Agenda Item 9

Joint overview and scrutiny representation response.

In response to the representation to Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee we have responded to the three issues you raised below:

COVID-19

We recognise that the world has changed, for everyone, not just the NHS. One of the only certainties being that we will be living with increased uncertainty for a long time.

That being the case it is tempting for organisations to shelve plans or put off decisions in the hope that the future becomes more certain or that someone comes along to tell them what to do.

We think that is the wrong approach especially now when we consider all that we have learnt in planning for, and dealing with, the impact of the first wave of the pandemic.

At the heart of the our clinical strategy (which drives the £450m reconfiguration plan) is the desire to focus emergency and specialist care at the Royal and the Glenfield hospitals and separate non-emergency care from emergency care so that when we are very busy those patients waiting for routine operations are not delayed or cancelled because we have had to prioritise an influx of emergency patients.

More recently, we have asked ‘does this still make sense when we look at what the pandemic has taught us?’ The short answer is yes, and these are the reasons.

Intensive Care:

One of the biggest challenges we faced preparing for the first COVID-19 peak was to create enough adult Intensive Care Unit (ICU) capacity. In steady state we have 50 ICU beds. The initial pandemic modelling suggested that we would require closer to 300 bed, which was a daunting ask of our clinical teams. Nonetheless, within a fortnight we had a plan to increase our capacity in-line with the predicted peak, largely as a result of converting every available space with the right oxygen supply into makeshift ICUs and by suspending children’s heart surgery so that we could convert children’s ICU into adult ICU.

Thankfully, largely as a result of the success of lockdown halting the spread of the virus, the peak was not as pronounced as we had first expected and we had, at the highest peak, 64 patients in intensive care.

In our reconfiguration plans we have said that we will create two ‘Super ICUs’ at the Royal and the Glenfield doubling our normal capacity to over 100 ICU beds. Had these been in place at the time of the pandemic our response would have been very different; we would have had enough ICU capacity with plenty to spare.

Children's Heart Surgery:

As mentioned above, we knew that COVID-19 would require us to care for very many more adult patients on ICU. Mercifully children were less affected by the virus. With limited ICU capacity we therefore took the difficult decision to halt children's heart surgery in Leicester, transfer those children awaiting their operation to Birmingham Children's Hospital and convert the Paediatric Intensive Care Unit at the Glenfield into an adult ICU. On balance we took the decision based on what would save the most lives, knowing that our children would still have their surgery albeit not in Leicester and as a consequence we could care for more of the terribly sick adults whose only hope was sedation and ventilation.

However in our reconfiguration plans we are going to create a standalone Children's Hospital at the Royal; the first phase of which is scheduled to complete in spring 2021. Had the Children's Hospital been built we would have been able to continue with heart surgery during COVID-19 knowing that the children were safe in a standalone hospital with a totally separate ICU.

Cancer and Elective operations:

Locally and nationally patients who had been previously listed for operations and procedures were cancelled in very large numbers as hospitals made preparations for the pandemic. This affected all services and all types of patients, even some with cancer. The only surgery we were able to continue was for those emergency cases that, without an operation within 24-72 hours, would have been likely to die. In terms of cancer cases where patients are often immuno-compromised there was the added concern about bringing them into a hospital with positive COVID-19 patients and the impact that this could have if, in their already poorly state, they picked up the virus.

In our reconfiguration plans we are going to build a standalone treatment centre at the Glenfield Hospital; this will be a brand new hospital next to the existing hospital. It fulfils our desire to separate emergency and elective procedures. Meaning that when we are busy with high numbers of emergencies, our elective patients still receive care. Had this been in place by the time of the pandemic we would have been able to maintain significant amount of our non-emergency work and create a 'COVID clean' site.

Impact on staff:

Even before the pandemic we regularly struggled to effectively staff our services. The fact that we have three separate hospitals with the duplication and triplication of services that entails means that we often have to spread our staff too thinly in order to cover clinical rotas. During the first peak of COVID we had 20% sickness across all staff groups meaning that 1 in 5 staff were either sick or self isolating. It is a testimony to all our staff that despite this we kept going but it is unsustainable in the long term.

Once reconfigured we would no longer have to run triplicate rotas for staff on three hospital sites. For example with two super ICUs rather than the current 3 smaller ones we would have been able to consolidate our staffing making it easier to cover absences when they occurred and perhaps even give staff the time to 'decompress' after repeat days of long and harrowing shifts.

Overall, it is clear to us that had the timing been different our hospitals would have been better able to cope with COVID 19 in their reconfigured state and our patients would have received a better, safer service.

COMMUNITY SERVICES

The consultation does not include proposals for community services including hospitals, GP practices or mental health.

We have engaged with the public on a number of occasions to understand what matters most to them about community services close to home. The clinical commissioning groups are fully committed to working with people at a 'placed-based' level to develop plans to transform local services, particularly taking into account the impact of the temporary changes made during the pandemic. It is our desire to move peoples' care closer to home and develop more services, not reduce the care provided in local areas. This engagement will take place after the acute consultation. If we find that through this engagement that the proposals are such that they require formal consultation, then this will be undertaken.

However, we will ensure that the insights we are receiving from people through our current consultation which are relevant to community care are fed into the development of these locally based community plans.

PROPOSALS FOR A COMMUNITY HUB AT LEICESTER GENERAL HOSPITAL

We are proposing to create a community campus at Leicester General Hospital. The cost for this development is not included in the £450 million. The reason for this is that our consultation outlines a range of possible services that could be included on the campus and asks people what they think and to share any additional ideas. These potential services were suggested as a result of hearing what people told us pre-consultation. We will not know until the consultation is complete and the findings published what local people would like to see on this site. Once this is known then we can further develop the plans and look at the funding requirements for a development that will not be realised until 2026/27.

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