# UHL Reconfiguration Update: Impact of capital delay on costs and clinical sustainability

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## Executive Summary

### Context

The longstanding need to reconfigure Leicester's Hospitals in order for them to be clinically and financially sustainable is well known and dates back nearly two decades. However, as time passes without clarity on capital funding, the clinical sustainability issues that were once *envisaged* start to become clinical *realities* which require addressing.

As reported in the paper to the Trust Board last month, we are still waiting to understand from NHS Improvement and NHS England what the next steps will be to access capital to progress with our reconfiguration programme. Owing to the acknowledged lack of national capital available this financial year, we are unlikely to hear in the near future.

Thus in view of the delay in progressing with the reconfiguration of services, this paper outlines the work undertaken to assess:

- the impact that delay has on the capital requested,
- the impact that delay has on the sustainability of our clinical services.

### Questions

1. What is the impact of delay on the capital requested?
2. What is the impact that delay has on the sustainability of our clinical services?

### Conclusion

1. The capital bid to deliver our reconfiguration programme submitted in July 2018 was for £367m, and reflected a point in time. This included the assumption that the capital for the new build elements of the scheme would be accessed via some form of private finance. In this year's Spring Budget, the Chancellor announced that Private Finance, in its current format, would no longer be a viable source of funding. The consequence of which is an increased cost to the programme because of Value Added Tax (VAT). In addition, the delay in the start point for the programme has the impact that inflation will increase the budget required to deliver the scheme. Exact costs will therefore be unclear until the point in time that we are successful in obtaining funding.

2. The delay has an impact on the sustainability of our clinical services. The more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in a small number of our clinical services. This paper

identifies the affected services and the mitigations. Affected areas are maternity and neonatal services; the Intensive Care Unit at the LRI and renal services. In addition, we are reviewing the models of care and standard operating procedures for urology and interventional radiology at the LGH once the level 3 ICU and associated services move off the LGH to the LRI and GH, to ensure continuation of safe and sustainable services.

### Input Sought

The Trust Board is requested to:

- **Discuss the content of this paper, and advise whether actions identified are sufficient**
- **Receive a further update on the agreed actions once the work to clearly articulate the actions and revenue impact has concluded.**

### For Reference

1. The following **objectives** were considered when preparing this report:

| | |
|---|---|
| Safe, high quality, patient centred healthcare | [Yes] |
| Effective, integrated emergency care | [Yes] |
| Consistently meeting national access standards | [Yes] |
| Integrated care in partnership with others | [Not applicable] |
| Enhanced delivery in research, innovation & ed' | [Yes] |
| A caring, professional, engaged workforce | [Yes] |
| Clinically sustainable services with excellent facilities | [Yes] |
| Financially sustainable NHS organisation | [Yes] |
| Enabled by excellent IM&T | [Yes] |
| | |
| Board Assurance Framework | YES: Reference PR7 |

2. Related **Patient and Public Involvement** actions taken, or to be taken: [Described in the report]
3. Results of any **Equality Impact Assessment**, relating to this matter: [A full EIA is being completed as part of the Pre-Consultation Business Case]
4. Scheduled date for the **next paper** on this topic: [03/10/19]
5. Executive Summaries should not exceed **4 sides** [My paper does comply]
6. Papers should not exceed **7 sides.** [My paper does comply]

# UHL Reconfiguration Update: Impact of capital delay

## Background

1. As reported in the paper to the Trust Board last month, we are still waiting to understand from NHS Improvement and NHS England what the next steps will be to access capital for our reconfiguration programme. Owing to the acknowledged lack of national capital available this financial year, we are unlikely to hear in the near future.

2. In view of the delay in progressing with the reconfiguration of services, this paper outlines the work undertaken to assess:

    - the impact on the capital requested,
    - the impact that delay has on the sustainability of our clinical services.

## Impact of delay on the capital budget required to deliver the programme.

3. The capital bid to deliver our reconfiguration programme submitted in July 2018 was for £367m, and reflected a point in time. This included the assumption that the capital for the new build elements of the scheme would be accessed via some form of private finance. In this year's Spring Budget, the Chancellor announced that Private Finance, in its current format, would no longer be a viable source of funding.

4. The consequence of which is an increased cost to the programme because of Value Added Tax (VAT). In addition, the delay in the start point for the programme has the impact that inflation will increase the budget required to deliver the scheme. Exact costs will therefore be unclear until the point in time that we are successful in obtaining funding.

## Clinical impact of the delay

5. It must be recognised that the more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in a small number of our clinical services. This includes maternity and neonatal services; the quality of the environment in the ICU at the LRI and renal services. In addition, we are reviewing the models of care and standard operating procedures for urology and interventional radiology at the LGH once the level 3 ICU and associated services move off the LGH to the LRI and GH, to ensure continuation of safe and sustainable services.

6. In considering the issues face by clinical services, a number of questions were posed, including:

    - Has the risk been appropriately escalated and scored to reflect the materiality? Are the mitigations identified sufficient?

    - Does adding workforce help mitigate the risk? Is there an alternative, less traditional staffing model? Are the staff available to be recruited?

    - How will the impact on the revenue budget be managed?

- How will we fund the capital required for mitigation?

**Split site neo-natal services**

7. Neo-natal services are currently split across two sites. This split site working breaches the British Association of Perinatal Medicine (BAPM) standards for consultant staffing, and has been raised as a concern by the Care Quality Commission (CQC) and the NHS England Quality & Safety Review. We are aware that we are one of a very few centres nationally who have a split site neonatal service.

8. The Maternity Unit at the LGH supports 4,000 births per year. The neo-natal unit at the LGH is essential to ensure newborns have access to any specialist care they need. This is not always predictable. It will therefore not be possible to resolve this split site working until the maternity services are moved off the LGH to create a single maternity hospital and neonatal unit at the LRI.

**Split site neo-natal services Interim Mitigation:**

9. The mitigation for the split site neonatal unit is to increase the consultant presence at the LGH. To do this, we will establish a resident consultant tier to cover the LRI neonatal unit, which is a much busier unit supporting the sickest babies, and have a second consultant available on call from home covering the LGH and the neonatal transport service. Consultant recruitment will help but will not fully resolve issues: there remain issues with nursing and junior medical staff cover in a split site model. The only medium to long term solution is a single site neonatal service.

10. We have identified that to do this we need to appoint up to five additional consultant posts which will mitigate this risk and ensure sustainability of the unit until it can be moved to the LRI with the maternity service.

11. We have started this process; a business case has been approved to appoint to two additional posts; one consultant has been appointed, the second post is out to advert. The outcome of the business case to appoint the additional three posts is awaited from the Revenue Investment Committee.

12. There is confidence that we will be able to recruit to these posts over next one to two years with an annual revenue cost of approximately £600k.

**Split site maternity services**

13. Since 2008, two clinical and two external peer reviews have concluded that the split site maternity services provided from the LGH and LRI are not sustainable, and should be co-located on one site.

14. An “Interim solution” was instigated in 2012 which has stabilised the capacity on both sites, but leaves continued risk in service provision as follows:

    - **Rotas and Services.** Duplication in services generates inefficiencies; the current need for all clinicians to work across sites creates inefficiencies (cover at the LGH is variable and between 1 to 4 consultants can be based on the LGH site during day; at times, a single consultant covers the delivery suite, clinic and emergencies).

    - **Medical Staffing.** There is a staffing deficit across the sites caused by split site working; medical staffing is lesser in number at the LGH with the staff cohort focussed at the LRI in order to maintain separate emergency and planned deliveries.

    - **Midwifery Staffing.** The Birthrate Plus report recommends that the midwifery establishment is enhanced overall, with additional establishment required at LGH to support the emergency theatre process out of hours.

    - **Better Births.** The emphasis on care for vulnerable women requires extra midwifery capacity in specialist midwifery, mental health and safeguarding. In addition to this, the number of women on the Continuity of Carer pathway needs to increase to 35% by March 2020, requiring increased Midwife to Birth ratios. (This pathway ensures that women have consistency with a small team of midwives who care for them throughout the antenatal, intrapartum and postnatal periods of care.)

**Split site maternity services Interim Mitigations**

15. The following mitigations are being considered to reduce the risk of split site working:

    - Enhancement of consultant presence at LGH by rostering SPA activities on that site during the day and by creating a separate elective pathway in obstetrics at LGH (currently elective activity at LGH is limited by the fact that it is delivered alongside emergency activity in Delivery Suite Theatre). This would require a dedicated theatre and theatre team for five half days per week and a minimum of 1.0 WTE additional obstetric consultant support and appropriate theatre surgical assistance.

    - Upgrade the current clean room adjacent to the maternity theatre at LGH to provide a second Theatre. This would allow separate elective and emergency pathways and provide a safer environment for a second theatre for emergencies when required. This would result in a second consultant being on-site in the morning with the option to interrupt the elective activity when necessary and provide support to delivery suite/Maternity Assessment Unit (MAU) where possible.

    - Implement a day care service at both LRI & LGH to take the pressure off MAU & inpatient beds. This will require a business case for added Midwifery and Medical resource and necessary estate and equipment.

    - Increase the presence of senior decision makers in MAU in support of medical trainees and midwives. We will need an increased resource to improve the consultant availability, particularly at LGH (helped by separating elective pathway and “freeing” Delivery Suite Consultant to cover emergency/unplanned activity).

- Increase the midwifery establishment (our professional review of the Birthrate Plus report recommendations support an additional 20 midwives and 10 Maternity Care Assistants) in all service areas and across all grades.

- Increase the medical staffing to fill separate split site middle grade and consultant rotas with increased consultant presence and support (particularly at LGH)

- Dedicated out of hours theatre team on the LGH site as currently emergency out-of hours theatre activity takes midwifery staff away from "normal" Delivery Suite care and/or the Ward

16. Work is underway to define the revenue and capital implications of these mitigations. This increase in staffing levels could cost in the region of £2m per annum.

**Intensive Care Unit (ICU) Capacity**

17. Whilst the Interim ICU project to move level 3 ICU beds and associated surgical services off the LGH to the LRI and GH resolves the impending clinical risk of sustainability of level 3 ICU services at the LGH it does not resolve the Trust wide overall lack of ICU beds. (We currently have 55 beds. If we had the UK average number of beds this would be 75; and within our future reconfiguration plans we estimate we need 115 ( which would meet the UK average bed number and allows inclusion of satellite High Dependency Units as per best practice) )

18. After the move of level 3 ICU beds from the LGH to the LRI and GH, the unit under most pressure is the LRI ICU. Our existing ICU at the Royal is very cramped and falls well below the National Standards in terms of space and number of beds which leads to potential issues with infection prevention. It does not have enough bed capacity for all the patients that require intensive care; one of the consequences of which is the cancellation of elective patients, who then need to wait longer for surgery. We currently have 21 beds on this unit, which will increase to 48 beds once we have received the capital to extend and improve our ICU. The new unit will have much larger bed spaces to create an environment which is better for both patients and staff.

**Intensive Care Unit (ICU) Capacity Mitigations:**

19. The ICU expansion at the LRI has been agreed as the first priority when external capital is announced.

20. In August 2018, Executive Strategy Board supported the approach that in the event that external capital is not forthcoming, then this will be progressed through internal capital (CRL). However at circa £31m, this will be very challenging to achieve given the many and competing calls on our very limited internal capital; but is being built into the 5 year capital plan over a number of years from 2021/22. (It cannot be expedited earlier owing to other pre-commitments e.g. the move of the East Midland Congenital Heart Centre from the GH to the LRI.)

21. In the meanwhile, a feasibility study is being undertaken this year to review and agree the location of the extended unit and the design solution to ensure that we are ready to go as soon as capital becomes available.

**Renal In-patient Beds**

22. It is known and recognised that the interim ICU project necessarily splits the transplant service from the inpatient renal service for a short period. Equally it is known that this is not clinically sustainable in the longer term, where it would create issues around quality of care, staffing, training and the requirement to meet NHS England service specification and national peer review recommendations.

**Renal In-patient Beds Mitigations**

23. The move of the inpatient service from the LGH to GH will take place approximately 6 months after the transplant service moves and will be funded from our internal capital (CRL).

24. The project to move the East Midlands Congenital Heart Centre (EMCHC) from the Glenfield to the LRI creates the opportunity move the renal service to GH at minimal cost (approximately £1.5m) as an interim measure; whilst the long term reconfiguration capital is being sought.

25. Construction work will commence when the EMCHC service has moved to the LRI (December 2020); construction will take 6 months.

26. As part of the service move, Lincolnshire in-patients will be re-patriated locally to Lincoln County Hospital. The Getting it Right First Time (GIRFT) (visit Jan 19) provided strong support for this development.

**Urology & Interventional Radiology**

27. We are reviewing the models of care and standard operating procedures for urology and interventional radiology at the LGH once the level 3 ICU and associated services move off the LGH to the LRI and GH, to ensure continuation of safe and sustainable services.

**Quality of the Estate**

28. There is a significant back log maintenance issue across the Trust due to capital constraints resulting in a lack of investment. The LGH is a specific concern; the delay in the availability of capital will exacerbate this issue as the LGH needs to function for the foreseeable future.

29. The Estates team are finalising a review of the essential infrastructure work needed to maintain operational performance and patient safety. This will be presented to a future Trust Board.

**Conclusion**

30. These issues were discussed at the Trust Board Thinking Day on the 13th June, and whilst further detail is required, especially on the mitigations for the maternity service, it was agreed that appropriate steps, including those identified above will be progressed to mitigate the risk, on the basis that even if the overall capital bid is supported soon, the solutions will still take a number of years to deliver. The pace of implementation of the various mitigating solutions will necessarily be impacted by financial and workforce resourcing considerations and this will be reflected in the continuing process of risk assessment.

31. The team will conclude the above piece of work in August.

32. This paper will form the basis of further communication with all our stakeholders, including the CQC, and our regulators.

33. In the meanwhile, the Chief Executive will continue to have conversations with NHSI/E about how best to position ourselves so that we are best placed for when national capital is announced.

## Input Sought

The Trust Board is requested to:

- **Discuss the content of this paper, and advise whether actions identified are sufficient**
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