at the car park provision (LRI and GH) and this includes possible new builds especially at the General Hospital.

Our aim is to obtain feedback from all site users and in this way understand the issues they face. To this end as well as the overall consultation we have set up a travel steering group and a travel forum. We have invited many representatives from a wide range of areas.

We are working closely with the city and county council as well as other large stakeholders to bring about a sea change in the options available to access the hospital sites.

ANY OTHER QUESTIONS

o) **Can we have an update on BREEAM rating of new construction and a wider narrative about the environmental targets of the PCBC project?**

Answer:

Any buildings that are new build will be designed to BREEAM excellent rating. This will be delivered within the capital funding allocated.

UHL has appointed a specialist consultant to support the development of the following key documents on behalf of the Trust.

These documents are

- A 'refresh' of the UHL Green Plan

The specialist consultant will work alongside the UHL sustainability team to write the new Green Plan for the UHL NHS Trust, which is required to plan sustainability activities and deliver environmental, social and financial value. This will cover areas that include waste reduction opportunities, financial savings and address priorities such as carbon reduction. The Specialist Consultant will ensure that the plan follows the Green Plan guidance provided by the Sustainable Development Unit and NHS England and NHS Improvement.

- A Sustainability Strategy

The specialist consultant will develop the sustainability strategy which will confirm that all newly constructed buildings developed as part of the Reconfiguration Programme will achieve a BREEAM rating of excellent. The strategy will develop and define a range of objectives that will enable the future delivery of a Net Zero Carbon programme.

- A Heat Decarbonisation strategy

UHL are currently looking to commission the development of a Heat Decarbonisation Strategy which will identify elements within the fabric of the existing estate which are suitable for investment to reduce the carbon emissions associated with the production of heat.