healthwatch Rutland

Paper 2
University Hospitals of Leicester Pre-consultation Business Case (September 2020 update v3.2) for the Acute and maternity reconfiguration plans: The impacts for Rutland?

1. Introduction

On 28th September the three Clinical Commissioning Groups (CCGs) for Leicester, Leicestershire and Rutland launched their consultation programme for the planned reconfiguration of the University Hospitals of Leicester NHS Trust (UHL) hospitals and maternity services. This paper, from the Healthwatch Rutland Board, examines the pre-consultation business case (PCBC) informing this consultation. It briefly outlines the proposals, teases out potential impacts for Rutland people and asks questions arising from the reconfiguration proposals.

2. The case for change

The PCBC outlines the need for the reconfiguration of the three acute hospitals: Leicester General Hospital (LGH), Glenfield Hospital (GH) and Leicester Royal Infirmary (LRI)This is driven by multiple considerations including:

Current challenges (PCBC p7)

- An ageing demography with an increasing number of people living with chronic disease and multiple comorbidities. This has been creating an extra demand on the acute (hospital) services.
- Increased demand for elective and maternity services.
- A need for a more clinically sustainable model of care.
- A need to balance demand between emergency and elective (planned) care. (Elective procedures often postponed due to emergencies).
- A need to improve standards.
- A need to improve finances eg backlog of maintenance now estimated at circa £77m and excess land which could be sold off for essential key workers' housing and fund improvements (PCBC p23).
- A need for more efficient use of staff (PCBC p3, p5).

Stated benefits for patients

- Increased consultant and senior staff presence will lead to better clinical outcomes.
- Multi-speciality teams in one place.
- Reduced cancellations.
- Improved clinical environment.
- Improvements in technology.

3. The proposals

3.1 What is proposed? (Consultation document pp 15-24)

Leicester Royal Infirmary

Plans include:

- Designed as a 'hot' site for emergency care.
- A bespoke children's hospital.
- A women's hospital for gynaecology.
- A maternity unit incorporating a neonatal unit, obstetrician unit and a midwife lead unit providing inpatient and outpatient antenatal, delivery, and postnatal care.
- Haematology.
- Infectious diseases.
- Improvements to car park facilities.
- 'Super' Intensive Care Unit.

Glenfield Hospital

Plans include:

- To be designed as a 'cold' site for elective (planned) care.
- A new build treatment centre for outpatients and day case procedures (including 23 hour recovery beds).
- 'Super' Intensive Care Unit.
- Sale of excess land.
- An outpatients' haemodialysis unit.
- Improvement to car parking facilities.

Leicester General Hospital

Plans include:

- Transfer of all acute services to GH and LRI.
- Retain Diabetes Centre of Excellence.
- Stroke rehabilitation unit in the Evington Centre.
- Closure of hydrotherapy pool with patients diverted to community facilities.
- Closure of outpatient haemodialysis unit and new units at Glenfield Hospital and in the south of Leicester.
- A General Practice imaging centre.
- A back-office facility.
- Subject to consultation:
    - A midwife-led birthing unit.
    - Primary care urgent treatment centre, open at least 12 hours per day with observation beds.
    - Community outpatient treatment facility.
    - An additional GP facility.

These proposals will be facilitated by:

- More care 'closer to home' to avoid inappropriate hospital admissions and to utilise community care services (including community hospitals).
- Decreased lengths of stay (in hospital).
- Better use of Information Technology.
- Improved models of care.
- Helping people to stay well and self-manage their long-term conditions.
- Avoiding unnecessary, low value outpatient appointments.
- Efficiencies measures such as 'Getting it Right First Time' (GIRFT), BADS (British Association of Day-case Surgery) pathway.

3.2 Bed Numbers (PCBC pp252-256)

- Bed numbers winter 2019 = 2033.
- Bed modelling suggests that during the peak demand of winter of 2023/23 there will need to be 2333 beds needed – an increase of 300.
- These extra beds will be achieved by:
  - Bringing former clinical space back into clinical use — 41 beds
  - Beds made available by removal of reablement ward — 28 beds
  - Through planned efficiency measures — minimum 161 beds
  - Potential shortfall — 70 beds

Depending on demand and the success of efficiency measures, there could be a shortfall of up to 70 beds which the PCBC states: UHL will '*if necessary, address … in later years through CRL (Capital Resource Limit) funding for what equates to 2.5 wards*' (p256).

The real number of actual beds is therefore increased by 139 (p120)[1]. Efficiencies will 'free up' 161-237 beds.

Planned percentage bed occupancy is elective and day care 93% and emergency 90%.

The PCBC (p289) states 64,506 patients on the Referral to Treatment waiting list in 2018/2019. This is projected to reduce to 61,493 by 2023/2024.

Questions

1. Given that, despite efficiency plans etc the waiting list will only reduce by 3013 patients by 2023/24, should the plans be modified to better meet demand and reduce waiting times?
2. What are the current and projected numbers for inpatient activity?
3. What is the impact of Covid-19 on RTT and what are now the projections for numbers on the waiting lists?

[1] Appendix V of the PCBC gives more details of the UHL plans to mitigate growth in activity and beds

4. What is the timing of extra bed provision as the building work will take several years to complete?

4. The impacts for Rutland residents

4.1 Travel

Travel to health care facilities is a problem for Rutland people. Public transport to all UHL hospitals from many Rutland villages involves two bus journeys and a train journey. Taxis are expensive. There are various voluntary driver schemes – at a cost.

In a 2019 Healthwatch survey[2] 92% of respondents with long term conditions said they used their own car or another's car to access health care. Appendix W of the PCBC, the traffic impact assessment, provides detail of the extra time that will be taken to reach LRI or LGH for services that are currently accessed at LGH:

From Postcode	To **LRI instead of LGH** – extra travel time by car (p450-452 Table 2)	Impacted inpatients 2014/15	Outpatients attendances 2014/15
LE15 6	10 minutes	167	669
LE15 7	9 minutes	73	401
LE15 8	9 minutes	46	309
LE15 9	10 minutes	72	447
PE9	10 minutes	5	32

The above table presents historical data only. The column titles differ slightly - undermining accuracy and clear understanding. For example, Leicester Royal Infirmary data is almost 6 years old and details the number of 'impacted inpatients' (ie those inpatients in 2014-15 who would have been impacted at that time by the proposed reconfiguration). The second is merely labelled 'outpatient attendances'.

The table below for Rutland residents travelling to Glenfield Hospital instead of Leicester General Hospital draws on similarly dated data (2014/15) but columns are titled 'potential impacted activity'.

From Postcode	**To Glenfield Hospital instead of LGH** – extra travel time by car (Appendix W p448-449 Table 2)	Potential inpatient activity impacted per annum (stays) 2014/5	Potential outpatient activity impacted (attendances)
LE15 6	9 minutes	219	443
LE15 7	7 minutes	97	266
LE15 8	11 minutes	62	213
LE15 9	11 minutes	104	291
PE9	11 minutes	6	25

[2] Healthwatch Rutland Engagement Report: The NHS Long Term Plan (2019)

Given the different column headings and the age of the data it is difficult to be sure that the figures represent the true numbers of Rutland people who will be impacted by the reconfiguration and whether the comparisons stated are 'like for like'.

Appendix W pp 450-451 suggests that patients from the LE15 6, 7, 8 and 9 and PE9 postcodes could use Peterborough and Stamford Hospitals and have shorter journey times. Patients from the LE15 8 and 9 postcodes also have Kettering Hospital and have shorter journey times.

On patient preference, the PCBC contains 2 confusing and conflicting statements:

1. '*The majority of people rated waiting times and access to specialist above travel time (PCBC p304).*
2. *UHL's experience shows that patients prefer locally based services, even if they have to wait longer, with less than 10% of patients choosing an alternative provide (PCBC p 310).*

Appendix W p456 continues by listing the positive and negative impacts of the reconfigurations by area. The positive impacts for Rutland people are listed as:

- Additional 18 Intermediate Care Service 'Hospital and home' beds.
- Circa 4000 additional planned care outpatient appointments at Rutland Memorial Hospital.
- Circa 600 additional planned care day case procedures at Rutland Memorial Hospital.
- New purpose-built outpatient and day-case facilities at Glenfield site for patients with higher need or undergoing complex specialist procedures.
- No residents of Rutland would be materially impacted from a travel and access perspective by the move of the paediatric congenital heart surgery.

Negative impacts for Rutland people are stated as:

- All (100%) 655 day-case procedures would be materially impacted by increased travel time by up to 11 minutes.
- All (100%) 2063 outpatients' appointments would be impacted by increased travel time by up to 11 minutes.
- All (100%) 299 inpatient stays would be impacted by increased travel time by up to 11 minutes.

The Appendix (p459) suggests that during the consultation the programme will:

- *With councils consider what transport options there are that might reduce the impact on patients who will be negatively impacted by these changes and plan for those to be commissioned and consider funding options.*

- *Consider the impact on the ambulance service and build any potential impact into future commissioning plans.*

Questions

1. Can more recent data be provided than 2014/15?
2. How have the travel times been calculated, at what time of day and in what road, weather and vehicle congestion conditions?
3. What are the possible mitigations being suggested for those in Rutland who are the most negatively impacted, other than 'go elsewhere'?

4.2 Going Elsewhere?

'Going elsewhere' has been the choice of may Rutland people, especially those in the East of the county. 'Going elsewhere' also means going outside of the Leicester, Leicestershire and Rutland health and care system which is moving towards integration. Also, UHL hospitals host many NHS commissioned specialist services which are unavailable in Kettering or Peterborough and Stamford hospitals. For some Rutland people UHL will remain the nearest choice. On pp247-248 The PCBC states:

> *In developing a new Treatment Centre and improving the facilities for patients there is an acknowledged risk that such a facility could attract more planned care work to UHL. This has not been included within UHL's current activity modelling assumptions; however, any such growth would be mitigated in the following ways:*
>
> - *The impact of the BCT planned care initiatives will continue to manage and mitigate demand.*
> - *The impact of increased travel times for some patients who have previously accessed services at LGH. (An assessment has been made of the impact on activity where patients need to travel further. It is estimated that this will impact same day-case and new outpatient activity adversely. Details of the travel impact are provided in Section 7.8.1).*

This statement above implies that Rutland patients 'going elsewhere' will be a mitigation of the risk of too many people opting to use the new-build and more attractive UHL hospitals.

The PCBC (pp309-316) considers the potential impact on other hospitals of patients migrating **to** them **from** UHL – predominantly those living in East Leicestershire and Rutland. The figures, shown in the following two tables, do not include offenders; overseas, emergency, military or private patients; patients using specialised services. The figures do include those registered in a post code of areas bordering the LLR health care area such as Stamford or Corby in addition to LLR residents. The higher calculations of 50% and 75% are to 'stress test'.

Potentially	New outpatients potentially migrating from UHL			
	10%	25%	50%	75%
Kettering	177	451	902	1353
Peterborough	86[3]	218	436	654

Potentially	Day cases migrating from UHL				Inpatients migrating from UHL			
	10%	25%	50%	75%	10%	25%	50%	75%
Kettering	61	153	306	459	34	85	170	255
Peterborough	27	68	136	204	16	40	80	120

The PCBC (p316) states these figures are a small percentage of a total of 73,000 total discharges out of LGH and 233,000 new outpatient appointments at LGH (no date/time span given).

Question

1. Will alternative hospitals be able to accommodate this potential influx of patients given their own demand pressures?

4.3 Maternity care

- **45 -** registerable births to women resident Rutland postcodes in 2017/18 (PCBC p180).
- **22 -** LE15 residents who were inpatients in St Mary's hospital, Melton Mowbray 2017/18 (Appendix X PCBC p469).
- **28 -** LE15 residents who were inpatients in Leicester General Hospital 2014/2015 (Appendix X p472).
- **215 -** registerable births to women resident in post codes in the vicinity of St Mary's 2017/2018– implying 84 births took places elsewhere (215-131 = 85) (PCBC p180).
- Steady decline in births at St Mary's 2012/13 = 261, 2017/2018 = 131 (PCBC p178).
- A midwife led unit costs £1.405m to run and must have at least 500 births per year to be viable (PCBC p177).

There are two options for the reconfiguration of maternity services:

1. All maternity services provided at Leicester Royal Infirmary.

[3] To align with the rest of the data presented, this figure should be 87

2. All maternity services provided at Leicester Royal Infirmary + a Midwife Led Unit (MLU) at Leicester General Hospital subject to consultation, dependent on a minimum of 500 deliveries on a twelve month basis (p5) and UHL's ability to provide safe staffing levels.

Antenatal and postnatal care in the community (including community hospitals) will continue.

Appendix X also provides a travel impact assessment and the following tables demonstrate how Rutland women from post codes LE15 6, 7, 8 and 9 and PE9 will be impacted.

From Postcode	To **Leicester Royal Infirmary** instead of St Mary's, Melton Mowbray - extra travel time by car (Appendix X p 462 table 4)	Difference in time if opting to go to **Kettering General Hospital** instead of LRI by car(appendix X p467 table 11)	Difference in time if opting to go to **Peterborough City Hospital** instead of LRI by car(appendix X p467 table 11)
LE15 6	20 minutes	-8 minutes	-8 minutes
LE15 7	27 minutes	-9 minutes	-16 minutes
LE15 8	17 minutes	-9 minutes	-6 minutes
LE15 9	7 minutes	Not stated	Not stated
PE9	Not stated	Not stated	Not stated

From Postcode	To **Leicester General Hospital** instead of St Mary's, Melton Mowbray - extra travel time by car (Appendix X p469 table 13)	Difference in time if opting to go to **Kettering General Hospital** instead of LGH by car(appendix X p467 table 11)	Difference in time if opting to go to **Peterborough and Stamford Hospital** instead of LGH by car (appendix X p467 table 11)
LE15 6	10 minutes	+2 minutes	+2 minutes
LE15 7	18 minutes	0	-7 minutes
LE15 8	8 minutes	0	+3 minutes
LE15 9	Not stated	Not stated	Not stated
PE9	Not stated	Not stated	Not stated

Other stated mitigations include:

- Home births – midwife attended (PCBC p470; appendix x p468).
- Neonatal unit on the same site as the Children's Hospital (PCBC p470).
- Short stay/drop off near Women's Hospital for women in labour (PCBC p475).
- Antenatal and postnatal services delivered locally PCBC p470).
- Women can use other hospitals (PCBC p470; appendix X p468).
- There will be improved facilities at LRI (appendix X p468).

Questions

1. What is the accuracy of time distances between post codes and do these times reflect peak or off-peak road congestion times and weather conditions?
2. The PCBC states that an MLU will conditionally remain at LGH. Will the new LRI Maternity unit be built with sufficient capacity to accommodate extra women should the LGH MLU be closed?
3. Which year will be the 'pilot year' for an MLU at LGH?
4. What are the complete data for LE15 9 and PE9?

4.4 Haemodialysis

Haemodialysis (being attached to a 'kidney machine') allows patients whose kidneys have failed to stay alive by filtering excess fluid and toxins from the blood. This means being connected to a machine for 3-4 hours approximately 3 times a week. Many patients opt to use a haemodialysis unit for this therapy. One of the nearest units to Rutland patients is at Leicester General Hospital. This will be relocated at Glenfield Hospital with a new unit being established south of Leicester (PCBC p152).

Questions

1. How many Rutland patients will be negatively impacted in terms of travel times by the relocation of the haemodialysis unit?
2. What are the reasons for not retaining a haemodialysis unit at Leicester General Hospital if it is to become a Community Hub?
3. Could a haemodialysis unit be a viable option in Rutland as part of 'care close to home'?
4. If the two new haemodialysis units are to be at Glenfield Hospital and south of the city and no satellite unit provided in Rutland, will there be sufficient capacity for Rutland patients to use the Hamilton dialysis unit if it is nearer for them?

4.5 'Care Closer to home'

The PCBC throughout is describes 'models of care' which are often predicated on 'care closer to home'. The PCBC (p60) states:

> *Currently there are no dependencies between the acute reconfiguration proposals and the future use of community hospitals. The proposals set out in this PCBC, for example, do not require a reduction or increase in the community bed stock or community services.… the second phase [of the community services review] will review provision and usage of our community hospitals. This is expected to have limited impact on UHL's reconfiguration programme.*

But, throughout, there is further reference to more outpatients and day cases being carried out in community hospitals (see for example p9, p128 and p320).

The PCBC (p60) also states:

> *The major change programme within BCTP that does have an interdependency to the acute reconfiguration proposals is LLR's system work on frailty/multi-morbidity. The modelling based on NHS Right Care case studies and local evidence, assumes that, as a result of the interventions within the frailty/multi-morbidity system of care, partial growth in the number of acute beds required will be mitigated.*

Additionally, and as stated in section 4.1 of this paper, there is an assumption that in Rutland there will be 18 'hospital and home beds', 4000 outpatient appointments and 600 day case procedures at Rutland Memorial Hospital (RMH) (p456). The ongoing community services review specifically looks at the future of community hospitals and community beds in the LLR healthcare region and the outcome is not yet known.

Question

1. Should the public be expected to comment on the consultation survey before the results of Community Service Review (specifically in relation to services and beds at Rutland Memorial Hospital) are known?

Collated questions

Page 3 (bed numbers)

1. Given that, despite efficiency plans etc the waiting list will only reduce by 3013 patients by 2023/24, should the plans be modified to better meet demand and reduce waiting times?
2. What are the current and projected numbers for inpatient activity?
3. What is the impact of Covid-19 on RTT and what are now the projections for numbers on the waiting lists?
4. What is the timing of extra bed provision as the building work will take several years to complete?

Page 6 (travel)

1. Can more recent data be provided than 2014/15?
2. How have the travel times been calculated, at what time of day and in what road, weather and vehicle congestion conditions?
3. What are the possible mitigations being suggested for those in Rutland who are the most negatively impacted, other than 'go elsewhere'?

Page 7 ('going elsewhere')

1. Will alternative hospitals be able to accommodate this potential influx of patients given their own demand pressures?

Page 9 (maternity)

1. What is the accuracy of time distances between post codes and do these times reflect peak or off-peak road congestion times and weather conditions?

2. The PCBC states that an MLU will conditionally remain at LGH. Will the new LRI Maternity unit be built with sufficient capacity to accommodate extra women should LGH be closed?
3. Which year will be the 'pilot year' for an MLU at LGH?
4. Why are the data for LE15 9 and PE9 incomplete?

Page 9. (haemodialysis)

1. How many Rutland patients will be negatively impacted in terms of travel times by the relocation of the haemodialysis unit?
2. What are the reasons for not retaining a haemodialysis unit at Leicester General Hospital if it is to become a Community Hub?
3. Could a haemodialysis unit be a viable option in Rutland as part of 'care close to home'?
4. If the two new haemodialysis units are to be at Glenfield Hospital and south of the city and no satellite unit provided in Rutland, will there be sufficient capacity for Rutland patients to use the Hamilton dialysis unit if it is nearer for them?

Page 10 ('care closer to home')

1. Should the public be expected to comment on the consultation survey before the results of Community Service Redesign work (specifically in relation to services and beds at Rutland Memorial Hospital), upon which it seems to be predicated, are known?

Glossary of abbreviations

BADS	British Association of Day Case Surgery
BCT	Better Care Together - the title given to the plans to create integrated care in Leicester, Leicestershire and Rutland
CRL	Capital Resource Limit
CSR2	Community Services Redesign phase 2
GH	Glenfield Hospital
GIRFT	Getting it right first time
LGH	Leicester General Hospital
LLR	Leicester, Leicestershire and Rutland
LRI	Leicester Royal Infirmary
MLU	Midwife-led unit
PCBC	Pre-consultation business case
RMH	Rutland Memorial Hospital
RTT	Referral to treatment time (i.e. waiting list)
UHL	University Hospitals of Leicester