Report to Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

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The Consolidation of Level 3 Intensive Care

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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.

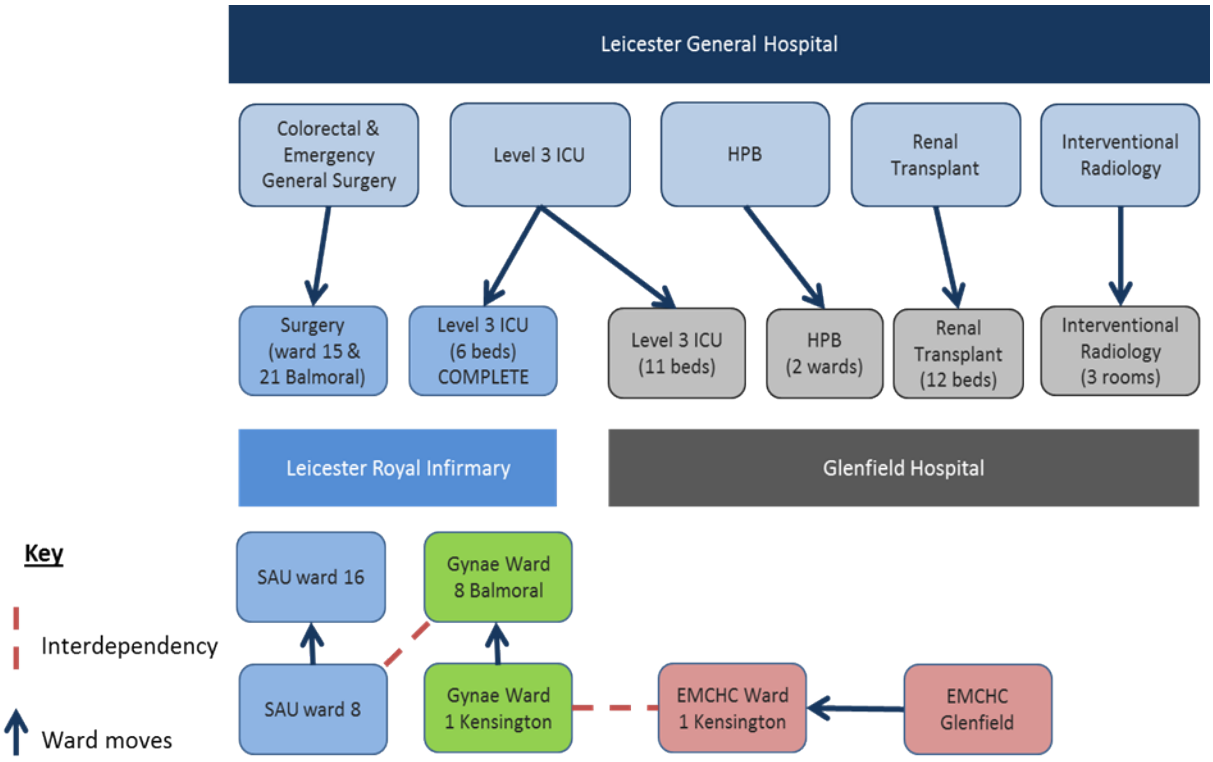
Of more concern is a key interdependency between the ICU project and the transfer of children's heart services, (EMCHC) from GH to the LRI by March 2020. Members will recall that a key clinical

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.