University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 5 February 2015

The proposed move of level 3 care off the Leicester General Hospital site and its impact on other services

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Partnerships (Local services and BCT Lead)
DATE:	5 February, 2015
PURPOSE:	To provide the Board with an outline: 1. Description of the issues requiring a move to rapidly consolidate Level 3 intensive care services. 2. A summary of the benefits expected by such a move. 3. An overview of the project structure, approach and governance.
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board: 13th January 2015 Better Care Together - UHL Programme Board: 29th January 2015
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The staff and stakeholder implications are set out in this paper.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[X] **Organisational Risk Register** **Board Assurance Framework** [X] **Not Featured** [ ]
ACTION REQUIRED *	For decision [X] For assurance [X] For information [ ]

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do**
♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together**
♦ **We are passionate and creative in our work*** tick applicable box

The proposed move of level 3 care off the Leicester General Hospital site and its impact on other services

Purpose of Paper

1. The purpose of this paper is to provide the Board with an outline:

2. Description of the rationale for, and the moves required to, rapidly consolidate Level 3 intensive care services on two sites.

3. A summary of the benefits expected by such a move.

4. An overview of the project structure, approach and governance.

Context

5. 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:

6. 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.

7. 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.

8. The retirement of experienced consultant grade staff.

9. 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.

10. A national shortage of experienced critical care nursing and medical staff compounding recruitment problems.

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

Background

12. 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.

13. The Trust Executive has agreed that providing all 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.

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

Governance and Project Framework

15. An ICU reconfiguration steering group has been established by the project team 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 3 care post operation (where this could not reasonably have been anticipated) from the LGH to LRI and GH units

16. 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.

17. 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

18. Options being considered 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.

19. A request for an estate feasibility study was presented and approved by the Capital Investment Committee on the 16th January. This will help scope the likely capital consequences of the options being considered.

20. This will involve significant changes for specialties that currently rely on Level 3 critical care provision at the LGH (these are listed in Appendix 1).

21. 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

22. 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 work stream 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

23. Clearly this will require sensitive and detailed communication. A draft Communications strategy is included in Appendix 2.

Benefits

24. 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 patients

- Sustainable 24/7 consultant cover

- Better recruitment and retention, providing a more attractive proposition for the next generation of intensivists 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

25. 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

26. A full register of risks has been identified as part of the process described (included within Appendix 3); current red rated risks are capacity restraints to enable moves and the timescales required for delivery.

27. A risk and mitigation plan is being developed and will reflect options including alternative skill mix rota's to cover the LGH service overnight for a very short time period.

28. 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.

Consultation, engagement and communications

29. A communication and engagement plan is in development and will form part of the overarching messaging within the BCT 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. Once this post is appointed to the CMGs will have expert support in formulating and delivering their Communication and Engagement plans.

30. It will be particularly important to liaise with the local Health Overview and Scrutiny Committees who will have key role in determining formal consultation requirements around the proposed changes in service configuration. Meetings are currently being arranged to facilitate that dialogue. It is important to stress that the indicative timetable in this report

may well be impacted by the outcome of these discussions. A briefing has also been sent to local MPs (included in a wider Better Care Together briefing).

31. Each CMG will be required to run engagement events with their affected specialties and patient representative will be sought through the Intensive care, Theatres, Anaesthetics, Pain and Sleep (ITAPS) CMG Board.

Staff Engagement

32. Members of staff have been involved as part of two evening events to 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.

33. 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.

Recommendations

34. The Trust Board are asked to:

- **Note** the operational and safety issues facing ICU services across UHL and **support** the need to reconfigure services rapidly

- **Agree** that the above project structure is both fit for purpose and addresses all necessary areas from the Trust's perspective

- **Agree** that the project's approach to communications and engagement is sufficient

- **Note** that the project will provide monthly updates to Executive Strategy Board (ESB). Regular updates can also be provided to the Board and/or one of the Board committees.

Appendix 1 - Current bed Numbers and activity at LGH

Summary

The below tables set out the geographical locations of the 47 currently funded level 3 ICU beds, shows that in 13/14 1,172 level 3 bed days were provided at LGH and finally shows the overall activity being recorded on the site

The current numbers of ICU/HDU beds in UHL are as follows:

Site	Physical ICU Beds	Funded ICU Beds	Satellite HDU Beds
LRI	22	19	13
LGH	12	9	4
GH	22	19	17

LGH – Patients requiring level 3 Critical Care by specialty:

Specialty	Patient Contacts	Level 3 Bed Days	Level 2 Bed Days	Non Critical-Care Bed Days
General Surgery	147	779	503	2,328
Hepatobiliary & Pancreatic Surgery	61	147	216	672
Nephrology	51	251	248	778
Urology	43	159	195	500
Renal Failure	17	86	96	287
Neurology	15	131	43	1,052
Gynaecology Oncology	7	12	8	111
Rehab Care of Elderly	7	55	27	256
Obstetrics	7	9	16	26
Transplant	7	21	24	107
Gynaecology	6	12	8	36
Critical Care Medicine	4	12	7	0
Orthopaedic Surgery	4	8	5	53
Stroke Medicine	4	19	10	336
Gastroenterology	1	11	6	115
	381	**1,712**	**1,412**	**6,657**

Overall LGH bed days by specialty

Local Specialty Name	Patient Contacts	Non Critical-Care Bed Days
Obstetrics	10,312	11,209
Urology	9,713	13,371
Orthopaedic Surgery	7,062	13,633
General Surgery	6,648	26,456
Gastroenterology	5,922	326
Gynaecology	4,219	4,607
Rheumatology	2,729	23
Sleep	2,090	215
Neurology	1,933	5,449
Nephrology	1,461	8,654
Clinical Immunology & Allergy	1,200	6
End Stage Renal Failure	799	5,506
Hepatobiliary & Pancreatic Surgery	794	4,895
Clinical Haematology	753	46
Renal Transplant	548	1,793
Integrated Medicine	499	269
Pain Management	425	3
Integrated Medicine (Elderly)	356	8,134
Chemical Pathology	296	0
Stroke Medicine	239	6,655
Renal Access Surgery	234	245
Sports Medicine	170	82
Neonatology	107	167
Dermatology	82	0
Infectious Diseases	72	9
Neonatal Intensive Care	28	415
Paediatric Other	16	0
Other	16	0
Paediatric Medical Specialties	6	14
Critical Care Medicine	5	0
Cardiology	2	112
Accident & Emergency	1	20
Trauma	1	0
	58,738	**112,314**

Data based on 13/14 activity

Appendix 2

Communication Plan:

Date	Task	Action/Info	Lead	Status
29 January	Agree 'core script' for internal / external stakeholders	Chris Allsager and Strategy Team lead agree / amend the current script	Mark Wightman	Immediate
29 January	Clarity on where we are in the process and decision making	Weekly updates to stakeholders	Mark Wightman (in the interim)	Immediate
29th January and ongoing	We need to take a view on the potential numbers of patients who may be affected by the service moves and decide how we involve stakeholders in the planning of this	Project Director / Project Manager to establish the likely impact and numbers of patients affected… then in conjunction with Mark Wightman, to determine the engagement approach.	Exec SRO (Kate Shields in interim)	In Progress
W/C 2nd February	Create presentation for staff briefings	Short Powerpoint presentation on hand for staff / external briefings	Project Manager	In Progress
Ongoing	Engagement by CMG leads with medical staff to build a consensus view	ITAPS Clinical Leaders present outline plans to their colleagues in ITAPS and other affected CMGs	Project Director / Project Manager	In progress
Ongoing	Engagement by CMG leads with nursing and other staff groups to build a consensus view	ITAPS Clinical / nursing leaders in collaboration with their peers in other CMGs present outline plans to their colleagues other affected CMGs	Project Director / Project Manager	In progress
29th January	Prepare and QA the 5th February Board Paper (In public)	Strategy Lead (borrowing from core script)	Strategy Lead	In progress
29th January	Brief / buy in from NHSE / NTDA	Need to be clear that they know about the plan and that is going into the public domain.	Kate Shields	TBC
30th January	Board papers sent out 30th January		Mark Wightman	TBC

Date	Task	Action/Info	Lead	Status
30th January	All staff message based on the core script / Board paper on January 30th	This to be sent out before the Board papers are posted online	Tiff Jones	TBC
21st January	Written stakeholder briefings (with the offer of face to face meetings) with key external stakeholders	As part of the BCT Strategic Outline Case communications	Mark Wightman / Stuart Baird	Done
6th February (TBC)	F2F MP briefings where appropriate / requested		Mark Wightman / City CCG	TBC
25th February / 10th March	Arrange briefings for City and County Health Overview and Scrutiny Committees	Meetings arranged for: County 25th February. City 10th March	Kate Shields / Chris Allsager / Mark Wightman	Done
March onwards	Maintain a rolling programme of communication and engagement within and external to the Trust	Confirm the Better Care Together programme activities ITAPS Clinical Leaders maintain regular communication with Trust colleagues	Mark Wightman Project Director / Project Manager	Planned

Key messages:

Leicester currently has 3 intensive care units, (ITUs), one at each hospital. However the service and clinical teams are spread too thinly across the three. So whilst demand for ITU grows at the Royal and the Glenfield, it has diminished at the General. Over the last few years this has meant that recruiting clinical staff to the ITU at the General has been problematic because new young intensivists want to practice in big, busy units.

The clinical teams have told us that it is time to bite the bullet and that the only way to make sure that ITU at the Royal and the Glenfield is capable of dealing with demand is to shift beds and expertise from the General, (in line with the strategy to have two, rather than three acute hospitals), and invest in two 'super ITUs' at the other hospitals. This therefore is the plan and though it is part of the overall strategy for Better Care Together, it is likely to be something that needs to be executed sooner rather than later, (within 12 months).

Spokespeople

Chris Allsager, Clinical Director, ITAPS
Andrew Furlong, Dept Medical Director
Kate Shields, Director of Strategy

Appendix 3 - Current Risk Register

Risk ID	Risk description	Likelihood (1-5)	Impact (1-5)	Risk severity (RAG)	Raised by	Risk mitigation	RAG post mitigation	Risk Owner
1	Capacity constraints within system to enable moves	4	5	Red	All groups	Rapid planning of capacity required and continuous communication throughout bed programme to determine space available through other workstreams	Amber	CA/JJ
2	Tight nature of timescale	4	5	Red	All groups	Early engagement and decision making with quick escalation of non-compliance and delays	Amber	CA/JJ
3	Failure to transfer critically ill patient in a timely manner	2	5	Amber	All groups	Clear modelling to identify capacity needed. Work with EMAS to ensure comprehensive support. Initial support at level 3 for patients needing ICU support until transport is arranged.	Amber	CA/JJ
4	Loss of DaVinci Robot activity whilst this is moved from LGH new site	2	4	Amber	All groups	Planned downtime with increased utilisation before and after move	Amber	LRI Group/ Gynae-Onc
5	Competing demands from other service changes not being accommodated in to the overall project	3	4	Amber	All groups	Project manager to provide cross fertilisation with other groups. Link into configuration cross cutting group. Cross CMG representation on all workstreams	Amber	CG
6	Deskilling of ICU nursing staff at LGH	3	4	Amber	All groups	Ensure that all staff can indicate where they would like to work in the future. Rotational posts across all three sites	Amber	CA/JJ
7	Increased bed pressures on the 2 busiest sites.	2	5	Amber	All groups	Detailed modelling to identify likely capacity needed at both sites. LRI and GGH workstream to agree co-location possibilities. Movement off LRI and GGH site of all specialities not needing to be on these sites. Consider ring-fencing of surgical beds	Amber	CA/JJ
8	Inability to replace activity moved out by LGH services moving off site	1	4	Green	All groups	Clear understanding of future use of LGH.	Green	CA/JJ