Reconfiguration of acute and maternity services at University Hospitals of Leicester NHS Trust

‘our life, our health, our care, our family and our community’

Decision Making Business Case

01 June 2021 update final V1.21
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FOREWORD

The NHS in Leicester, Leicestershire and Rutland (LLR) is part of one of the best health systems in the world, but we do not consistently perform at that level. We do not always reach the very best standards; we do not always achieve the best patient outcomes and we could do better.

The NHS shared planning guidance 2016/17 to 2020/21 outlined an approach to help ensure that every local health and care system in England developed sustainable services for the future, based around the needs of the local population, enabling an accelerated implementation of the Five Year Forward View (5YFV) and NHS Long Term Plan. Locally, the 5YFV and NHS Long Term Plan are being implemented by the LLR Integrated Care System (ICS) (formerly the Sustainability and Transformation Partnership and Better Care Together partnership), which comprises of NHS commissioners and providers working closely with the three local authorities in LLR.

Through the NHS White Paper ‘Integration and Innovation: working together to improve health and social care for all’, published in February 2021, the NHS and local authorities will be given a duty to collaborate with each other. This will bring forward measures for statutory Integrated Care System (ICSs), which will build further on our strong history of partnership working in LLR through the STP ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

The local health economy has made significant strides to reset the system to achieve its potential and to achieve the goals set out in the 5YFV and NHS Long Term Plan. We already have a single management team across the three LLR CCGs and we have partnership arrangements in place to work together across the system.

Over the next few months we will develop our governance in line with the statutory status of the LLR ICS from April 2022. This will include a LLR ICS NHS Board who will be responsible for the day to day running of the NHS in LLR and the Health and Care Partnership who will be responsible to develop a plan across wider partners to address wider determinants of health and the integration of health and care.

The system has one predominant community and mental health provider for our population, one ambulance provider and Together with one community urgent care provider working across our sub-region. As we begin to design one ICS, barriers are slowly disappearing and people are talking about a once-in-a-career opportunity to create a world-class service for patients.

Since the Pre-consultation Business Case (PCBC) was written the world has changed, for everyone, not just the NHS. Understanding the long term impact of COVID19 still requires feats of both foresight and imagination, 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 and for that matter, individuals to
shelve plans and 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 and backwash of the pandemic. Not least because there is one other certainty namely, the public needs the NHS, now more than ever and as such the NHS has a duty to be the best it can be in a COVID endemic world. The pandemic has revealed things that were hitherto unseen or at least unrecognised; the NHS’s ability to adapt.

At the heart of UHL’s clinical strategy (which drives the Reconfiguration Programme) is the desire to focus emergency and specialist care at the Leicester Royal Infirmary and Glenfield Hospital and separate elective care from emergency care so that when UHL are very busy those patients waiting for routine operations are not delayed or cancelled because an influx of emergencies have had to be prioritised. In asking clinical leaders whether the reconfiguration plans still make sense in light of the pandemic, the answer has been a resounding, 'yes'; moreover, it is clear that had the timing been different UHL would have been better able to cope with COVID19 in their reconfigured state.

This Decision Making Business Case (DMBC) is a critical and tangible step towards sustainable health and care for the people of LLR. It aligns with the Triple Aim Duties outlined in the Government White Paper pursuing the three aims of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. While also keeping our planned development of primary, community and social care clearly within view, we deal with the urgent need to redefine the future shape of our acute hospitals provided by the University Hospitals of Leicester NHS Trust (UHL, “the Trust”) to ensure long term clinical and financial sustainability. The reconfiguration of services across three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes; while at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

In this document, we show how the results of the consultation on UHL’s Reconfiguration Programme have informed the development of the Reconfiguration Programme and also provide details of updates to the Reconfiguration Programme since the PCBC.

**Statement of support from LLR CCG Chairs and UHL Medical Director**

“Through our local ICS, we will transform the health and care system in LLR so that it meets the future needs of local people in line with the national NHS Long Term Plan and the NHS White Paper. Our intent is to maximise value for the citizens of LLR by improving the health and wellbeing outcomes that matter to them, their families and carers. We will do this by enhancing quality of care at the same time as reducing cost across the public sector to within allocated resources, restructuring the provision of safe, high quality services into the most efficient and effective settings.
Over the past four years, patients, clinicians, managers and staff from across health and social care have contributed their time and expertise to the design of the programme and the care pathways within it, including those outlined in this Decision Making Business Case. Our active Patient and Public Involvement group is an integral part of the programme. We thank each of them for their contributions to the programme so far and to the development and assurance of this Decision Making Business Case.

We will continue to ensure that this programme is led in line with best practice throughout, and will engage widely with patients, the public and our stakeholders. Above all, we will maintain our ambition to deliver, in partnership, on behalf of the people of LLR.”

Professor Azhar Farooqi
Leicester City CCG Chair

Dr Vivek Varakantam
East Leicestershire & Rutland CCG Chair

Professor Mayur Lakhani
West Leicestershire CCG Chair

Andrew Furlong
UHL Medical Director
1 Executive Summary

1.1 Introduction

Background and context

For nearly two decades the need to consolidate acute services in Leicester has been widely recognised. The current three acute site configuration of the University Hospitals Leicester NHS Trust (UHL) is an accident of history, not design, and is suboptimal in clinical, performance and financial terms. Medical and nursing resources are spread too thinly making services operationally unstable and the duplication and triplication of clinical and support services is inefficient. Many planned, elective and outpatient services currently run alongside emergency services, and as a result, when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations.

Looking wider, to the whole Leicester, Leicestershire and Rutland (LLR) health and social care economy, the need for service transformation has been widely recognised and is being addressed through the LLR Better Care Together (BCT) programme which was established in January 2014. The BCT programme supports the LLR health and social care commissioners and providers to enact system wide change that will both improve the quality of care from a citizen or patient perspective, while also achieving overall system sustainability. BCT is all about ‘working together to provide individuals with better care, in the most appropriate, setting in a financially sustainable way’. The reconfiguration of acute services provided by UHL is an integral part of the BCT programme.

Over the last two decades there has also been significant and sustained under-investment in UHL’s acute estate relative to other acute hospitals across the UK, and UHL has a significant backlog maintenance requirement, of circa £77m, which will be reduced substantially to circa £33m, a reduction of 58% through the consolidation of services onto two sites.

This reconfiguration allows UHL to move all acute care to the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH), whilst enhancing critical care provision. It creates a new single site maternity hospital at LRI, a dedicated Children’s Hospital at LRI, a new Treatment Centre and wards at GH as well as delivering the supporting ward refurbishments at LRI and GH and supporting infrastructure across all three sites.

The proposals also protect planned elective activity and facilitate the disposal of the vast majority of the Leicester General Hospital (LGH) site. Crucially, the reconfiguration will eliminate the sub-optimal and thinly spread configuration of acute services in Leicester, enabling a more effective response to emergency pressures in particular and thus consistent achievement of the Emergency Department (ED) 4 hour standard.

Scope of this DMBC
The Pre Consultation Business Case (PCBC), approved by Leicester City, Leicestershire and Rutland (LLR) Commissioners (‘Commissioners’) and NHS England and NHS Improvement (NHSE/I) in summer 2020, set out proposals for the reconfiguration of acute and maternity services provided by University Hospitals of Leicester NHS Trust (‘UHL’). Having now completed the required consultation, this Decision Making Business Case (DMBC) has been prepared to allow Commissioners and NHS England (NHSE) Specialised Commissioning to make an informed decision on the proposal for reconfiguring services and whether UHL should move forward to develop an Outline Business Case (OBC) and subsequently a Full Business Case(s) (FBCs) in respect of the required capital schemes to support the reconfiguration of its acute and maternity services.

Lead commissioners are required to prepare a DMBC to document the results of consultation and its impact on proposed changes in services. The DMBC informs the CCGs decision on the proposals which have been consulted on and also the subsequent OBC and FBCs, to be prepared by UHL, as required by NHSE/I.

From the outset UHL identified that, in order to meet the challenges it faced, and to support the delivery of the transformation required in LLR, it needed a wide ranging Reconfiguration Programme encompassing the whole estate and in particular its three main sites:

- Leicester Royal Infirmary (LRI).
- Glenfield Hospital (GH).
- Leicester General Hospital (LGH).

As a result, UHL embarked on the reconfiguration of acute services and the associated changes to the estate in the form of their Development Control Plan (DCP).

The following elements of the UHL DCP have already been delivered or are in the process of being delivered:

- Relocation of vascular services from LRI to GH (completed in 2017).
- LRI emergency floor redevelopment (new ED and assessment units – completed in June 2018).
- Relocation of paediatric element of East Midlands Congenital Heart Centre (EMCHC) from GH to LRI (move planned for May 2021).
- Relocation of Level 3 Intensive Care Unit (ICU) from LGH to LRI and GH (funded from Wave 1 STP capital and was the subject of a previous consultation).

The following elements of the UHL DCP do not directly impact upon patients or have
already been consulted on and are therefore not within the scope of this PCBC.

- GH decontamination unit.
- Enabling - back office reconfiguration, demolitions and early infrastructure.
- LRI ICU expansion.
- LRI infrastructure.
- LRI support functions (pharmacy and mortuary).
- GH ICU expansion.
- GH infrastructure.
- GH support functions (pharmacy).
- LGH relocation of Stroke Services.
- LGH services and IT isolations.

The remaining elements of the DCP are the subject of this PCBC. These are summarised below:

- LRI development of a new Maternity Hospital.
- LRI development of a dedicated Children’s Hospital by refurbishment works.
- LRI inpatients, day case and Gynaecology outpatients relocation (only Gynaecology outpatients relocation within scope for the PCBC).
- GH new build development (including Treatment Centre, theatres and new wards).
- GH development of surgical admissions unit by refurbishment works.
- GH ward refurbishment.

**Conclusion on scope of this DMBC**

The required reconfiguration and transformation of services, at UHL, outlined in the PCBC and this DMBC is entirely consistent with UHL’s Sustainability and Transformation Partnership (STP) capital bid submission and UHL’s Hospital Investment Programme (HIP) phase 1 (now described as a ‘New Hospital Programme’ front running project) capital bid submission which is predicated on the delivery of the UHL DCP.
1.2 Update to the strategic context

1.2.1 Introduction

‘Update to the strategic context’ sets out details of the changes in the strategic context since the PCBC was prepared and approved in terms of the impact of COVID on the Reconfiguration proposals and changes to UHL’s Workforce Strategy. It also updates the bed bridge which supports the case for change.

1.2.2 Impact of COVID on the reconfiguration proposals

Since the PCBC was written the world has changed, for everyone, not just the NHS. Understanding the long term impact of COVID requires both foresight and imagination, 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 and individuals to put plans on hold and put off decisions, in the hope that the future becomes more certain or that someone comes along to tell them what to do. However, as a health system, we believe that is the wrong approach especially now considering all that has been learnt in planning for, and dealing with the impact and aftermath of the pandemic. The public needs the NHS now more than ever and as a result the NHS has a duty to be the best it can be in a COVID endemic world.

At the heart of the UHL’s clinical strategy (which drives the reconfiguration plan) is the desire to focus emergency and specialist care at the LRI and GH and separate elective care from emergency care so that when we are very busy those patients waiting for routine operations are not delayed or cancelled because UHL have had to prioritise an influx of emergencies.

UHL have been working with their clinical teams to understand if this still makes sense when considering what has been learnt from the pandemic. This has been confirmed, for the reasons set out below.

Intensive Care

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

In the reconfiguration plans UHL have said that they will create two ‘Super ICUs’ at the LRI and GH doubling UHL’s capacity to over 100 ICU beds. Had these ICU beds been in place by the time of the pandemic UHL’s response would have been very
different, they would have had enough ICU capacity with some to spare.

**Childrens Heart Surgery**

As mentioned above, UHL knew that COVID would require them to care for many more adult patients on ICU. Thankfully children have been less affected by the virus. With limited ICU capacity UHL 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 GH into an adult ICU. On balance UHL took the decision based on what would save the most lives, knowing that children would still have their surgery albeit not in Leicester and as a consequence UHL could care for more of the terribly sick adults whose only hope was sedation and ventilation.

However, in UHL’s reconfiguration plans UHL are going to create a standalone Children’s Hospital at the LRI, the first phase completes in spring 2021. Had the Children’s Hospital been built UHL would have been able to continue with heart surgery during COVID 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 UHL were able to continue with 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 of bringing them into a hospital with positive and query COVID patients and the impact that this could have if, in their already poorly state they contracted the virus.

In UHL’s reconfiguration plans they are going to build a standalone treatment centre at GH. This will be to all intents and purposes a new hospital alongside the existing hospital. It fulfils UHL’s desire to separate emergency and elective procedures. Meaning that when UHL are busy with high numbers of emergencies, elective patients still receive care. Had this been in place by the time of the pandemic UHL would have been able to maintain a significant amount of non-emergency work and potentially create a ‘COVID clean’ site.

1.2.3 **Workforce Strategy update**

Since the PCBC submission, the context and background to UHL workforce planning has changed. This is due to a number of factors including:

- The direction set out in the NHSE/I People Plan (2020/21) and UHL People Strategy (2020).
The COVID pandemic and the restoration and recovery of services.

In addition, the Trust will need to respond to changes in the national contracting scheme, proposed Integrated Care Systems and the Trust’s underlying financial position.

Even before the pandemic UHL regularly struggled to effectively staff their services. The fact that UHL have three separate hospitals with the duplication and triplication of services that entails means that they often have to spread their staff too thinly in order to cover clinical rotas. During the first peak of COVID UHL had 20% sickness across all staff groups meaning that 1 in 5 staff were either sick or self-isolating as a consequence of someone else in their household being symptomatic. It is a testimony to all UHL’s staff that despite this they kept going but, this is unsustainable in the long term.

Once reconfigured UHL will no longer have to run triplicate rotas for staff. For example with two super ICUs rather than the current 3 smaller ones UHL would have been able to consolidate their 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.

1.2.4 Bed bridge update

Introduction

The mantra for reconfiguration and particularly for ‘right sizing’ UHL’s hospitals remains as stated in the PCBC, namely that UHL should be ‘big enough to cope, but no bigger than necessary’. As was stated previously, ‘big enough’ is largely determined by demand, activity and the models of care that manage that activity.

Since the PCBC was written, the world has changed, not least in respect of the fundamental changes to activity in 2020/21 brought about by the COVID19 pandemic. A combination of capacity restraints during first and second waves, public anxiety about coming in to hospital, and the necessity to cancel and reschedule everything except the most urgent surgery, means the capacity and activity plan in the PCBC for 2020/21 bore little resemblance to the reality of dealing with a pandemic.

As UHL begin the development of an Outline Business Case (OBC) and Full Business Case (FBC), the extraordinary year is being disregarded for planning purposes and pre-pandemic assumptions being used as the last known fixed point from which to plan. It is important to note that this does not mean that the experience and learning of the pandemic has been forgotten. Section 1.2.1 above describes how the last year has altered UHL’s view on, for example, the numbers of single rooms they will provide in new build wards and in Intensive Care.

The revised model bed 2021 to 2032

The first thing to recognise about the revised model is that the timeline has been...
extended in line with DHSC/HM Treasury guidance for business cases. This means UHL are now planning to a 10 year horizon i.e. to 2032. The extended timeline means that the demand and capacity assumptions change because an activity growth rate of 3% per annum over 5 years produces a very different number to the same rate applied over 10 years.

As mentioned above UHL have to plan from a fixed point with commonly agreed assumptions and as such UHL are basing their future activity and capacity plan on pre-pandemic models of anticipated demand, (see above). The logic being that to a greater extent the demography, birth rates, epidemiology, disease burden in the population we serve remains.

However, at the same time as the NHS was dealing with the pandemic the policy landscape was brought into sharper focus. The publication of the white paper, ‘Integration and Innovation: working together to improve health and social care for all’ (The Department of Health and Social Care’s legislative proposals for a Health and Care Bill) is explicit in regards to fundamental changes in the way that healthcare is delivered, essentially a transition from episodic, crisis triggered care to a model based on managing population health such that crisis episodes are reduced or at the very least anticipated and planned for in advance.

That shift in approach was a key theme in the original PCBC, particularly around the improved management of frail and multi-morbid patients, which would have a beneficial impact on their health and also on levels of demand in hospital. UHL expect this crystallisation of policy with the attendant requirements for local health systems to act very differently to have an impact in future years on both emergency and elective activity. However, in recognition that there is some considerable way to go on all this work in both the planning and the execution, UHL have taken a prudent approach to demand modelling and kept in line with the PCBC.

**The revised bed bridge**

The revised bed bridge (below) starts with the same opening position as that of the PCBC i.e. 2,033 acute beds. UHL have then modelled the anticipated growth as outlined above for day-case, inpatient, maternity, ICU activity and extrapolated this across 10 years. This shows that the unmitigated demand growth would increase the requirement by 797 beds to the year 2032.

As with the original model UHL’s approach to bridging the gap involves making both planned efficiency savings brought about by changes to pathways as follows:

- Reducing demand and or reducing length of stay (this accounts for 460 beds).
- Creating new capacity in new build wards (this accounts for 111 beds).
- Should the need arise, the reinstatement of wards that were previously assumed to be ‘mothballed’ as a consequence of the new children’s hospital development, (195 beds).
How does the Children’s Hospital Scheme create capacity?

As set out in the PCBC it is UHL’s intention to create a new maternity hospital and a new children’s hospital at the LRI. The schemes are interdependent. Once the new maternity hospital is built, the Trust’s current maternity services located in the Kensington Building at the LRI will combine with those moving from LGH to establish a purpose built maternity hospital at the LRI. The space vacated by LRI’s current maternity service in the Kensington building will be remodelled and transformed into the new standalone children’s hospital. At this point the 7 children’s wards (195 beds) which are currently located in LRI’s Balmoral building will be either surplus to requirements or capable of providing capacity for adult inpatients, subject to demand driven alterations.

The combination of new build beds (111) and the repurposed children’s wards means that the total available capacity at the end of this plan will increase by 306 beds to 2,339 from the current baseline of 2,033 beds.

Summary - A work constantly in progress

During the writing of the original PCBC and the consultation and engagement with public and stakeholders UHL have emphasised that the business of activity and capacity modelling in the NHS never stops, largely as a reflection of the fact that new pathways, new treatment regimes, technology and epidemiology are also in a constant state of change. As such and even as the update was being written the system clinical design groups are busy working up their plans for e.g. ‘Urgent and
emergency’ and ‘Planned Care’ pathways whilst at the same time UHL is looking into Model Hospital and GIRFT data to reassess the achievable levels of efficiencies that they can prudently plan for.

This means that activity modelling will continue as UHL progress through to the OBC and FBC stages of the Reconfiguration Programme. As a result, it is important to note that whether the future is viewed through the lens of the original system Model of Care or the developing place based models that reflect the aims of the white paper, the mantra remains the same, namely that Leicester’s Hospitals have to be ‘big enough to cope but no bigger than necessary.’

**Future flexibility**

If further capital developments are needed to meet growth in population or health need after 2024, then UHL has flexibility in their existing estate to develop. UHL retain 33 acres of developable land (the equivalent to approximately 22 football pitches) located at the Glenfield Hospital. More than 25 acres of this land is already empty space.

UHL will also continue to maximise space at LRI, with appropriate planning consent if necessary, subject to the need to consider travel, access and car park when considering what services are provided on this site.

If future developments are needed, they would likely be funded from the UHL’s own capital budgets and, working with local NHS and local government partners, through access to section 106 funding and Community Infrastructure Levy to support services when housing growth puts pressure on them.

1.2.5 **Conclusions and next steps**

UHL have worked with their clinical leaders to understand whether the reconfiguration plans still make sense in light of the pandemic and this has been confirmed. Moreover, it is clear that had the timing been different UHL would have been better able to cope with COVID19 in their reconfigured state. However, it is important to recognise that whilst UHL are, in light of all that they have been through, more determined than ever to deliver the investment in their local hospitals, there is still a large amount of detailed planning work to do before UHL can say with assurance that the whole reconfiguration is ‘pandemic proof’. That detailed work is underway and UHL and the wider LLR health economy continue ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

1.3 **The Reconfiguration Programme proposals**

1.3.1 **Introduction**

The ‘**Reconfiguration Programme proposals**’ describes the Reconfiguration Programme proposals for each of UHL’s current sites that have been the subject of the consultation.
1.3.2 Overview of proposals

The main proposals for UHL’s Reconfiguration Programme are:

- **Acute services** - There would be two acute sites LRI and GH. An outpatient and day case Treatment Centre would be located at GH with the Diabetes Centre of Excellence remaining at LGH.

  Aspects of some services may relocate to a community setting.

- **Maternity services** - All women’s services would be at LRI with no MLU at LGH. However, the consultation also included the option of a standalone MLU at LGH on the basis of a 12 month trial to establish whether the number of births can sustain a standalone MLU.

1.3.3 UHL Road Map for service reconfiguration

The figure below shows UHL’s planned journey to deliver the service reconfiguration.

![UHL Road Map for service reconfiguration](image)

Details of the programme management arrangements and delivery plan for the reconfiguration are included in Sections Error! Reference source not found. and Error! Reference source not found..
1.3.4 Conclusion on the Reconfiguration Programme proposals

The reconfiguration of services across UHL’s three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes, whilst at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

1.4 The consultation process and outcomes

1.4.1 Introduction

The consultation process and outcomes sets out the background and legal framework within which the consultation has taken place. It also describes the consultation process and questions and summarises the responses to the consultation.

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by Section 14Z2 of the NHS Act 2006. In summary, any significant commissioning decision or reconfiguration is caught by the statutory requirements set out in the NHS Act 2006. The statute does not insist on “consultation” but seeks to make sure that service users are “involved”. In practice, for any significant proposed change to services, some form of consultation exercise is required to comply with this duty.

It should be noted that as this was a system wide approach, albeit with the commissioners as the final decision-makers, then such duty as applied to UHL under s.242 of the NHS Act 2006, was met through the CCG led process. Equally, NHS England have also met their duty under s.13Q of the NHS Act and such other duties as apply to them in being decision-makers, through the CCG led process as well.

1.4.2 Consultation process

The consultation started on 28th September 2020 and ran for 12 weeks, to ensure sufficient time and opportunities for meaningful discussions. The consultation document is included in Appendix A.

The main activities included:

- A widely published consultation document, with other versions and formats available on request.
- Widely published shorter versions.
- Online feedback questionnaire (printed version also available).
- Associated presentation materials and support information, such as material for newsletters, articles and social networking.
• A supporting publicity campaign, including engagement and special features with local and national media.

• A distribution cascade, using all outlets offered by partner organisations within the BCT programme, plus external partners including the voluntary and community sector.

• Social networking to signpost to the main websites of all partners, alongside a suite of contextual materials, such as podcasts, films, presentations, and reports from previous engagement.

• A programme of open public events and meetings to reach diverse audiences, and involving a range of techniques developed during the engagement phases.

• Range of discussion techniques through collaboration with Healthwatch and voluntary organisations e.g. outreach to reach a good demographic mix.

• A programme of consultation meetings for staff and stakeholders.

• Coordinated handling of feedback, enquiries and FOI requests.

The BCT programme appointed NHS Midlands and Lancashire Commissioning Support Unit to collate all feedback and analyse and evaluate it and produce a consultation report. In preparing the consultation report for final consideration there have been a series of assurance checks by:

• BCT Clinical Leadership Group and PPI Group.

• The three Health Overview and Scrutiny Committees, with input from the three Health and Wellbeing Boards.

• The Programme Executive and Programme Board, with input from regulators.

1.4.3 Consultation responses

The table below provides an overview of the responses received to the consultation by channel.

<table>
<thead>
<tr>
<th>Channel</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey responses (this includes 4,645 submitted online, 33 submitted by paper response and 4 submitted by telephone call)</td>
<td>4,682</td>
</tr>
<tr>
<td>Correspondence (email and letter)</td>
<td>70</td>
</tr>
<tr>
<td>Number of event participants across 113 events</td>
<td>923</td>
</tr>
<tr>
<td>Total response to the consultation</td>
<td>5,675</td>
</tr>
</tbody>
</table>
Set out below is an overview of the geographical and demographic profile of consultation survey responses. For further detail, please see the profiling section of the detailed report included in Appendix B.

- **Geography:** 25% (1120) were from Leicestershire South and East, 22% (989) from Leicestershire North and West, 20% (891) from Leicester, 6% (283) from Rutland and 27% (1199) from outside of the area or postcode provided / verified.

- **Ethnicity:** 81% (3,647) were of White ethnicity and 19% (835) non-white BME ethnicity.

- **Age:** 52% (2,375) were aged 50 or over.

- **Religion:** 50% (2,225) were Christian.

- **Sex:** 67% (3,079) were female and 29% (1,315) were male.

- **Sexual orientation:** 87% (3,911) were heterosexual.

- **Relationship status:** 60% (2,740) were married.

- **Health problem or disability:** 27% (1,214) had a health problem or disability limiting day-to-day activities.

- **Carers:** 65% (2,928) were not carers.

### 1.4.4 Consultation outcomes

The detailed consultation report is included in Appendix B and the outcomes are summarised in Section 5.6.

The consultation process has been wide ranging and has received 5,675 responses, overwhelmingly supportive of the main proposals. Where relevant issues have been raised these have been considered by UHL and commissioners as described in the following section.

### 1.5 Response to the consultation outcomes

‘Response to the consultation outcomes’ describes the response to the outcomes of the consultation on the UHL Reconfiguration Programme proposals. It concludes by demonstrating how the proposals have been shaped to ensure that they continue to contribute to the delivery of the BCTP aims and priorities for ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

The consultation has been wide ranging and has elicited responses from a wide range of members of the public as well as local healthcare professionals and clinicians. The responses to the consultation outcomes are summarised below.
1.5.1 Summary of clinical proposals included in the consultation

The table below summarises the clinical proposals that were included in the consultation and identifies those areas where changes to the original proposals are now proposed as a result of the consultation process.

Table 1-2 Clinical proposals included in the consultation

<table>
<thead>
<tr>
<th>Consultation Question No.</th>
<th>Proposal as stated in PCBC</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2</td>
<td>Relocation of clinical services on to 2 acute sites – the Leicester Royal Infirmary (LRI) and the Glenfield Hospital (GH)</td>
<td>Proceed as planned apart from: • Brain Injury Unit (was LRI) Specialist Neurological Rehabilitation Unit (was LRI)</td>
<td>Brain Injury Unit (now GH) Specialist Neurological Rehabilitation Unit (now GH)</td>
</tr>
<tr>
<td>3, 4</td>
<td>Relocate outpatient services from the Leicester Royal Infirmary (LRI) to the Glenfield Hospital (GH)</td>
<td>Proceed as planned apart from: • Ear Nose &amp; Throat (was GH) • Ophthalmology – (was GH) • Plastic Surgery – (was GH) Endocrinology – (was GH)</td>
<td>• Ear Nose &amp; Throat (now LRI) • Ophthalmology – (now LRI) • Plastic Surgery - LRI Endocrinology (now LRI)</td>
</tr>
<tr>
<td>6, 7</td>
<td>Utilise new technology to provide certain aspects of pre-planned care</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>8 - 13</td>
<td>Provide a GP Led Urgent Treatment Centre at the Leicester General Hospital (LGH)</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>14, 15</td>
<td>Relocate the Midwifery Led Unit from St. Mary’s Hospital and trial a new Midwifery Led Unit on the LGH Site</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>16, 17, 18</td>
<td>Provide 2 new Haemodialysis Units. 1 at the GH and 1 on the south side of the city</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>20, 21</td>
<td>Utilise pools located within the community to provide Hydrotherapy services</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>22, 23</td>
<td>Provide a new Maternity Hospital at the LRI</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Enhance breastfeeding services and provide post-natal drop-in sessions</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>25, 26</td>
<td>Provide a new Children’s Hospital at the LRI</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Travel and access issues</td>
<td>Proceed as planned</td>
<td>Travel Action Plan enhanced to address feedback</td>
</tr>
</tbody>
</table>

1.5.2 Responses to consultation with the public

The main areas where concerns were expressed in respect of the proposals were:

- Relocation of the standalone maternity unit from St Mary’s (Melton Mowbray)
and trial a new maternity unit on the LGH site.

- Proposed new haemodialysis units
- Travel and access issues.

**Relocation of maternity unit from St Mary's to Leicester General Hospital**

The proposed relocation of the midwifery led unit from St Mary’s to the Leicester General Hospital received significant feedback with 41% (1909) of respondents not agreeing with the proposals. In total, 36% agreed (1678) and 23% (1048) neither agreed or disagreed.

The top three sub-themes raised in agreement were:

- **Access** - Proposal will improve access to maternity services (e.g. accessible for wider population).
- **Quality of care** - Relocation of maternity services to Leicester General Hospital will improve quality of care (e.g. access to intensive support, co-location of services).
- **General** - Agreement with proposal.

The top three sub-themes raised in disagreement were:

- **Access** - Proposal will reduce accessibility for patients (e.g. rural communities, too centralised, closing St. Mary’s).
- **Quality of care** - Consider the high quality of care at St. Mary’s Birth Centre (e.g. aftercare, breastfeeding).
- **Service provision** - St. Mary’s Birth Centre should remain open.

The top three observation sub-themes raised by survey respondents were:

- **Service provision** - Consider the need for access to specialist care on site.
- **Communication** - Consider better promotion of St. Mary’s Birth Centre to increase number of patients.
- **General** - More details about the proposal are required.

The consultation findings (as detailed in the Report of Findings, p51), including the geographical location of respondents have been reviewed by a group comprising clinicians, service managers, patient representatives and commissioners.

The proposed response from UHL is to proceed with the original proposals to relocate the unit to LGH on a trial basis. This provides greater equity of access for women.
across Leicester, Leicestershire and Rutland; offers closer proximity to acute services in the event of an emergency and offers opportunity to make the unit clinically and financially viable in the longer term.

The following were noted as key to the proposed response and to addressing the points raised by respondents during consultation:

- **Clinical Strategy** - The proposed relocation of the service at St Mary’s to the LGH is part of the Trust’s overall clinical strategy and is an essential component in ensuring improved access to a greater proportion of women across Leicester, Leicestershire and Rutland.

- **Clinical Risk** - The risks associated with transfer from St Marys in an emergency are better managed if the service moves to the LGH due to proximity to acute services at the LRI. Community maternity services would remain in Melton Mowbray. We would ensure that there is support for home births and care before and after the baby is born in the local community both in Melton and across Leicester, Leicestershire and Rutland. If someone has a complicated pregnancy, care afterwards would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

- **Clinical sustainability and workforce** - The long-term sustainability of the maternity led unit is improved by relocation to LGH. This is due to improved access for more women across Leicester, Leicestershire and Rutland who meet criteria and anticipated increase in the number of women choosing this option for birth. There are also currently significant workforce considerations, with difficulties in recruitment of midwives to support the service at St Marys. It is anticipated that this will be mitigated by a more central service at the LGH.

- **Staff at St Marys** - The staff at St Marys have a wealth of knowledge and experience. Their involvement in development of the new service at the LGH, and in how maternity services, including postnatal and breastfeeding support will be delivered in the community across Leicester, Leicestershire and Rutland, and in Melton in particular, will be crucial to ensuring continued high quality of care.

- **Patient experience** - implementation of the proposals will be supported by significant ongoing improvement work in postnatal services, underpinned by the local work on the Better Births model. This will see more women in Leicester, Leicestershire and Rutland able to benefit from an expanded team of midwives who will provide continuity of care throughout pregnancy and provide postnatal and breastfeeding support in the community and in people’s own homes. These services will remain available to all women – including those from Melton.
Based on occupancy figures at St Mary’s midwifery led unit, the number of women who go there specifically for breastfeeding support is small. Across Leicester, Leicestershire and Rutland there are good rates of breastfeeding initiation and UHL would continue to support women in line with good practice with this support available in the community and in people’s own homes in Melton and across Leicester, Leicestershire and Rutland. Working with the Maternity Voices Partnership, women from all walks of life, young mums, older mums and partners, will help shape how services look in future.

- **Cost effectiveness** - the current service does not see enough patients to make it financially viable with less than three babies born there on average every week. By moving to the LGH and the anticipated increase in the number of women using the service, the proposals offer better long term financial sustainability. There is a gap nationally in midwifery-led birthing units between capacity (the number of births that can take place) and actual use, and many are under-utilised. If we can care for 500-plus women then the cost per birth, with the staffing models to support this, will prove more cost-effective and sustainable. (See note below re process of assessment for long term viability).

**Long term viability of a standalone MLU at the LGH**

UHL is committed to trialling a new midwifery led maternity unit on the LGH site and supporting the unit to help it become viable in the longer term. Work will be undertaken to define how the long term viability of the unit is assessed UHL recognises the fact that the new unit is unlikely to attract 500 births in its first year and viability will, therefore be based on a phased approach. Work will also be undertaken develop promotional plans for the unit Both aspects of this work will involve staff, stakeholders and patients/patient representatives.

**Proposed new haemodialysis units**

The proposal consulted upon was for two separate dialysis units in the south of the city and at the GH, but it was not specified how they would be delivered. Proposals will be developed taking into account the following:

- **Clinical strategy** - It is not considered that there were any objections to the need to replace the LGH dialysis unit and provide a dialysis facility co-located with the inpatient service.

- **Clinical risk** - None of the feedback related to clinical risk.

- **Clinical sustainability and workforce** - The model suggested was opposed by 5% of respondents within the staff category.

- **Patient experience** - The responses here were conflicting because the sub-themes people supported were also those which were opposed. This was split along geographical lines with responses from Rutland residents having
most misgivings. Rutland Health Watch have previously been informed that the number of people needing treatment would not support a standalone unit in Rutland and that area is served by surrounding units in Peterborough, Leicester, Kettering and Grantham.

Oadby and Market Harborough were also suggested as potential sites. Whilst Oadby may yet be an option, Market Harborough would involve transport for the vast majority of city patients, and it is also very close to an existing unit in Kettering. The final decision on location will be informed by the impact on service users and their views.

Very few people from the North West of the county raised concerns. This is further evidence that the GH site must be delivered and of satisfaction with existing unit in Loughborough.

A full menu of home based treatments is offered and encouraged.

- **Cost-effectiveness** - The feedback contains proposals for a larger number of units throughout LLR. This would be inefficient to run and difficult to staff. However, the UHL Haemodialysis Service are committed to exploring innovative ways of delivering dialysis. For those for whom a home therapy is unsuitable, self or minimal care facilities in GP surgeries have been considered. A successful pilot in Earl Shilton has received national recognition and further proposals could be worked up to expand that in the future.

**Travel and access**

Some concerns were expressed over the impact of the changes to individuals with regards to travel and access to and from the acute hospital sites. As a result, a detailed Travel Action Plan has been developed taking into consideration the points raised during consultation. The Travel Action Plan is included in Appendix C.

The Travel Action Plan includes the footfall impact of services moving between the sites and proposes different ways of enabling staff and patients to travel without being reliant on cars. The changes identified in the Travel Action Plan have been modelled into the revised footfall numbers for each site and continue to show a decrease in footfall for the LRI of about 30% in 2024/25.

There has been a significant focus in the travel planning work undertaken since October 2020. Below are some of the key actions being progressed that will assist:

- Plans to develop a new Park & Ride facility for a minimum of five years at LGH (in partnership with Leicester City Council).

- Development of a new Park & Ride facility at Beaumont Leys (in partnership with Leicester City Council) to provide additional off-site parking for GH.
EXECUTIVE SUMMARY

- Introduction of PlusBus ticketing on the Hospital Hopper. This now makes it possible to travel by rail and then by bus to GH, LGH and LRI, on a single ticket purchase.

- Improved promotion of schemes to assist with patient travel (e.g. volunteer car scheme).

- Introduction of ANPR (Automatic Number Plate Recognition) technology on the main patient car parks at LRI and GH. This technology will assist with access issues at the LRI and remove the need for patients to estimate length of stay at the GH. As well as ANPR technology, additional temporary car parking is being created at the GH in recognition of the additional demand that will be created during the building phase.

- Promoting of the new Santander Cycles Leicester e-bike share scheme from spring. This will improve connectivity for those travelling by bus and train, by improving connectivity between the main transport interchanges in Leicester city centre and LRI.

All of the above are detailed within the Travel Action Plan which was approved by the UHL Trust Board in March 2021.

1.5.3 Response to the consultation with clinicians

As a direct result of the consultation with clinicians and operational staff, changes are proposed to the Reconfiguration Proposals presented for consultation and summarised in Section 4 above in respect of the following services:

- Ear Nose and Throat (ENT).
- Ophthalmology.
- Brain Injury Unit (BIU) and Specialist Neuro Rehabilitation Unit (SNRU).
- Plastic Surgery.
- Endocrinology.

Ear Nose and Throat

Current proposals

The consultation proposals involved the following assumptions for ENT.
**Executive Summary**

Reconfiguration of acute and maternity services at University Hospitals of Leicester NHS Trust

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**Table 1-3 ENT proposals**

<table>
<thead>
<tr>
<th>Service</th>
<th>Proposed location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT (Adult)</td>
<td>Outpatient</td>
</tr>
<tr>
<td></td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td></td>
<td>Day case</td>
</tr>
<tr>
<td></td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
</tr>
<tr>
<td></td>
<td>LRI (Balmoral)</td>
</tr>
<tr>
<td></td>
<td>Emergencies</td>
</tr>
<tr>
<td></td>
<td>LRI (Balmoral)</td>
</tr>
<tr>
<td>ENT (Paeds)</td>
<td>All services</td>
</tr>
<tr>
<td></td>
<td>LRI (Kensigton)</td>
</tr>
<tr>
<td>Balance</td>
<td>Outpatient</td>
</tr>
<tr>
<td></td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Audiology</td>
<td>Outpatient</td>
</tr>
<tr>
<td></td>
<td>LRI and GH Treatment Centre</td>
</tr>
</tbody>
</table>

**Revised proposals**

Following comprehensive clinical engagement, the revised proposals are now for all services to remain at the LRI for the reasons set out in section 6.2.3.

**Ophthalmology**

**Current proposals**

The consultation proposals involved the following assumptions for Ophthalmology.

**Table 1-4 Ophthalmology proposals**

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology (Adult)</td>
<td>Outpatient/Daycase relocate to GH</td>
<td>All services to remain at the LRI</td>
</tr>
<tr>
<td></td>
<td>Elective &amp; Emergencies (In-p.t)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>remain at LRI</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology (Paeds)</td>
<td>Remain at the LRI</td>
<td>No change</td>
</tr>
</tbody>
</table>

**Revised proposals**

Following comprehensive clinical engagement, the revised proposals are now for all Ophthalmology services to remain at the LRI for the reasons set out section 6.2.3.

**Brain Injury Unit (BIU) and Specialist Neuro Rehabilitation Unit (SNRU)**

**Proposals**

The consultation proposals involved the following assumptions for the BIA and SNRU.
Table 1-5 BIU and SNRU proposals

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain Injury Unit</td>
<td>Relocate to the LRI</td>
<td>Relocate to the LRI</td>
</tr>
<tr>
<td>Specialist Neurological</td>
<td>Relocate to the LRI</td>
<td>Relocate to the GH</td>
</tr>
<tr>
<td>Rehabilitation Unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised proposals

Following comprehensive clinical engagement, the revised proposals are for the BIU and SNRU to relocate to GH for the reasons set out section 6.2.3.

Plastic Surgery

Current proposals

The consultation proposals involved the following assumptions for Plastic services.

Table 1-6 BIU and SNRU proposals

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery (Adult)</td>
<td>Inpts/Emergencies – LRI</td>
<td>All to remain at the LRI</td>
</tr>
<tr>
<td></td>
<td>Outpatients/Daycase - GH</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery (Paeds)</td>
<td>Inpts/Emergencies – LRI</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Outpatients/Daycase - LRI</td>
<td></td>
</tr>
</tbody>
</table>

Revised proposals

Following comprehensive clinical engagement the revised proposals are for Plastic Surgery outpatient and daycase activity to remain at the LRI for the reasons set out section 6.2.3.

Endocrinology

The consultation proposals involved the following assumptions for Endocrinology.

Table 1-7 Endocrinology proposals

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrinology (Adult)</td>
<td>In-pts/Emergencies – LRI</td>
<td>All services to remain at the LRI</td>
</tr>
<tr>
<td></td>
<td>Outpatients/Daycase - GH</td>
<td></td>
</tr>
<tr>
<td>Endocrinology (Paeds)</td>
<td>All services at the LRI</td>
<td>No change</td>
</tr>
</tbody>
</table>

Revised proposals

Following comprehensive clinical engagement, the revised proposals are now for all Endocrinology and clinical genetics services to remain at the LRI for the reasons set out section 6.2.3.
1.6 **Equality Impact Assessment**

A full Equality Impact Assessment (EIA) was included in the PCBC. This has been updated to reflect the impact of the proposed changes to the original PCBC proposals. The purpose of the EIA is to assure key decision makers and the population of Leicestershire that providers’ legal obligations concerning their duties under the **NHS Act 2006** and subsequent **Equality Act 2010** are satisfied.

The **Equality Act 2010** protects people against discrimination, harassment, or victimisation in employment, and as users of private and public services based on nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The **NHS Act 2006** determines that health inequalities must be properly, and seriously considered and respective Clinical Commissioning Groups must have regard to the need to reduce inequalities between patients in their access to health services as well as the outcomes achieved for them, by the provision of such health services. As part of this multifactorial assessment by the CCG, it has a duty to balance all its legal duties and conscious efforts are then to be taken to mitigate any potential negative impacts upon those from protected groups. The EIA is included in **Appendix D**.

1.7 **Conclusions on the response to the consultation outcomes**

The consultation responses largely support the proposals as presented in the PCBC and the consultation document. Those areas where issues have been raised have either been revised in response to the feedback or further considered, to confirm the proposal are still appropriate, before deciding to proceed.

1.8 **Financial implications**

1.8.1 **Introduction**

This section sets out the financial implications of the reconfiguration proposals. It identifies the anticipated capital costs and funding and the procurement route for the required capital developments.

UHL are one of the eight identified front running schemes within the National ‘New Hospitals Programme’, and as such are in the pipeline of funded schemes with allocated capital funding.

There have been a number of policy changes since the PCBC was published, which could not have been anticipated or accounted for in the budget set out in the PCBC. Work is ongoing with the ‘New Hospital Programme’ to define the impact of these changes to national policy on the capital costs, with the expectation that additional
capital will need to be allocated centrally.

This DMBC reflects a step in the journey to get a HM Treasury approved Full Business Case (FBC) that allows the drawdown of capital funding to deliver the changes identified. The Outline Business Case (OBC) will ‘test’ the affordability of the scheme. Once the exact parameters of the policy change are agreed with the New Hospital Programme, the affordability and Value for Money assessments will be reassessed and updated in the OBC.

Once the OBC is approved, the FBC will be developed which will confirm the affordability and Value for Money based on final contract prices and scheme costs.

1.8.2 Overview of capital costs from PCBC

The estimated capital costs of the proposed developments as set out in the PCBC (based on the DHSC Healthcare Premises Cost Guides) together with the timing of the developments are summarised in the table below.

Table 1-8 Estimated capital costs from PCBC

<table>
<thead>
<tr>
<th>Projects within the scope of this PCBC</th>
<th>UHL DCP</th>
<th>Capital cost (including inflation)</th>
<th>SITE 19/20</th>
<th>20/21</th>
<th>21/22</th>
<th>22/23</th>
<th>23/24</th>
<th>24/25</th>
<th>25/26</th>
<th>26/27</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI Maternity Hospital</td>
<td></td>
<td>£107,130,776</td>
<td>LRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LRI Children’s Hospital</td>
<td></td>
<td>£38,959,630</td>
<td>LRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LRI inpatients, day case and Gynaecology outpatients relocation</td>
<td></td>
<td>£15,649,510</td>
<td>LRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH new build (including Treatment Centre, theatres and new wards)</td>
<td></td>
<td>£189,736,677</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH surgical admissions unit</td>
<td></td>
<td>£3,787,815</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH ward refurbishment</td>
<td></td>
<td>£2,759,619</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total capital cost of PCBC specific projects</strong></td>
<td></td>
<td><strong>£338,024,027</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Projects outside the scope of this PCBC</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GH decontamination unit</td>
<td></td>
<td>£8,914,332</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>Enabling (back office reconfiguration, demolitions and early infrastructure)</td>
<td></td>
<td>£19,682,950</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>LRI ICU expansion</td>
<td></td>
<td>£25,896,014</td>
<td>LRI</td>
<td></td>
</tr>
<tr>
<td>LRI infrastructure</td>
<td></td>
<td>£12,224,918</td>
<td>LRI</td>
<td></td>
</tr>
<tr>
<td>LRI support functions (pharmacy and mortuary)</td>
<td></td>
<td>£2,147,450</td>
<td>LRI</td>
<td></td>
</tr>
<tr>
<td>GH ICU expansion</td>
<td></td>
<td>£20,462,287</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>GH infrastructure</td>
<td></td>
<td>£15,603,749</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>GH support functions (pharmacy)</td>
<td></td>
<td>£1,666,950</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>LGH relocation of Stroke Services</td>
<td></td>
<td>£2,809,879</td>
<td>LGH</td>
<td></td>
</tr>
<tr>
<td>LGH services and IT isolations</td>
<td></td>
<td>£5,567,444</td>
<td>LGH</td>
<td></td>
</tr>
<tr>
<td><strong>Total capital cost of DCP</strong></td>
<td></td>
<td><strong>£453,000,000</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Underlying assumptions

The above cost estimates were prepared by UHL’s cost consultants Rider Levett Bucknall (RLB) and were based on the following assumptions:

- Inflation was assumed to mid-point on construction period for each individual project.
- Optimism Bias of 6% was included. This was lower than would normally be expected at that stage as a significant amount of development work (including the preparation of detailed schedules of accommodation) and review had already taken place. In addition, there were costed allowances for infrastructure which was being developed as its own project as part of the
DCP.

- An element of the VAT was assumed to be recoverable which related to fees and the type of development being proposed, for new build developments this is limited, but it is more extensive on refurbishments.

1.8.3 Updated capital costs

The estimated capital costs of the developments, based on the scope of works as set out in the PCBC, have not changed. The scope of the scheme, as described in the PCBC, is still deliverable within the identified capital envelope of £453m. However, since the PCBC was developed, there have been a number of changes relating to national policy and local scope changes which may have an impact on the capital cost. These policy changes do not undermine the clinical model that was consulted on. These are summarised below.

National policy changes

- Change in national approach to commercially funded ventures (car parks and Welcome Centres).
- Impact on designs of COVID19 and pandemic proofing.
- Impact of central NHS requirements in terms of sustainability (Net Zero Carbon)\(^1\).
- Impact of central NHS requirements in respect of the use of Modern Methods of Construction (MMC).
- Impact of central NHS requirements in terms of the approach to digital transformation.

Local scope changes

- System related changes:
  - Additional beds as identified in the bed bridge as being provided through in-fill beds at the LRI, will now be included as new build beds to optimise their usage.
  - An increase in neo-natal cots over those originally planned in the PCBC as requested by the neo-natal network and the NHSE/I specialised commissioners.

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\(^1\) The government has an aspiration for all new NHS buildings to comply with ‘Net Zero Carbon’ requirements. The detailed guidance is currently being developed for the government’s ‘New Hospitals Programme’. When the guidance is issued UHL will incorporate this into their ‘Green Plan’ and apply the guidance to the Reconfiguration Programme as required.
EXECUTIVE SUMMARY

- UHL changes:
  - Increase in accommodation to reflect communications space and pandemic proofing.

**Impact on capital costs**

Because of the uncertainty over the above issues, it is not currently possible to accurately assess the impact on the capital costs. However, work is on-going with the New Hospital Programme to agree the scope of inclusion in the programme, and the potential sources of capital.

**1.9 Funding for capital developments**

In September 2019, the DHSC included UHL as a front runner in the Health Infrastructure Programme (HIP) with a capital envelope of £453m with £450m funded through Public Dividend Capital (PDC). The HIP has now evolved into the New Hospital Programme and UHL continues to be a front runner scheme within the overall programme and allocation of PDC funding.

In addition to the original budget identified of £453m, additional budget has been identified from additional charitable funding sources and from the land receipt from the sale of parts of the LGH site to create a budget of £492m:

- £450m PDC.
- £3m Charitable funding.
- £5m additional charitable funding supported by the Charitable Funds Committee.
- £27m land receipt from LGH.
- £7m Trust Capital Contribution.

As a result of the national policy changes identified above UHL propose to request additional PDC funding from DHSC. The PDC funding will be confirmed when UHL have confirmed the scope of change owing to the policy change and submit their OBC for the Reconfiguration Programme. This is currently anticipated to be in spring 2022.

In addition, as described above, UHL anticipates additional funding being available from the capital receipt from the sale of part of the LGH site and increased charitable fundraising.

As set out above, UHL have been approved for funding by the DHSC, as a front running scheme in the New Hospital Programme. Whilst the original funding of £450m PDC has been identified, in the event that further PDC funding is not made available to fund the additional national policy changes such as the requirement for
New Zero Caron and Digital, then the scope of the scheme will be reviewed again in order to fit the budget available.

1.10 Potential procurement route for capital developments

The UHL Reconfiguration Programme is one of the first wave of eight projects that comprise the DHSCs New Hospital Programme of forty new hospitals. The New Hospital Programme are currently developing a procurement strategy that will be enacted across the national programme As such it is highly likely that the procurement will be coordinated and managed by the central NHP team.

1.11 Affordability

Reflecting that discussions are ongoing in relation to the capital envelope as described in paragraph 7.1.2 above, the affordability assessment will be updated and reassessed as part of OBC development and incorporated into the OBC submission in Spring 2022.

1.12 Value for Money

The PCBC set out that as part of their 2018 STP capital bid, UHL provided an economic appraisal of the proposed service reconfiguration and developments covered by the PCBC. This focussed on a comparison of the estimated capital and revenue costs of the developments compared to the monetisable benefits, together with the identification of the non monetisable benefits. The analysis was prepared in line with the requirements of the HM Treasury 'Green Book' (concentrating on cash flows to the public sector only). The appraisal calculated the incremental economic costs and benefits to society of the proposed developments, over a 60 year appraisal period, and the resulting VfM ratio.

Reflecting that discussions are ongoing in relation to the capital envelope as described in paragraph 7.1.2 above, the Value For Money assessment will be updated and re-assessed as part of OBC development including a detailed economic appraisal using the DHSC’s Comprehensive Investment Appraisal (CIA) model in the OBC.
1.14 Conclusion on financial implications

The UHL Reconfiguration Programme was announced as being funded as one of the eight front running schemes within the government’s ‘New Hospitals Programme’. The cost of the scheme outlined in the PCBC was £453m. Since the approval of the PCBC, there have been a number of policy changes announced by the DHSC that require consideration in the scheme. These changes will require funding from additional PDC to be allocated from the government. In the event that the additional funding is not forthcoming or is not allocated in full, then the scope of the additional requirements will be reviewed to ensure the budget is not exceeded.

As such, reflecting that discussions are on-going with the ‘New Hospitals Programme’ to define the impact of changes to national policy, the affordability and Value for Money assessments will be updated for inclusion in the OBC submission in Spring 2022.

The delivery of the UHL Reconfiguration Programme and the wider service transformation in LLR, together with the financial implications, are a clear demonstration of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

1.15 Delivering the reconfiguration

1.15.1 Introduction

‘Delivering the reconfiguration’ addresses how the reconfiguration will be delivered. It demonstrates that the Commissioners and the Trust have the appropriate plans in place and the capacity and capability to deliver the project and to realise the benefits.

1.15.2 DMBC approvals

The decision for approving this DMBC is the responsibility of the three LLR CCGs. In addition, the DMBC is supported by the UHL Board and NHSE Specialised Commissioning. The UHL Board considered the DMBC, at its meeting on 3rd June 2021 and confirmed its support. The DMBC was considered by NHSE Specialised Commissioning at its Senior Leadership Team on 3rd June 2021 and its support was also confirmed.
1.15.4 Conclusion on delivering the reconfiguration proposals

Commissioners and UHL have the appropriate plans in place in terms of:

- Programme governance at the STP / BCT and UHL levels.
- Programme management.
- Risk management.
- Post programme review and benefits realisation.

There is also the capacity and capability to deliver the project and to realise the benefits of 'working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way'.

1.16 Overall conclusions and recommendations

1.16.1 Context

This DMBC is a critical and tangible step towards sustainable health and care for the people of LLR. While keeping our planned development of primary, community and social care clearly within view, we deal with the urgent need to redefine the future shape of our acute hospitals provided by UHL to ensure long term clinical and financial sustainability.

The reconfiguration of services across the three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes; while at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

This DMBC is critical in order for UHL to progress to an OBC and subsequently an FBC so that we can secure the investment needed to reconfigure our acute hospitals. It is urgent because acute services are overstretched, with staff battling daily to deliver the quality of care that they believe in and our current configuration is not financially viable. It is compelling because there is significant potential to improve services and outcomes for our patients by 'working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way'.

1.16.2 Conclusions

The consultation responses largely support the proposals as presented in the PCBC and the consultation document. Those areas where issues have been raised have either been revised in response to the feedback or further considered, to confirm the proposal are still appropriate, before deciding to proceed.

Commissioners and the Trust have the appropriate plans in place to deliver the
reconfiguration and to realise the benefits of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

A summary of the reconfiguration benefits are set out in the table below.

**Table 1-9 Summary of reconfiguration benefits**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong></td>
<td>• A new single site Maternity Hospital and a dedicated Children’s Hospital at the Leicester Royal Infirmary.</td>
</tr>
<tr>
<td></td>
<td>• A new Treatment Centre, wards and theatres at the Glenfield Hospital protecting planned elective activity and eliminating cancellations at times of peak emergency activity.</td>
</tr>
<tr>
<td></td>
<td>• Reduction in clinical risk due to the consolidation of services, resources and equipment.</td>
</tr>
<tr>
<td></td>
<td>• Enhanced critical care provision on the two acute sites allowing UHL to meet national standards.</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>• Improved outcomes for patients through increased Consultant presence and earlier, more regular senior clinical decision-making.</td>
</tr>
<tr>
<td></td>
<td>• Co-location of specialties to enable enhanced input and multi-specialty management of patients in one location resulting in more timely management with fewer hand-offs thus promoting early recovery.</td>
</tr>
<tr>
<td></td>
<td>• Reduced cancellations ensuring patients are operated on at the earliest possible point in time leading to improved patient experience and clinical outcomes.</td>
</tr>
<tr>
<td></td>
<td>• Improved patient experience from transformation and the improved clinical environment.</td>
</tr>
<tr>
<td></td>
<td>• Patient space which complies with the highest expectations of the Patient Led Audit of the Care Environment (PLACE) and delivers therapeutic spaces which aid wellbeing and recovery.</td>
</tr>
<tr>
<td></td>
<td>• Technology used to connect with patients and ensure their information is available electronically for all consultations.</td>
</tr>
</tbody>
</table>
1.16.3 Recommendations

The Governing Bodies are asked to approve the following proposals in respect of the UHL reconfiguration of acute and maternity services:

1. **Reconfiguration of acute services** – moving acute services on to two of the current three hospital sites with acute services being provided at LRI and GH.

2. **New treatment centre** – moving outpatient services from LRI to a new purpose build treatment centre at GH.

3. **Use of new technologies** – offering appointments by telephone or video call for certain aspects of pre-planned care.

4. **Primary Care urgent treatment centre** – creating the following services at LGH in a Primary Care Urgent Treatment Centre:
   - Observation area with beds where patients can be observed when they are not well enough to go home, but don’t meet the criteria to be admitted to hospital.
   - Diagnostic service - this provides appointments for people to have a test or simple procedure.
Community outpatients service – this is treatment for people with health problems requiring a diagnosis or treatment, but do not require a bed or to be admitted for overnight care.

Potentially extra primary care capacity - to provide family health care to people living in the east of the city.

5. **New standalone maternity unit** – relocating the standalone maternity unit at St Mary’s in Melton Mowbray and trial a new standalone midwifery unit at LGH to assess its viability.

6. **New haemodialysis treatment units** – providing two new haemodialysis treatment units, one at GH and the second in a new unit to the south of Leicester.

7. **Hydrotherapy pools** – using hydrotherapy pools already located in community settings.

8. **New maternity hospital** – building a new maternity hospital on the LRI site, including a midwifery-led birth centre provided alongside the obstetric unit. Moving existing maternity services (services provided in pregnancy, childbirth and post-pregnancy) and neonatal services from LGH to LRI.

9. **Breastfeeding services** – enhancing breastfeeding services for mothers by providing post-natal breastfeeding drop-in sessions alongside peer support.

10. **Children’s hospital** – refurbishing the Kensington building at LRI to create a new children’s hospital including a consolidated children’s intensive care unit, co-located with maternity services.
2 Introduction

2.1 Purpose and scope of the DMBC

This section sets out the purpose of this DMBC and explains how the proposals which, have been the subject of consultation, form part of UHL’s wider Development Control Plan for the redevelopment of its estate.

2.1.1 Background

The Pre Consultation Business Case (PCBC), approved by Leicester City, Leicestershire and Rutland (LLR) Commissioners (‘Commissioners’) and NHS England and NHS Improvement (NHSE/I) in spring 2020, set out proposals for the reconfiguration of acute and maternity services provided by University Hospitals of Leicester NHS Trust (‘UHL’). Having now completed the required consultation, this Decision Making Business Case (DMBC) has been prepared to allow Commissioners and NHS England (NHSE) Specialised Commissioning to make an informed decision on the proposal for reconfiguring services and whether UHL should move forward to develop an Outline Business Case (OBC) and subsequently a Full Business Case(s) (FBCs) in respect of the required capital schemes to support the reconfiguration of its acute and maternity services.

Lead commissioners are required to prepare a DMBC to document the results of consultation and its impact on proposed changes in services. The DMBC informs the CCGs decision on the proposals which have been consulted on.

The DMBC also informs the subsequent OBC and FBCs, to be prepared by UHL, as required by NHSE/I.

2.1.2 Scope of this DMBC

UHL has been considering its options to deliver the required service transformation in the LLR health economy since the LLR Better Care Together (BCT) programme was established in January 2014. However, prior to BCT, UHL had also been considering reconfiguration since 2000. The BCT programme supports the LLR health and social care commissioners and providers to enact system wide change that will both improve the quality of care from a citizen or patient perspective, while also achieving overall system sustainability. BCT is all about ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

From the outset UHL identified that, in order to meet the challenges it faced and to support the delivery of the transformation required in LLR, it needed a wide ranging reconfiguration programme encompassing the whole estate and in particular its three main sites:

- Leicester Royal Infirmary (LRI).
• Glenfield Hospital (GH).

• Leicester General Hospital (LGH).

As a result, UHL embarked on the reconfiguration of acute services and the associated changes to the estate in the form of its Development Control Plan (DCP).

The following elements of the UHL DCP have already been delivered or are in the process of being delivered:

• Relocation of vascular services from LRI to GH (completed in 2017).

• LRI emergency floor redevelopment (new Emergency Department and assessment units – completed in June 2018).

• Relocation of paediatric element of East Midlands Congenital Heart Centre (EMCHC) from GH to LRI (move planned for May 2021).

• Relocation of Level 3 Intensive Care Unit (ICU) from LGH to LRI and GH (funded from Wave 1 STP capital and was the subject of a previous consultation).

The following elements of the UHL DCP do not directly impact upon patients or have already been consulted on and are therefore not within the scope of this DMBC and the previous Pre Consultation Business Case (PCBC).

• GH decontamination unit.

• Enabling - back office reconfiguration, demolitions and early infrastructure.

• LRI ICU expansion.

• LRI infrastructure.

• LRI support functions (pharmacy and mortuary).

• GH ICU expansion.

• GH infrastructure.

• GH support functions (pharmacy).

• LGH relocation of Stroke Services.

• LGH services and IT isolations.

The remaining elements of the DCP are the subject of this DMBC and the previous
PCBC. These are summarised below:

- LRI development of a new Maternity Hospital.
- LRI development of a dedicated Children’s Hospital by refurbishment works.
- LRI inpatients, day case and Gynaecology outpatients relocation (only Gynaecology outpatients relocation within scope for the PCBC).
- GH new build development (including Treatment Centre, theatres and new wards).
- GH development of surgical admissions unit by refurbishment works.
- GH ward refurbishment.

**Conclusion on scope of this DMBC**

The required reconfiguration and transformation of services, at UHL, confirmed by this DMBC is entirely consistent with UHL’s Sustainability and Transformation Partnership (STP) capital bid submission and UHL’s Hospital Investment Programme (HIP) phase 1 (now described as a ‘New Hospital Programme’ front running capital project) which is predicated on the delivery of the UHL DCP.
3 Update to the strategic context and case for change

3.1 Introduction

This section sets out details of the changes in the strategic context since the PCBC was prepared and approved in terms of the impact of COVID on the Reconfiguration proposals and changes to UHL’s Workforce Strategy. It also updates the bed bridge which supports the case for change.

3.2 Impact of COVID on the reconfiguration proposals

Since the PCBC was written the world has changed, for everyone, not just the NHS. Understanding the long term impact of COVID requires both foresight and imagination, 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 and individuals to put plans on hold and put off decisions, in the hope that the future becomes more certain or that someone comes along to tell them what to do. However, as a health system, we believe that is the wrong approach especially now considering all that has been learnt in planning for, and dealing with the impact and aftermath of the pandemic. The public needs the NHS now more than ever and as a result the NHS has a duty to be the best it can be in a COVID endemic world.

At the heart of the UHL’s clinical strategy (which drives the reconfiguration plan) is the desire to focus emergency and specialist care at the LRI and GH and separate elective care from emergency care so that when we are very busy those patients waiting for routine operations are not delayed or cancelled because UHL have had to prioritise an influx of emergencies.

UHL have been working with their clinical teams to understand if this still makes sense when considering what has been learnt from the pandemic. This has been confirmed, for the reasons set out below.

3.2.1 Intensive Care

One of the biggest challenges UHL faced preparing for the first COVID peak was to create enough adult Intensive Care (ICU) capacity. In steady state UHL have 50 ICU beds, the initial pandemic modelling suggested that UHL would require closer to 300 beds. Which was a daunting ask of clinical teams. Nonetheless within a fortnight UHL had a plan to increase capacity in line with the peak, largely as a result of converting every available space with the right oxygen supply and isolation capability into ICU equivalents and by suspending children’s heart surgery so that UHL could convert paediatric ICU, (PICU) into adult ICU.
In the reconfiguration plans UHL have said that they will create two ‘Super ICUs’ at the LRI and GH doubling UHL’s capacity to over 100 ICU beds. Had these ICU beds been in place by the time of the pandemic UHL’s response would have been very different, they would have had enough ICU capacity with some to spare.

3.2.2 Children’s Heart Surgery

As mentioned above, UHL knew that COVID would require them to care for many more adult patients on ICU. Thankfully children have been less affected by the virus. With limited ICU capacity UHL 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 GH into an adult ICU. On balance UHL took the decision based on what would save the most lives, knowing that children would still have their surgery albeit not in Leicester and as a consequence UHL could care for more of the terribly sick adults whose only hope was sedation and ventilation.

However, in UHL’s reconfiguration plans UHL are going to create a standalone Children’s Hospital at the LRI, the first phase completes in spring 2021. Had the Children’s Hospital been built UHL would have been able to continue with heart surgery during COVID knowing that the children were safe in a standalone hospital with a totally separate ICU.

3.2.3 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 UHL were able to continue with 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 of bringing them into a hospital with positive and query COVID patients and the impact that this could have if, in their already poorly state they contracted the virus.

In UHL’s reconfiguration plans they are going to build a standalone treatment centre at GH. This will be to all intents and purposes a new hospital alongside the existing hospital. It fulfils UHL’s desire to separate emergency and elective procedures. Meaning that when UHL are busy with high numbers of emergencies, elective patients still receive care. Had this been in place by the time of the pandemic UHL would have been able to maintain a significant amount of non-emergency work and potentially create a ‘COVID clean’ site.
3.3 Workforce Strategy update

3.3.1 Introduction

Since the PCBC submission, the context and background to UHL workforce planning has changed. This is due to a number of factors including:

- The direction set out in the NHSE/I People Plan (2020/21) and UHL People Strategy (2020).
- The COVID pandemic and the restoration and recovery of services.

In addition, the Trust will need to respond to changes in the national contracting scheme, proposed Integrated Care Systems and the Trust’s underlying financial position.

Even before the pandemic UHL regularly struggled to effectively staff their services. The fact that UHL have three separate hospitals with the duplication and triplication of services that entails means that they often have to spread their staff too thinly in order to cover clinical rotas. During the first peak of COVID UHL had 20% sickness across all staff groups meaning that 1 in 5 staff were either sick or self-isolating as a consequence of someone else in their household being symptomatic. It is a testimony to all UHL’s staff that despite this they kept going but, this is unsustainable in the long term.

Once reconfigured UHL will no longer have to run triplicate rotas for staff. For example with two super ICUs rather than the current 3 smaller ones UHL would have been able to consolidate their 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.

3.3.2 UHL People Strategy

The UHL People Strategy (2020) sets out the strategy over the next five years and provides the context for the Reconfiguration Programme and workforce planning. It details the short and long-term ambition for UHL and is aligned to the national NHS People Plan (2020/21), the NHS Long Term Plan and the LLR System People Plan. This is as well as consolidating the commitments UHL has worked towards since the COVID pandemic and looking to restoration and recovery.

The services UHL deliver as part of networks and partnerships will need to continue to adapt and transform in order to ensure high quality care is delivered to every patient, every time and that UHL and the wider system becomes clinically and financially sustainable.

‘This means that the people, on whom we rely to provide high quality care regardless of which part of our health and care system they work in, may also need to adapt and
transform the way in which they work.’ UHL People Strategy (2020).

The People Strategy highlights the importance of culture and leadership, and health and well-being of UHL staff, and improved working environments. There is also focus on increased flexible and remote working and the Trust’s Agile working policy is being introduced (subject to Trust Board approval) in FY21/22 and which will support the objectives of reconfiguration.

Learning from experience around the management of change, staff engagement and organisation development interventions for the Interim ICU Reconfiguration and EMCHC transition in 2021 will be particularly important for the next phase.

3.3.3 National contract

The impact on workforce of the national contracting stream changes and proposed Integrated Care Systems is still to be determined fully. The Trust is reviewing its activity, financial, workforce and transformation plans and processes in response and working with system partners to ensure that workforce models are developed to support new models of care. However, the current UHL Workforce planning methodology and the Six Steps model will support analysis and future workforce modelling.

3.3.4 Cost Improvement Programmes

The Trust’s underlying financial position in 2020/21 and the schemes proposed to the Financial Recovery Board (FRB) and Cost Improvement Programme (CIP) are driving the need to achieve significant workforce efficiencies. Of the original UHL CIP £35m target for 2021/22, £15m was attributed to workforce. At this stage £14.6m has been identified, approximately £10.8m is allocated to premium pay and £3.8m for substantive staff savings. Workforce CIP schemes include Premium Pay, 1:1 Nursing reduction on agency cover, and Restructure. There is also ongoing work to reduce the reliance on Waiting List Initiative’s through a demand and capacity review.

In addition, the Outpatient’s Efficiency CIP is tasked with efficiency targets and defining the future shape of outpatients through centralised services. It will also embed changes in practice and increased use of virtual options. The scale and pace of digital transformation in response to COVID has really shown the possibilities for change. Furthermore, the EPR programme originally aligned with the Treatment Centre timescales will also commence rollout from 2022 and including Nervecentre eOutpatients.

As a result, a proportion of workforce efficiency opportunities and benefits specified within the PCBC relating to premium pay, waiting list initiatives, virtual outpatients and digitisation may be achieved earlier than anticipated by the Trust. However, the Reconfiguration Programme still will enable the infrastructure for physical design and integrated digital solutions to further support efficient working.
3.3.5 Workforce risks and mitigations

The main workforce risks associated with the reconfiguration together with mitigations are summarised in the table below.

Table 3.1 Workforce risks and mitigations

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff shortages and gaps</td>
<td>• An integrated workforce strategy that aligns with transformative Models of Care and ways of working and new roles to create more flexibility in staffing.</td>
</tr>
<tr>
<td></td>
<td>• An improved environment has been shown to increase recruitment and retention of staff.</td>
</tr>
<tr>
<td></td>
<td>• Provide organisation development support to managers to ensure that the changing needs of service can be delivered.</td>
</tr>
<tr>
<td>Lack of organisational development resources to deliver the workforce changes required for successful transition into new Models of Care</td>
<td>• Adequate OD resource assigned early in project programme.</td>
</tr>
<tr>
<td></td>
<td>• Executive Senior Responsible Officers assigned to individual projects will hold accountability for delivery of Models of Care and transition.</td>
</tr>
<tr>
<td></td>
<td>• Post Project Evaluation will ensure lessons learnt from individual projects are considered within future projects and engagement and benchmarking with other comparable Trusts to take account of their experience.</td>
</tr>
</tbody>
</table>

3.3.6 Delivering benefits

The physical future build will enable the move of services from 3 to 2 sites and provide an optimised design solution to support future workforce efficiency through the co-location of services and the ability to streamline working practices, rostering and out of hours coverage.

UHL continues to face significant workforce challenges associated with staff supply in key areas of medical and nursing staff. This impacts on staff costs arising from expensive agency and non-contracted workforce costs. In addition to mitigating workforce gaps and associated premium costs through reduction in demand for staff and re-design of roles, the physical build can improve long term sustainable supply by offering a more attractive, purpose built workspace offering modern facilities and an improved environment.

3.3.7 Changes in scope

Changes in scope from the PCBC include:
• Increased percentage of single/isolation rooms for new build wards.

• Change in scope of Treatment Centre outpatients.

Single rooms

Where changes in scope are likely to impact on workforce and staffing levels, work is underway to assess the impact of those changes and will inform the Outline Business Case. For example, the potential impact on staffing levels associated with 70% single/isolation rooms on new build wards has been reviewed at Deputy Chief Nurse level for generic wards, and is being considered at speciality level for Maternity, Neonatal and Critical Care. Additional factors include current workforce gaps, benchmarks with national standards, such as Birthrate Plus (BR+), BAPM and GPICS, and supernumery staff, as well as design factors associated with sightlines, communication and teamwork.

Treatment Centre

Changes in scope of the Treatment Centre, from the September 2020 baseline to March 2021, may impact on achieving economies of scale and workforce efficiencies. This is currently driving discussions at system level by reconfiguration project managers and clinical teams to consider options for transformation. For example, Medical Daycase is being reviewed with respect to patient activity suitable for community care, as well as the potential redesign of nursing and medical roles. The impact of this requires further review through activity and workforce modelling which will inform the OBC.

Where there may be changes to proposed site location, due to clinical or workforce interdependencies (for example, ENT and Ophthalmology to remain at the LRI, or wider system transformation) the workforce impact has been taken in account during such decisions.

Summary and conclusion

As highlighted earlier, the context and background to the UHL Workforce Strategy has changed since the PCBC submission. However, the Trust has demonstrated that it can respond, act and adapt to the workforce challenges faced, in particular to COVID. UHL will continue to review and learn from COVID, and the EMCHC and Interim Reconfiguration moves, which will support future workforce planning, leadership, culture, organisation development, engagement and communication.

As Models of Care and clinical services develop further, the application of the UHL Six Steps Methodology will enable targeted modelling of change, mitigation of short and long term risks, and delivery of an optimised solution which supports future workforce efficiency. This approach will continue to be applied as UHL progress through to the OBC and FBC stages of the Reconfiguration Programme.
In addition, the implementation of the UHL People Strategy and a transformed UHL People Services will strengthen the Trust's response in future to support the workforce to deliver the PCBC vision.

3.4 Bed bridge update

3.4.1 Introduction

The mantra for reconfiguration and particularly for 'right sizing' UHL’s hospitals remains as stated in the PCBC, namely that UHL should be 'big enough to cope, but no bigger than necessary'. As was stated previously, 'big enough' is largely determined by demand, activity and the models of care that manage that activity.

Since the PCBC was written, the world has changed, not least in respect of the fundamental changes to activity in 2020/21 brought about by the COVID19 pandemic. A combination of capacity restraints during first and second waves, public anxiety about coming into hospital, and the necessity to cancel and reschedule everything except the most urgent surgery, means the capacity and activity plan in the PCBC for 2020/21 bore little resemblance to the reality of dealing with a pandemic.

As UHL begin the development of an Outline Business Case (OBC) and Full Business Case (FBC), the extraordinary year is being disregarded for planning purposes and pre-pandemic assumptions being used as the last known fixed point from which to plan. It is important to note that this does not mean that the experience and learning of the pandemic has been forgotten, Section 3.3 above describes how the last year has altered UHL’s view on, for example, the numbers of single rooms they will provide in new build wards and in Intensive Care.

Before considering the revised demand and capacity model, it is worth revisiting the original model described in the PCBC.

3.4.2 The original PCBC bed model

The opening bed position, in the PCBC i.e. the number of actual beds the UHL was providing at the time was 2,033. The projected bed requirement was 2,333 beds by 2023/24. This was the unmitigated number i.e. without efficiencies factored in.

In calculating this UHL took the following into account:

- An opening bed position as of winter 2019 of 2,033 beds.
- Activity growth assumptions have increased at 3% in line with those contained in the LLR system Long Term Plan. (Emergency activity across the UK grew between 2% and 6%, with the majority of UHL’s peer trusts showing a growth rate of c4%. Whilst UHL has noted year on year growth rates of between 4% and 5% in the first 2 quarters of 2019/20, this includes significant pathway changes which have influenced the growth rate. This growth rate was also
higher than most of UHL’s regional peers have included in their plans).

- Occupancy levels were set at 93% for electives, 93% day case and 90% emergency which will allow more flexibility and improve flow. (NB, the BMA reviewed the busiest day over winter 2017/18 and found that an additional 15,000 beds were required across the country to achieve 85% occupancy therefore 92% would be a more realistic goal as deterioration in A&E performance begins to accelerate above this point (‘BMA beds in the NHS’ 2018). The impact of this change in occupancy levels and growth assumptions means the unmitigated bed gap is 300 beds at its highest during peak winter months in 2023/24. Conversely during summer months, the bed gap reduces significantly.

3.4.3 Bridging the gap

To bridge the gap UHL planned for two types of intervention, the first was designed to increase actual physical bed capacity above the current baseline of 2,033 whilst the second was to reduce the number of beds required through improvements to clinical pathways and changes to Length of Stay, (LoS).

As a result, over the life of the plan UHL anticipated increasing the actual bed stock by 139 beds (approximately 4 wards) and decreasing the requirement for beds by a minimum of 161 through pathway and LoS improvements. Taken together these interventions bridge the 300 bed gap.

The figure below and subsequent narrative explains this in more detail.

Figure 3-1 UHL bed bridge
3.4.4 Planned efficiencies

As shown above, UHL applied a series of mitigations, including assumptions around LoS & admission avoidance to the likely bed requirement in 2023/24. The work underpinning this looked at changes to individual clinical pathways, approaches to population health management, particularly in frail and multi-morbid patients and internal efficiencies impacting LoS. Taken together this produced a potential efficiency range of 161-237 beds.

The underpinning modelling for each of these schemes took into account benchmarked data from GIRFT, NHS RightCare, Model hospital and other relevant national and international benchmarks, including a range of population health management tools from the John Hopkins Adjusted Clinical Groups system. The opportunity improvement in our frailty and multi-morbidity programme was derived using these data sets, overlaid with evidence from various NHS Right Care case studies.

For planning purposes UHL took a conservative approach to the modelling and used the minimum efficiency expectation to define future bed requirements. In other words if we were to over achieve against what GIRFT / Model Hospital and our own internal assumptions indicate, there was potential for a beds upside and / or reductions in occupancy.

The high level breakdown of efficiencies is shown in the table below.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Bed reduction range 2023/24</th>
<th>Evidence base</th>
</tr>
</thead>
</table>
| Optimal management of frail and multi-morbid patient cohort | 57 to 67 | ▪ Local evidence of delivery  
▪ NHS Right Care case study/STP pack  
▪ GIRFT data |
| Optimal length of stay through implementation of Safe and Timely Discharge processes | 28 to 51 | ▪ CHKS benchmarking data  
▪ GIRFT data |
| Optimal BADS pathway | 14 to 20 | ▪ British Association of Day Surgery guidelines |
| Specialty specific schemes | 62 to 99 | ▪ GIRFT data  
▪ NHS Right Care data |
| Total | 161 to 237 | |
3.4.5 Increase in physical beds

As well as efficiency / pathway improvements UHL chose to create more physical bed capacity within the revised plan as an insurance policy should it be the case that either the necessary clinical transformation did not happen or that future demand was above the 3% per annum value.

There were three elements to this depicted in the Bed Bridge above.

- **Conversion of non-clinical space** - There are areas, particularly at the LRI, where clinical space has been converted into non-clinical space. As such there is an opportunity to reverse that and in doing so create extra bed capacity. The estimate was that this would release the space for the creation of 41 more beds.

- **Transfer of services** - The LRI is home to the ‘Hampton Suite’, a therapy led reablement ward. Given the nature of the patient cohort, this service could be equally successful if based at LGH. The move would free up 28 acute beds.

- **Additional contingency** - Taken together the conservative efficiency improvements and the increase in physical beds amounts to 230 beds worth of capacity over and above the 2019 opening position of 2,033 beds. This left a potential residual gap of 70 beds if, for example, efficiency improvements were actually at the lowest calculated and / or activity growth is greater than 3%. As such the Trust said that, if necessary, this would be addressed in later years through CRL funding for what equates to 2.5 wards.

3.4.6 Summary of the PCBC bed model

The variables impacting the future bed requirements for an acute trust are numerous. Equally, for a trust of the size of UHL even the smallest change to activity/efficiency projections makes a significant difference to bed requirements. For example, a half day improvement in length of stay releases 38 beds worth of capacity. Conversely a 1% increase in activity would result in the need for 76 more beds.

3.4.7 The revised model bed 2021 to 2032

The first thing to recognise about the revised model is that the timeline has been extended in line with DHSC/HM Treasury guidance for business cases. Essentially this means UHL are now planning to a 10 year horizon i.e. to 2032. The extended timeline means that the demand and capacity assumptions change, not least because an activity growth rate of 3% per annum over 5 years produces a very different number to the same rate applied over 10 years.

As mentioned above UHL have to plan from a fixed point with commonly agreed assumptions and as such UHL are basing their future activity and capacity plan on pre-pandemic models of anticipated demand, (see above). The logic being that to a
greater extent the demography, birth rates, epidemiology, disease burden in the population we serve remains.

However, at the same time as the NHS was dealing with the pandemic the policy landscape was brought into sharper focus. The publication of the white paper, ‘Integration and Innovation: working together to improve health and social care for all’ (The Department of Health and Social Care’s legislative proposals for a Health and Care Bill) is explicit in regards to fundamental changes in the way that healthcare is delivered, essentially a transition from episodic, crisis triggered care to a model based on managing population health such that crisis episodes are reduced or at the very least anticipated and planned for in advance.

That shift in approach was a key theme in the original PCBC, particularly around the improved management of frail and multi-morbid patients, which would have a beneficial impact on their health and also on levels of demand in hospital. UHL expect this crystallisation of policy with the attendant requirements for local health systems to act very differently to have an impact in future years on both emergency and elective activity. However, in recognition that there is some considerable way to go on all this work in both the planning and the execution, UHL have taken a prudent approach to demand modelling and kept in line with the PCBC.

3.4.8 The revised bed bridge

The revised bed bridge (below) starts with the same opening position as that of the PCBC i.e. 2,033 acute beds. UHL have then modelled the anticipated growth as outlined above for day-case, inpatient, maternity, ICU activity and extrapolated this across 10 years. This shows that the unmitigated demand growth would increase the requirement by 797 beds to the year 2032.

As with the original model UHL’s approach to bridging the gap involves making both planned efficiency savings brought about by changes to pathways as follows:

- Reducing demand and or reducing length of stay (this accounts for 460 beds).
- Creating new capacity in new build wards (this accounts for 111 beds).
- Should the need arise, the reinstatement of wards that were previously assumed to be ‘mothballed’ as a consequence of the new children’s hospital development, (195 beds).
3.4.9 Planned Efficiencies to 2032

As was the case in the PCBC, the new modelling of planned efficiencies has been based on Model Hospital, GIRFT reports and most importantly on the work that has continued over the last year to review models of care, and new pathways across the system. The results show that the efficiency range has increased to a ‘saving’ of between 322 - 460 beds. At this stage UHL have chosen the upper limit of that range based on their experience of those schemes that have, despite the pandemic, shown that they can deliver significant results in terms of reducing inpatient activity, ambulance conveyance and admissions. For example, the Pre Transfer Clinical Discussion, PTCDA scheme by which paramedics who are called to care home residents first discuss the patients baseline, care plan and current status with hospital based acute physicians/geriatricians before a decision is made to bring the patient into the Emergency Department has resulted in an 80% non-conveyance of older frail patients, this principle of seeking specialist input before care is escalated is now being considered in other settings rather than just care homes.

Another example of changes in approach resulting in reduced pressure on inpatient beds has been the use of virtual wards during the pandemic to care for patients predominantly on respiratory or heart failure pathways. 900 patients who required more monitoring and intervention than was typically available in primary care have been supported at home or in their usual place of residence by a team of physicians and other professionals, this has enabled both the hospitals to ‘step down’ patients
sooner at the end of their acute stay and primary care to admit patients into a virtual ward who otherwise would have been admitted to hospital.

Overall, as the understanding of population health management develops and the use of risk stratification improves (i.e. the ability to target/monitor those citizens who are most at risk of an unplanned hospital admission), UHL are more confident that they can safely and effectively ‘manage’ frail and multi-morbid patients in the community without the necessity of a lengthy stay in hospital. However, this requires a different approach from UHL’s clinical teams in primary, community and acute care, specifically as the complexity of illness increase then to manage that complexity out of hospital necessitates more specialist input into clinical decision making and risk sharing in community. In summary, to prevent people having to come into hospital, UHL are going to have to export skills and resource out of hospital.

Table 3-3 UHL planned efficiencies to 2032

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Bed reduction range 2031/32</th>
<th>Evidence base</th>
</tr>
</thead>
</table>
| Optimal management of frail and multi-morbid patient cohort | 148 to 210 | ▪ Local evidence of delivery  
▪ NHS Right Care case study/STP pack  
▪ GIRFT data |
| Optimal length of stay through implementation of Safe and Timely Discharge processes | 67 to 94 | ▪ CHKS benchmarking data  
▪ GIRFT data |
| Optimal BADS pathway | 14 to 20 | ▪ British Association of Day Surgery guidelines  
▪ GIRFT data  
▪ NHS Right Care data |
| Specialty specific schemes | 93 to 136 | ▪ GIRFT data  
▪ NHS Right Care data |
| Total | 322 to 460 | Range based on min’ of 70% schemes delivering |

3.4.10 How does the Children’s Hospital Scheme create capacity?

As set out in the PCBC it is UHL’s intention to create a new maternity hospital and a new children’s hospital at the LRI. The schemes are interdependent. Once the new maternity hospital is built, the Trust’s current maternity services located in the Kensington Building at the LRI will combine with those moving from LGH to establish a purpose built maternity hospital at the LRI. The space vacated by LRI’s current maternity service in the Kensington building will be remodelled and transformed into the new standalone children’s hospital. At this point the 7 children’s wards (195 beds) which are currently located in LRI’s Balmoral building will be either surplus to requirements or capable of providing capacity for adult inpatients, subject to demand.
driven alterations.

The combination of new build beds (111) and the repurposed children’s wards means that the total available capacity at the end of this plan will increase by 306 beds to 2,339 from the current baseline of 2,033 beds.

3.4.11 Summary - A work constantly in progress

During the writing of the original PCBC and the consultation & engagement with public and stakeholders UHL have emphasised that the business of activity and capacity modelling in the NHS never stops, largely as a reflection of the fact that new pathways, new treatment regimes, technology and epidemiology are also in a constant state of change. As such and even as the update was being written the system clinical design groups remain busy working up their plans for e.g. ‘Urgent and emergency’ and ‘Planned Care’ pathways.

This means that activity modelling will continue as UHL progress through to the OBC and FBC stages of the Reconfiguration Programme. As a result, it is important to note that whether the future is viewed through the lens of the original system Model of Care or the developing place based models that reflect the aims of the white paper, the mantra remains the same, namely that Leicester’s Hospitals have to be ‘big enough to cope but no bigger than necessary.’

3.4.12 Future flexibility

If further capital developments are needed to meet growth in population or health need after 2024, then UHL has flexibility in their existing estate to develop. UHL will retain 33 acres of developable land (the equivalent to approximately 22 football pitches) located at the Glenfield Hospital. More than 25 acres of this land is already empty space.

UHL will also continue to maximise space at LRI, with appropriate planning consent if necessary, subject to the need to consider travel, access and car park when considering what services are provided on this site.

If future developments are needed, they would likely be funded from the UHL’s own capital budgets and, working with local NHS and local government partners, through access to section 106 funding and Community Infrastructure Levy to support services when housing growth puts pressure on them.
3.5 Conclusions and next steps

UHL have worked with their clinical leaders to understand whether the reconfiguration plans still make sense in light of the pandemic and this has been confirmed. Moreover, it is clear that had the timing been different UHL would have been better able to cope with COVID19 in their reconfigured state. However, it is important to recognise that whilst UHL are, in light of all that they have been through, more determined than ever to deliver the investment in their local hospitals, there is still a large amount of detailed planning work to do before UHL can say with assurance that the whole reconfiguration is ‘pandemic proof’. That detailed work is underway and UHL and the wider LLR health economy continue ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.
4 The Reconfiguration proposals

4.1 Introduction

This section describes the Reconfiguration Programme proposals for each of UHL’s current sites that have been the subject of the consultation.

4.2 LRI proposals

LRI will continue to be the primary site for emergency care. It will accommodate a consolidated Maternity service in a new build facility and all Gynaecology services accommodated adjacent to Adult Surgical services, as well as the creation of a ‘super ICU’. The Paediatric element of the East Midlands Congenital Heart Centre (currently at GH) will relocate to LRI consolidating Paediatric services on one site with a future proposal being the development of a dedicated Children’s Hospital. Brain Injury and Neurological Rehabilitation Unit were to relocate here from LGH within Adult Medical services.

Additional car parking and a Welcome Centre will be provided to support the expansion of services.

Maternity proposals

The outcome of the DH national review on Maternity services 2016 (Better Births) provided us with the opportunity to develop further our preferred option for Maternity services within the BCT programme and articulate the direction of travel for the next five years and beyond for Maternity and Neonatal services across LLR. A Transformational Plan for Maternity Services was published in February 2018 and subsequently refreshed in 2019. The plan sets out a description of how the Local Maternity System (LMS) aims to continue to transform local services and implement national initiatives in the context of Better Births. Following on from the results of the Maternity services options appraisal, the proposed Maternity Hospital at LRI has been developed to facilitate the delivery of the Transformational Plan for Maternity Services.

The proposed developments at LRI are show in the figure below.
Figure 4-1 LRI proposed developments

<table>
<thead>
<tr>
<th>Projects at LRI</th>
<th>LRI Ward Refurbishment</th>
<th>EMCHC</th>
<th>LRI ICU Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Internal refurbishment to create new inpatients (for services transferred from LGH), Gynaecology outpatients and day case.</td>
<td>Internal refurbishment of areas and new build to create the new East Midlands Congenital Heart Centre.</td>
<td>New build ICU.</td>
</tr>
<tr>
<td><strong>Programme</strong></td>
<td>May 26 – Aug 27</td>
<td>Jan 19 – Apr 21</td>
<td>Mar 23 – Oct 25</td>
</tr>
<tr>
<td><strong>Design Strategy</strong></td>
<td>Mixed Refurb</td>
<td>Mixed Refurb</td>
<td>Mixed New &amp; Refurb</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>£15.6m</td>
<td>£10m</td>
<td>£25.9m</td>
</tr>
<tr>
<td><strong>Size (m2)</strong></td>
<td>4,787</td>
<td>2,687</td>
<td>3,369</td>
</tr>
<tr>
<td><strong>Potential funding</strong></td>
<td>NHS capital</td>
<td>NHS capital</td>
<td>NHS capital</td>
</tr>
</tbody>
</table>
4.3 GH proposals

GH will expand considerably by almost one third as services move from both LGH and LRI. The relocation of vascular services from LRI, in 2017, was the first of these moves creating a complete cardiovascular centre. A ‘super ICU’ will be developed to support the growth in demand across all services. Elective Orthopaedics, Hepatobiliary, Renal (medicine and transplant), and Urology services will relocate from LRI to create a specialised surgical hub with a supporting admissions unit. These facilities will be delivered within a mixture of retained estate and new build elements.

The largest development of the entire Reconfiguration Programme is delivered here which will comprise of a new build Treatment Centre which will cater for all outpatients, 23hr Care, Theatres, Imaging and additional wards.

Additional car parking and a Welcome Centre will be provided to support the expansion of services.

The proposed developments at GH are shown in the figure below.
### Projects at GH

<table>
<thead>
<tr>
<th>Description</th>
<th>GH New Build (including Treatment Centre, Theatres and New Wards)</th>
<th>GH Surgical Admissions Unit</th>
<th>GH ICU Expansion</th>
<th>Car Park development</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 new build wards on the roof of existing hospital, new build ICU extension and an internal refurbishment to create an Interventional Radiology suite and associated enabling works.</td>
<td>Large new build development: Treatment Centre, In-patient Wards &amp; Theatres.</td>
<td>New build development adjacent to existing unit.</td>
<td>Internal refurbishment of existing Paediatric ICU to expand Adult ICU</td>
<td>Car Park to be funded through commercial venture.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Design Strategy</td>
<td>New build &amp; Refurbishment</td>
<td>New Build</td>
<td>New Build</td>
<td>Refurbishment</td>
<td>New Build</td>
</tr>
<tr>
<td>Cost</td>
<td>£30.8m</td>
<td>£169.7m</td>
<td>£3.8m</td>
<td>£20.5m</td>
<td>Commercial Venture</td>
</tr>
<tr>
<td>Size (m²)</td>
<td>9,150</td>
<td>26,774</td>
<td>580</td>
<td>4,832</td>
<td>n/a</td>
</tr>
<tr>
<td>Proposed funding</td>
<td>NHS capital</td>
<td>NHS Capital</td>
<td>NHS capital</td>
<td>NHS capital</td>
<td>Commercial</td>
</tr>
</tbody>
</table>
4.4 LGH proposals

As part of the Reconfiguration Programme UHL proposes to retain some facilities at LGH. These being:

- **The Leicester Diabetes Centre of Excellence** – a dedicated facility where it currently resides within the H-Block. This facility has been developed over recent years and provides services from newly refurbished buildings. It is proposed that this building is technically isolated and will be able to be maintained independently.

- **Dedicated GP Access Imaging Hub** – The current Imaging facilities will be retained and reconfigured to provide an independent facility. This will both serve to alleviate the increased footfall on the two acute sites, release space on the two acute sites for additional development and separate urgent inpatient imaging from GP imaging.

- **Stroke Rehabilitation** - Most of the clinical functions at LGH are captured within the Reconfiguration Programme and are relocating to LRI or GH with the exception of Stroke Rehabilitation which will locate to Evington Centre currently owned by LPT.

- **Brandon Unit** – This is a large currently unoccupied building which is intended to provide administrative and education and training accommodation - alleviating space constraints on the acute sites. Service functions which are not needed to be accommodated on the acute sites will be relocated here

- **Midwifery Led Unit** – Dependant on public consultation an MLU will be provided within the existing Coleman Centre.

The proposed developments at LRI are shown in the figure below.
4.5 **Support services**

Supporting services such as expansion to the Mortuaries, Pathology and Pharmacies will form part of the plans as will the expansion to the technical infrastructure and IT provision across the sites. In addition the provision of administrative support functions will be reviewed to ensure the right services are in the right location ensuring the estate is used to maximum clinical efficiency.

4.6 **Proposed configuration of acute services**

The tables below show the proposed configuration of adult day case, inpatient and outpatient services at the three current sites and the proposed Treatment Centre at GH, along with services proposed to be provided in community hospitals by the PCA. Children’s services are excluded from this list as they will all be located at LRI when the EMCHC service relocates from GH following the national consultation process.
### Table 4-1: Location of day case services

<table>
<thead>
<tr>
<th>Day case speciality</th>
<th>Current location</th>
<th>Future location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Pathology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Clinical Immunology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Dermatology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Ear Nose and Throat (ENT)</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>ESRF</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>General Surgery</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>LGH and LRI</td>
<td>LRI</td>
</tr>
<tr>
<td>Gynaecology Oncology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Haematology</td>
<td>LGH and LRI</td>
<td>LRI</td>
</tr>
<tr>
<td>Hand Trauma</td>
<td>LRI</td>
<td>GH</td>
</tr>
<tr>
<td>Hepatobiliary &amp; Pancreatic Surgery</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Integrated Medicine</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>LGH</td>
<td>LRI and GH</td>
</tr>
<tr>
<td>Nephrology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Neurology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Pain Management</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Renal Access Surgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Sleep</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
</tbody>
</table>
### Table 4-2 Location of inpatient services

<table>
<thead>
<tr>
<th>Inpatient speciality</th>
<th>Current location</th>
<th>Future location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Surgery</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>LGH</td>
<td>LRI and GH</td>
</tr>
<tr>
<td>ESRF</td>
<td>LGH</td>
<td>GH</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Emergency General Surgery</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Gynaecology Oncology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Hepatobiliary &amp; Pancreatic Surgery</td>
<td>LGH and LRI</td>
<td>GH</td>
</tr>
<tr>
<td>Neonatal Intensive Care</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Neonatology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Nephrology</td>
<td>LGH</td>
<td>GH</td>
</tr>
<tr>
<td>Neurology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>LRI</td>
<td>GH</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>LGH</td>
<td>GH</td>
</tr>
<tr>
<td>Renal Access Surgery</td>
<td>LGH</td>
<td>GH</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
</tbody>
</table>
### Table 4-3 Location of outpatient services

<table>
<thead>
<tr>
<th>Outpatient specialty</th>
<th>Current location</th>
<th>Future location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Audiology</td>
<td>LRI</td>
<td>LRI and GH Treatment Centre</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>LGH and LRI</td>
<td>Community provision</td>
</tr>
<tr>
<td>Chemical Pathology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Clinical Immunology</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Dermatology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>End Stage Renal Failure</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>General Surgery (incl colorectal)</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Outpatient specialty</td>
<td>Current location</td>
<td>Future location</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Gynaecology Oncology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Hepatobiliary &amp; Pancreatic Surgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Hepatology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>LGH</td>
<td>LRI/ GH</td>
</tr>
<tr>
<td>Maternity Scans</td>
<td>LGH and LRI</td>
<td>LRI</td>
</tr>
<tr>
<td>Neonatal Intensive Care</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Neonatology</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Nephrology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Neurology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>LGH</td>
<td>LRI</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Pain Management</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>LGH</td>
<td>Community</td>
</tr>
<tr>
<td>Renal Access Surgery</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Sleep</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Spinal Surgery</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>LGH and LRI</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Transplant</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Urology</td>
<td>LGH</td>
<td>GH Treatment Centre</td>
</tr>
</tbody>
</table>
Table: Reconfiguration proposals

<table>
<thead>
<tr>
<th>Outpatient specialty</th>
<th>Current location</th>
<th>Future location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Surgery</td>
<td>LRI</td>
<td>GH</td>
</tr>
</tbody>
</table>

4.7 UHL Road Map for service reconfiguration

The figure below shows UHL’s planned journey to deliver the service reconfiguration.

Figure 4.4 UHL Road Map for service reconfiguration

Details of the programme management arrangements and the delivery plan for the reconfiguration are included in Sections Error! Reference source not found. and REF _Ref22034008 r't'h 8.4.

4.8 How the reconfiguration proposals meet the five NHS tests of service reconfiguration

4.8.1 Introduction

In 2010, the Government introduced four tests of service reconfiguration. These tests are “designed to build confidence within the service, with patients and communities”. The organisations involved in developing service change proposals are responsible for working together to show that the evidence in each test is convincing, and thereby
to reassure themselves and their communities.

The four tests are for the proposed service changes to demonstrate evidence of:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioner support for the proposals.

We have set out below our approach to assessing the reconfiguration plans against each of the four tests of reconfiguration for clinical assurance, and an additional ‘fifth test’, introduced in March 2017 in respect of justification for bed closures (should these be proposed).

The five tests have been applied throughout the pre-consultation and consultation phases and will continue through the post-consultation phase of this programme. The following sections describe how the ICS has engaged with a broad range of stakeholders to meet the five tests. Each section describes:

- The guidance.
- The approach taken.
- Future planned activities.

4.8.2 Test 1 - Strong public and patient engagement

Guidance

Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHSE must make arrangements to ensure that people who use, or may use, services are properly involved in the following:

- Planning the provision of services.
- Developing and considering proposals for change in the way those services are provided.
- Considering the NHS organisation’s decisions affecting the operation of services.

Providers of NHS-funded services have a separate but similar legal duty, under Section 242 of the NHS Act 2016, to involve service users.

Guidance in “Planning and delivering service change for patients” states that
engagement activity should be proactive and should reach out to local populations, engaging them in ways that are accessible and convenient for them. The approach should take account of the differing information and communication needs of the audiences, and their differing preferences. Communities should be actively involved as partners rather than as passive recipients.

**Approach taken**

Public and Patient involvement (PPI) has been central to the approach taken by both UHL and the wider ICS. A summary of the key approaches taken are set out below.

- **June 2014 to 2017** - Development of the UHL five year plan clearly stated the ambition to move from three acute sites to two. This plan is published annually on UHL website.

- **September 2014 to 2017** – UHL annual public meetings attended by 100+ people received presentation on the five year plan. This is presented at the public meeting every year.

- **March 2015** – BCT Awareness and Engagement Campaign stated explicitly the proposal to reduce from three to two sites. This LLR wide campaign utilised Media Outlets including local radio and TV reaching over 375,000 people. Local Authority publications distributed to over 375,000 households. A mobile unit deployed to 12 key locations around the Leicestershire and Rutland with an estimated footfall of over 150,000.

- **November 2016** – May 2017 – STP published with ten public events, local groups and meetings, published on the BCT website and social media with approximately 11,929 interactions.

- **October 2018 to 2019** – Open public engagement events, outreach work through voluntary and community sector agencies/groups, online briefings, press and broadcast media briefings.

- **September 2020** to December 2020 – Public consultation.

Each of these phases has resulted in changes to the overall Models of Care in the reconfiguration proposals.

**4.8.3 Test 2 - Consistency with current and prospective need for patient choice**

**Guidance**

The NHS Constitution outlines the right to informed choice on the following elements:

- The right to choose your GP practice.
• The right to express a preference for seeing a particular doctor within your GP practice.

• The right to make choices about your NHS care and to information to support these choices.

• The right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointments with a service led by a consultant.

The Health and Social Care Act 2012 requires commissioners to ensure good practice and to promote and protect patient choice. Choice and competition are effective tools that a commissioner can use to improve services for patients.

In March 2013, NHSE and Monitor published a joint statement on choice and competition in commissioning clinical services in the NHS. According to the statement, it is for commissioners to decide how best to use choice and competition to improve the quality and efficiency of services, beyond the rights in the NHS Constitution. Commissioners need to make balanced judgments on a variety of factors, such as delivering care in a more integrated way, ensuring service sustainability, and determining whether there is a range of suitable providers.

Approach taken

In the development of proposals locally, patient choice (for appropriate, high quality services) has been a key factor:

One of the four criteria used for narrowing the options for service changes was maintaining appropriate access to services for patients, relatives and staff. This criterion includes the impact of the proposals on patient travel times and the impact on patient choice.

A clinically focused review panel assessed the impact of the proposals on each of the options appraisal criteria, including patient choice. Scores were combined to give an overall assessment of each proposal – an assessment that balanced the need for appropriate patient choice with the need for safe and effective care. No option scored below neutral for patient choice.

An Equality Impact Assessment (EIA) was undertaken, to demonstrate that there will be equitable access for everyone and no group of people would be inadvertently excluded (on the basis of protected characteristics, for example). This EIA has been updated following the outcome of the public consultation and is included in Appendix D.

Proposals were developed to ensure that services are locally accessible wherever possible and centralised where necessary. For example:
• Proposals include consolidation of services only where clinically necessary; the option of a MLU to be retained at LGH is one consideration.

• Direct access to imaging was retained at LRI and GH following feedback from commissioners and the public.

Table 4-4 Assessment of impact of proposals on patient choice (acute)

<table>
<thead>
<tr>
<th>Patient Cohort</th>
<th>Choice Now</th>
<th>Choice Future</th>
<th>Impact on Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients receiving planned care at LGH</td>
<td>Majority of activity carried out at UHL sites, small level of activity available in community hospitals.</td>
<td>Increase in activity, both amount and type, in community hospitals and over time primary care facilities, development of a Treatment Centre at GH, where necessary planned care at LRI</td>
<td>More options to choose from for many specialities, impacts circa 30,000 patients (2.8% of the LLR population)</td>
</tr>
<tr>
<td>Patients receiving inpatient (not day case) services at LGH</td>
<td>Activity split between LRI and LGH</td>
<td>All LLR services delivered via LRI, outside of LLR remains an option</td>
<td>One less option impacting circa 2,000 patients (0.18% of the LLR population)</td>
</tr>
<tr>
<td>Patients in UHL’s acute hospitals who no longer need acute care</td>
<td>Remain in acute hospital until full rehabilitated and potentially deteriorate</td>
<td>Home First “hospital and home” beds and inpatient beds in six community hospitals distributed across LLR</td>
<td>More options to choose from impacting circa 2,800 patients (0.26% of the LLR population)</td>
</tr>
</tbody>
</table>

Table 4-5 Assessment of impact of proposals on patient choice (maternity)

<table>
<thead>
<tr>
<th>Option</th>
<th>Patient cohort</th>
<th>Choice now</th>
<th>Choice future</th>
<th>Impact on choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1 MLU at LGH</td>
<td>Pregnant women</td>
<td>St Mary’s, LGH MLU and Obstetrics, LRI MLU and Obstetrics or Home birth</td>
<td>LGH MLU, LRI MLU and Obstetrics, Home birth</td>
<td>Retaining four choices, reducing to four locations</td>
</tr>
<tr>
<td>Option 2 No standalone MLU</td>
<td>Pregnant women</td>
<td>St Mary’s, LGH MLU and Obstetrics, LRI MLU and Obstetrics or Home birth</td>
<td>LRI MLU and Obstetrics, Home birth</td>
<td>Reduced to three choices and locations</td>
</tr>
</tbody>
</table>

Future planned activities
Patient choice will continue to be a focus for the programme, and to inform the programme’s proposals. This consultation has reviewed the feedback from patients, public and clinicians, including feedback regarding the impact of the proposals on patient choice.

4.8.4 Test 3 - A clear clinical-evidence base

Guidance

The objective of this test is to ensure that the service change proposals are underpinned by a clear clinical evidence base and align with up to date clinical guidelines and best practices.

Approach taken

Clinical leadership has been at the heart of the approach adopted in developing these proposals, resulting in a strong focus on the evidence base underpinning the Models of Care proposed. Key developments have included:

- Proposals were developed by frontline clinicians (including nurses, midwives and other healthcare professionals). Lead clinicians, together with clinical subgroups involving 60 clinicians from across the Trust, developed the Future Model of Care for acute and maternity services.

- There have been two reviews by the East Midlands Clinical Senate, which were carried out in August 2015 and July 2018, to provide independent clinical advice on the proposals for the programme.

- National guidance and recommendations from the Royal Colleges have been included in the proposal development process.

- Emerging proposals were tested and refined by a broad clinical and professional leadership group, including circa 40 leaders from primary care, community services, mental health, public health and acute care.

- Proposals have been developed in accordance with national policies and guidelines.

Future activities to maintain compliance

The proposals will continue to be clinically led and will include views from a wider group of clinicians during future phases.

4.8.5 Test 4 – GP Commissioners support for the proposals

Guidance

All service change needs GP Commissioner ownership, support and leadership (even
if change is initiated by a provider or other organisation).

Commissioners have a duty to ensure that proposals meet certain conditions, including that they:

- Align with commissioning intentions and expenditure plans.
- Will meet the current and future healthcare needs of the patient.
- Will deliver high-quality care.
- Will install services that have long-term sustainability.

**Approach taken**

Proposals for service change have been developed with local commissioning organisations and GPs and have broad support from partners from across the sub-region. Commissioning organisations have led much of the ICS planning and have been involved in the Reconfiguration Programme at a number of levels:

The Clinical Chairs and Accountable Officers of all three LLR CCGs have been members of the System Leadership Group, which steered and advised the Programme in its early stages.

The Senior Responsible Owner (SRO) for original Sustainability and Transformation Programme was the Accountable Officer for West Leicestershire CCG, and has ensured close liaison and joint working with the other Accountable Officers from the CCGs.

GPs from across the patch have been involved in both the development of proposals (working alongside acute and maternity colleagues) and in the wider engagement on the programme.

**Decision making**

The LLR CCGs Joint Governing Body will formally approve this DMBC in June 2021.

**Future activities to maintain compliance**

The three CCGs in the ICS are the owners of the Reconfiguration Programme proposals and will continue to monitor and review the implementation of the proposals.

**4.8.6 Test 5 – Bed closures**

**Guidance**

In March 2017, NHSE published “Next Steps on the NHS Five Year Forward View”,...
which introduced a ‘fifth test’ for proposed service reconfiguration:

From 1 April 2017, NHS organisations also have to show that proposals for significant bed closures, requiring formal public consultation, can meet one of three common sense conditions:

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.

- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care.

Approach taken

The proposals developed across UHL include aspects of all three of the conditions set out above. For example, the consolidation of services will improve bed utilisation.

The proposals for acute and maternity reconfiguration involve consolidating some services from three sites to two; however, there are no plans to reduce the aggregate bed base across UHL.

Future planned activities

The bed model is being continually updated, and the position in relation to aggregate bed levels will be kept under review.

4.9 Conclusion on the Reconfiguration Programme proposals

The reconfiguration of services across UHL’s three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes, whilst at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

The proposals meet the 5 tests for service reconfiguration and will result in local health and social care partners ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.
The consultation process and outcomes

5.1 Introduction

This section sets out the background and legal framework within which the consultation has taken place. It also describes the consultation process and summarises the responses to the consultation.

5.2 Background and the legal framework

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by Section 14Z2 of the NHS Act 2006, which states:

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) In the planning of the commissioning arrangements by the group.

(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them.

(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

There are two other relevant aspects to Section 14Z2. Subsection 3 requires all CCGs to include in their constitution a description of their public engagement arrangements and a statement of the principles that they will follow in when implementing them. Subsection 4 empowers NHSE to publish guidance on compliance with this section, which CCGs must have regard to. This was published in September 2013 – see below for more details.

Section 13Q of the Act applies to NHSE and contains effectively identical provisions to Section 14Z2. With Section 242 of the Act containing similar obligations for NHS Trusts and Foundation Trusts. Any NHS body considering changing the services it
commissions or provides must be aware of the obligations discussed in this note.

In summary, any significant commissioning decision or reconfiguration is caught by these statutory requirements. The statute does not insist on "consultation" but, seeks to make sure that service users are "involved". In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.

5.3 The engagement

5.3.1 Background

The LLR BCT partners collectively and individually have been engaging and involving patients, carers, staff, GP practices and other stakeholders in BCT and the acute and maternity reconfiguration since 2014. In particular the BCT Patient and Public Involvement (PPI) reference group and the BCT Communications and Engagement group have been working together to ensure the patient and public voice is heard in the Reconfiguration Programme. These two groups have been crucial to the engagement so far and have been part of the development of the consultation and engagement plans so far.

The launch of the 2018 BCTP marked a new phase in engagement ahead of any formal consultation. Throughout 2018 and 2019, the Oversight and Scrutiny Committees, Health & Wellbeing Boards and Healthwatch organisations, among others further scrutinised the BCTP. We also worked with all our stakeholders to develop a robust Consultation Plan which was reviewed by NHS England Specialised Commissioning and NHSE/I.

5.3.2 Aims of the consultation

The aims of the consultation exercise have been:

- To inform people about how the proposals have been developed.

- To describe and explain the proposals for reconfiguring acute and maternity services.

- To seek people’s views, and understand the impact of the proposals on them.

- To ensure that a range of voices are heard which reflect the diverse communities involved in the consultation.

- To understand the responses made in reply to our proposals and take them into account in decision-making.

5.3.3 Audiences

There are a large variety of audiences and stakeholders for the BCT programme to
engage with and a detailed stakeholder mapping exercise was undertaken and used to deliver a successful pre-consultation campaign in 2015. This was updated and also reflected in the Consultation Plan. Stakeholders have different needs and the first principle of good communication and engagement is that activities / products are audience specific.

The general principles which have underpinned our engagement or consultation are:

- We will be as open and transparent as possible.
- Plans will be in plain English and a variety of formats.
- Consultation will be based, as far as possible, on reaching people where they are and on their own terms.

A wide range of tools have been used including locality and thematic approaches, outreach, events, workshops, video and social media.

**Activities for the pre consultation engagement period**

Engagement activities continued during 2018 and 2019 to engage with communities in LLR.

The activities provided opportunities for patients, the public and wider stakeholders to discuss changes to the care they receive in ways that suit them. This included talking through the underpinning detail of the rationale for the proposed changes and what it would mean in practical terms for patients using services currently being provided by the three hospitals in Leicester run by UHL.

The activities were a combination of deliberative events and outreach work with patient, voluntary and community sector groups, to give the public the opportunity to raise any questions or concerns that need to be addressed as we move through the stages of the programme and towards formal public consultation. A programme of communications supported the events and outreach work.

Feedback from the events was captured to influence the decision making processes within each work stream of Better Care Together (BCT) and the acute and maternity Reconfiguration Programme.

The public engagement work also combined public events with community outreach, along with online/social media and other communications.

**Public events**

To start this process, the CCGs and UHL jointly hosted a series of open engagement events during late October and November to share more widely the plans for acute hospital reconfiguration and maternity services.
The events also recognised that people had questions about the proposals for the consolidation of level 3 intensive care services onto two hospital sites. We took the opportunity to explain why it is so important and what impact this change has on wider reconfiguration plans.

People used the nine events as a drop-in to informally discuss NHS plans for improvements and as formal events with presentations and question and answer session. Feedback from the events was captured to influence the decision making processes within each work stream of BCT and the acute and maternity reconfiguration.

**Outreach work**

Throughout 2018 and 2019 we also undertook a programme of outreach work.

The outreach work took two differentiated approaches. To recognise our duties under the Equality Act 2010 to consider potential impacts of service change on people with protected characteristics we have reached out to these communities attending their existing meetings and events. We particularly worked through voluntary and community sector agencies and local support networks to involve these communities.

Examples of the type of groups we engaged are:

- Mental health partnerships.
- Carers groups.
- Youth Councils (Leicester City and Leicestershire).
- Carers of people with learning disabilities.
- Children living with mental health conditions.
- Cancer patients.
- Deaf community.
- Blind and sight impaired community.
- Older Peoples’ Network.
- Young on-set dementia group.
- Maternity voices.

In addition, the second approach to outreach was manned drop-in sessions situated
in community venues where there is reasonable footfall e.g. libraries. This allowed the public to view the same BCT displays on show at the deliberative events and have informal conversations about health services, but in their local area.

**Other engagement and communications**

- **Staff** - To provide further opportunities for staff to be engaged, face to face briefings were organised. Existing mechanisms available through organisations to reach staff including newsletters and online briefings were also used.

- **Online communications** - We raised awareness of BCT and the acute and maternity reconfiguration through a range of online communication including social media channels (Twitter, Facebook and YouTube) and partner websites. We have produced a regular BCT e-newsletter and video case studies and explored interactive content.

- **Press and broadcast media** – We worked with local print and broadcast media to coordinate regular articles and updates utilising case studies. Video case studies are being used to communicate the acute reconfiguration proposals. The Leicester Mercury has also produced regular features on various key aspect of the work. We also capitalised on the reach of our weekly newspapers encouraging them to replicate the features for their local audiences.

- **Existing communication mechanisms** – We also used existing established mechanisms to provide information and communicate with a range of stakeholders:
  - BCT partner websites.
  - Presentations at Healthwatch (Leicester and Leicestershire, Rutland), Voluntary Action Leicester and other voluntary groups.
  - Patients groups and members including PPG networks.
  - GP newsletters and locality/federation meetings.

**Engagement with councillors** - Discussions have been ongoing with individual local authorities with regard to engagement with councillors using differentiated approaches. This included an all members briefing, in December, for Leicestershire County Council members and the Labour Group within Leicester City Council.

5.3.4 **Consultation period and activities**

The period of consultation ran for 12 weeks, to ensure sufficient time and opportunities for meaningful discussions.
The main activities included:

- A widely published consultation document, with other versions and formats available on request.

- Widely published shorter versions.

- Online feedback questionnaire (printed version also available).

- Associated presentation materials and support information, such as material for newsletters, articles and social networking.

- A supporting publicity campaign, including engagement and special features with local and national media.

- A distribution cascade, using all outlets offered by partner organisations within the BCT programme, plus external partners including the voluntary and community sector.

- Social networking to signpost to the main websites of all partners, alongside a suite of contextual materials, such as podcasts, films, presentations, and reports from previous engagement.

- A programme of open public events and meetings to reach diverse audiences, and involving a range of techniques developed during the engagement phases.

- Range of discussion techniques though collaboration with Healthwatch and voluntary organisations e.g. outreach to reach a good demographic mix.

- A programme of consultation meetings for staff and stakeholders.

- Coordinated handling of feedback, enquiries and FOI requests.

The ICS appointed NHS Midlands and Lancashire Commissioning Support Unit to collate all feedback and analyse and evaluate it and produce a consultation report. In preparing the consultation report for final consideration there have been a series of assurance checks by:

- ICS Clinical Leadership Group and PPI Group.

- The three Health Overview and Scrutiny Committees, with input from the three Health and Wellbeing Boards.

- The programme executive and programme board, with input from regulators.
5.4 Consultation questions

The Consultation Document, which includes the consultation questions, is included in Appendix A.

5.5 Consultation outcomes

The consultation outcomes are summarised below, and the detailed report of findings is included in Appendix B.

5.5.1 Introduction

The report provides an in-depth analysis and presentation of the feedback received during the consultation on reconfiguring acute and maternity services held between 28 September and 21 December 2020.

Set out in the following sections are a summary of the key findings in respect of each proposal.

For each proposal respondents were asked the extent to which they agreed or disagreed. They were then asked to explain the rating they provided and give more detail.

5.5.2 Consultation responses received

The table below provides an overview of the responses received to the consultation by channel.

<table>
<thead>
<tr>
<th>Channel</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey responses (this includes 4,645 submitted online, 33 submitted by paper response and 4 submitted by telephone call)</td>
<td>4,682</td>
</tr>
<tr>
<td>Correspondence (email and letter)</td>
<td>70</td>
</tr>
<tr>
<td>Number of event participants across 113 events</td>
<td>923</td>
</tr>
<tr>
<td>Total response to the consultation</td>
<td>5,675</td>
</tr>
</tbody>
</table>

Set out below is an overview of the geographical and demographic profile of consultation survey responses. For further detail, please see the profiling section of the detailed report.

- **Geography:** 25% (1120) were from Leicestershire South and East, 22% (989) from Leicestershire North and West, 20% (891) from Leicester, 6% (283) from Rutland and 27% (1199) from outside of the area or postcode provided / verified.

- **Ethnicity:** 81% (3,647) were of White ethnicity and 19% (835) non-white BME ethnicity.
• **Age**: 52% (2,375) were aged 50 or over.

• **Religion**: 50% (2,225) were Christian.

• **Sex**: 67% (3,079) were female and 29% (1,315) were male.

• **Sexual orientation**: 87% (3,911) were heterosexual.

• **Relationship status**: 60% (2,740) were married.

• **Health problem or disability**: 27% (1,214) had a health problem or disability limiting day-to-day activities.

• **Carers**: 65% (2,928) were not carers.

### 5.5.3 Proposal 1: Acute Services

Respondents were asked the following questions:

• **Q1** - To what extent do you agree or disagree with this proposal?

• **Q2** - Please explain why you agree or disagree with this proposal.

**Q1 - To what extent do you agree or disagree with this proposal**

Most respondents were in agreement with this proposal.

The table below shows the response to question 1: 58% (2691) of all respondents agreed and 28% (1310) disagreed with the proposal to provide acute services at Leicester Royal Infirmary and Glenfield Hospital.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1086</td>
</tr>
<tr>
<td>Agree</td>
<td>1605</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>656</td>
</tr>
<tr>
<td>Disagree</td>
<td>474</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>836</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td>4657</td>
</tr>
</tbody>
</table>

**Q2 - Please explain why you agree or disagree with this proposal**

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:
Survey: General - Agreement with proposal (e.g. good proposal, makes sense).

Events: General - Agreement with proposal (e.g. good proposal, makes sense).

In disagreement:

Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).

Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).

In observation:

Survey: Demographics – Consider demographics of different areas (e.g. growing population).

Events: Access - Consider the need to improve access to services (e.g. public and hospital transport, park and ride) and General - More details about the proposal are required (e.g. what are acute services).

**Key themes from other channels**

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: No agreement sub-themes were raised in the correspondence.
- In disagreement: Service provision - Concern over existing services being removed (e.g. from Leicester General Hospital, Rutland, Melton).
- In observation: Service provision - Acute services should be provided at multiple sites (e.g. all three hospitals, spread around the county, different sides of the city).

### 5.5.4 Proposal 2: New treatment centre

Respondents were asked the following questions:

- **Q3** - To what extent do you agree or disagree with this proposal?
- **Q4** - Please explain why you agree or disagree with this proposal.
- **Q5** - Please tell us your views on this including how we can avoid negative impacts or disadvantages on you, your family or any groups and how we can
ensure the new treatment centre is right to meet the needs of people.

**Q3 - To what extent do you agree or disagree with this proposal**

Most respondents were in agreement with this proposal.

The table below shows the response to question 3: 60% (2786) of all respondents agreed and 25% (1143) disagreed with the proposal to provide outpatient services at a new purpose-built treatment centre at Glenfield Hospital.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1178</td>
</tr>
<tr>
<td>Agree</td>
<td>1608</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>709</td>
</tr>
<tr>
<td>Disagree</td>
<td>516</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>627</td>
</tr>
<tr>
<td>Base</td>
<td>4638</td>
</tr>
</tbody>
</table>

**Q4 - Please explain why you agree or disagree with this proposal**

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: Access - Glenfield Hospital is a more suitable location than Leicester Royal Infirmary (e.g. transport links, parking).
- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).
- Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).

In observation:

- Survey: Access - Consider the need to improve parking at Glenfield Hospital (e.g. more spaces, affordable parking, payment system).
- Events: 
Q5 - Please tell us your views on this including how we can avoid negative impacts or disadvantages on you, your family or any groups and how we can ensure the new treatment centre is right to meet the needs of people.

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: Access - Glenfield Hospital is a more suitable location than Leicester Royal Infirmary (e.g. transport links, parking).

- Events: No agreement sub-themes were raised by event respondents.

In disagreement:

- Survey: Access - Outpatient services should be provided locally (e.g. local clinics, Rutland, Hinkley, Oakham Melton Mowbray).

- Events: Access - Consider locating outpatients services at Leicester General Hospital (e.g. more accessible).

In observation:

- Survey: Access - Consider the need to improve parking at Glenfield Hospital (e.g. more spaces, free parking, payment system).

- Events:
  - Access - Ensure the new building is accessible for all including disabled people (e.g. good signage, clear thoroughfares, separate entrance, disabled parking).
  - General - More details about the proposal are required.

Key themes from other channels

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal are set out below.
• In agreement: General - Agreement with proposal and Quality of care - Proposal will improve quality of care.

• In disagreement:
  o Access – Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).
  o Access - Glenfield Hospital is not a suitable location for outpatients services (e.g. poor accessibility).
  o Capacity - Consider the capacity of Glenfield Hospital (e.g. too small).

• In observation:
  o Access - Consider the need to improve parking at Glenfield Hospital (e.g. more spaces, affordable parking, payment system).
  o Specific groups - Consider the needs of patients whose first language is not English.
  o Specific groups - Consider the needs of diverse ethnic and religious groups.
  o Estate and facilities - Consider provision of patient and visitor facilities (e.g. Wi-Fi, waiting rooms, catering, play area, gardens).
  o Staff - Consider the need to ensure adequate staffing.

5.5.5 Proposal 3: New technologies

Respondents were asked the following questions:

• Q6 - To what extent do you agree or disagree with this proposal?

• Q7 - Please tell us your views on using technology to reduce the need for attending appointments - including how we can avoid negative impacts or disadvantages on you, your family or any groups.

Q6 - To what extent do you agree or disagree with this proposal

Most respondents were in agreement with this proposal.

The table below shows the response to question 6: 64% (2955) of all respondents agreed and 23% (1046) disagreed with the proposal to use new technology to provide certain aspects of pre-planned care.
Table 5-4  New technologies: To what extent do you agree or disagree with this proposal

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1259</td>
<td>27%</td>
</tr>
<tr>
<td>Agree</td>
<td>1696</td>
<td>37%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>633</td>
<td>14%</td>
</tr>
<tr>
<td>Disagree</td>
<td>557</td>
<td>12%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>489</td>
<td>11%</td>
</tr>
<tr>
<td>Base</td>
<td>4634</td>
<td></td>
</tr>
</tbody>
</table>

Q7 - Please tell us your views on using technology to reduce the need for attending appointments - including how we can avoid negative impacts or disadvantages on you, your family or any groups

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with proposal (e.g. good idea).
- Events: General - Agreement with proposal (e.g. good idea).

In disagreement:

- Survey: Specific groups - Consider groups who require face-to-face appointments or cannot use technology (e.g. dementia, children, elderly, hearing problems).
- Events: Specific groups - Consider groups who require face-to-face appointments or cannot use technology (e.g. dementia, children, elderly, hearing problems).

In observation:

- Survey: Quality of care - Virtual appointments may be suitable depending on the medical issue (e.g. if tests or assessment not required).
- Events: Quality of care - Virtual appointments may be suitable depending on the medical issue (e.g. if tests or assessment not required).

*Key themes from other channels*

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:
• In agreement:
  
  o Access - Technology improves access to services by reducing travel (e.g. good for environment, save time).
  

• In disagreement:
  
  o Access - Consider lack of access to digital technology (e.g. PCs, laptops, smartphone, Internet).
  
  o Specific groups - Consider groups who require face-to-face appointments or cannot use technology (e.g. dementia, children, elderly, hearing problems).

• In observation: Specific groups - Consider the needs of patients whose first language is not English.

5.5.6 Proposal 4: Leicester General Hospital

Respondents were asked the following questions:

• Q8 - To what extent do you agree or disagree with this proposal?

• Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site:
  
  o Q9 - Primary care urgent treatment centre.
  
  o Q10 - Observation area.
  
  o Q11 - Diagnostic service.
  
  o Q12 - Community outpatients service.
  
  o Q13 - Extra GP/primary care capacity.

Q8 - To what extent do you agree or disagree with this proposal

Most respondents were in agreement with this proposal.

The table below shows the response to question 8: 67% (3104) of all respondents agreed and 14% (638) disagreed with the proposal to create extra services at Leicester General Hospital in a GP led primary care urgent treatment centre.
Table 5-5  Leicester General Hospital: To what extent do you agree or disagree with this proposal?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1149</td>
</tr>
<tr>
<td>Agree</td>
<td>1955</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>900</td>
</tr>
<tr>
<td>Disagree</td>
<td>280</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>358</td>
</tr>
</tbody>
</table>

Q9 - Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site: Primary care urgent treatment centre

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with proposal.
- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).
- Events:
  - Access - Leicester General Hospital is not a suitable location for a primary care urgent treatment centre (e.g. poor accessibility, transport).
  - Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).
  - General - Disagreement with proposal
  - Service provision - Concern that the service would be an extra waiting room for those waiting to be admitted to a hospital (e.g. like waiting in a corridor).
  - Service provision - Proposal duplicates existing service provision (e.g. MIUs, UCCs).
In observation:

- Survey: Access - Services should be provided locally (e.g. Rutland, Melton, local urgent care centres).

- Events: General - Further consultation is required or consultation process is ineffective (e.g. proposal is a wish list).

Q10 - Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site: Observation area

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal were:

In agreement:

- Survey: General - Agreement with proposal.

- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - disagreement - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).

- Events: Quality of care - Concern over transferring patients between different sites.

In observation:

- Survey: General - More details about the proposal are required.

- Events: Quality of care - Consider the need for effective discharge, triage and referrals.

Q11- Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site: Diagnostic service

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this are set out below.

In agreement:

- Survey: General - Agreement with proposal.

- Events: General - Agreement with proposal.

In disagreement:
• Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).

• Events: Service provision - Proposal duplicates existing service provision.

In observation:

• Survey: General - More details about the proposal are required.

• Events: General - More details about the proposal are required:
  o Quality of care - Consider the need for effective discharge, triage and referrals.
  o Service provision - Consider improving provision of other services (e.g. mental health).
  o Specific groups - Consider the needs of patients with long-term conditions or complex needs.

Q12 - Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site: Community outpatients service

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal were:

In agreement:

• Survey: General - Agreement with proposal.

• Events: General - Agreement with proposal.

In disagreement:

• Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).

• Events: No disagreement sub-themes were raised by event participants.

In observation:

• Survey: General - More details about the proposal are required.

• Events: General - More details about the proposal are required.

Q13 - Please explain why you agree or disagree with this proposal to create these services on the Leicester General Hospital site: Extra GP/primary care services
capacity

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this are set out below.

In agreement:

- Survey: General - Agreement with proposal.
- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).
- Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities and west of city residents).
  - Service provision - Concern about existing services being removed.

In observation:

- Survey: General - More details about the proposal are required.
- Events: Access - Services should be provided locally.

Key themes from other channels

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: No agreement sub-themes were raised in the correspondence.
- In disagreement: General - Disagreement with proposal.
- In observation: Service provision - Consider the need to improve community healthcare.

5.5.7 Proposal 5: New standalone maternity unit

Respondents were asked the following questions:

- Q14 - To what extent do you agree or disagree with this proposal?
- Q15 - Please explain why you agree or disagree with this proposal.

Q14 - To what extent do you agree or disagree with this proposal
Most respondents were in disagreement with this proposal.

The table below shows the response to question 14: 36% (1678) of all respondents agreed and 41% (1909) disagreed with the proposal to relocate the standalone maternity unit to Leicester General Hospital.

Table 5-6 New standalone maternity unit: To what extent do you agree or disagree with this proposal?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>742</td>
</tr>
<tr>
<td>Agree</td>
<td>936</td>
</tr>
<tr>
<td>Neither agree nor</td>
<td>1048</td>
</tr>
<tr>
<td>disagree</td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>679</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1230</td>
</tr>
<tr>
<td>Base</td>
<td>4635</td>
</tr>
</tbody>
</table>

Q15. Please explain why you agree or disagree with this proposal

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: Access - Proposal will improve access to maternity services (e.g. accessible for wider population).

- Events: Access - Proposal will improve access to maternity services (e.g. accessible for wider population).

In disagreement:

- Survey: Access - Proposal will reduce accessibility for patients (e.g. rural communities, too centralised, closing St. Mary’s).

- Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities, too centralised, closing St. Mary’s).

In observation:

- Survey: Service provision - Consider the need for access to specialist care on site.

- Events: Staff - Consider the need to ensure adequate staffing.

Key themes from other channels
The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: Quality of care - Locating maternity services on one site will improve quality of care (e.g. access to more specialists).
- In disagreement: Service provision - St. Mary's Birth Centre should remain open.
- In observation: General - More details about the proposal are required.

5.5.8 Proposal 6: New haemodialysis treatment units

Respondents were asked the following questions:

- Q16 - To what extent do you agree or disagree with this proposal?
- Q17 - Please explain why you agree or disagree with the proposal for one unit to be at Glenfield hospital.
- Q18 - Please explain why you agree or disagree with the proposal for one unit to be in the south of Leicester City.
- Q19 - Please tell us where in the south of Leicester you think that the new unit should be.

Q16 - To what extent do you agree or disagree with this proposal

Most respondents were in agreement with this proposal.

The table below shows the response to question 16: 69% (3181) of all respondents agreed and 7% (334) disagreed with the proposal to provide two new haemodialysis treatment units, one at Glenfield Hospital and another in the south side of Leicester City.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1247</td>
</tr>
<tr>
<td>Agree</td>
<td>1934</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>1098</td>
</tr>
<tr>
<td>Disagree</td>
<td>150</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>184</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td>4613</td>
</tr>
</tbody>
</table>

Q17 - Please explain why you agree or disagree with the proposal for one unit
to be at Glenfield hospital

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

• Survey: General - Agreement with proposal.
• Events: General - Agreement with proposal.

In disagreement:

• Survey: Access - Proposal will reduce accessibility for patients (e.g. too centralised).
• Events:
  o Access - Leicester General Hospital is a more suitable location.
  o Access - Proposal will reduce accessibility for patients (e.g. too centralised).
  o Service provision - Concern over existing haemodialysis treatment units being removed (e.g. from Leicester General Hospital, Loughborough).

In observation:

• Survey: General - More details about the proposal are required.
• Events: General - More details about the proposal are required.
**Q18 - Please explain why you agree or disagree with the proposal for one unit to be in the south of Leicester City**

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: Access - Proposal will improve access to haemodialysis services (e.g. accessible for wider population, reduce travelling time).
- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - Proposal will reduce accessibility for patients (e.g. too centralised).
- Events: Access - Proposal will reduce accessibility for patients (e.g. too centralised).

In observation:

- Survey: General - More details about the proposal are required.
- Events: General - More details about the proposal are required.

**Q19 - Please tell us where in the south of Leicester you think that the new unit should be**

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with proposal.
- Events: General - Agreement with proposal.

In disagreement:

- Survey: Access - Consider the east of the county instead.
- Events: No disagreement sub-themes were raised by event participants.

In observation:

- Survey: Access - Consider the most accessible location (e.g. transport,
motorway links).

- Events: Location - Oadby.

**Key themes from other channels**

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: Patient choice - Proposal improves patient choice.

- In disagreement: Access - Proposal will reduce accessibility for patients (e.g. too centralised) and Access - Leicester General Hospital is a more suitable location.

- In observation: Access - Haemodialysis treatment units should be provided locally across the county (e.g. Hinckley, Rutland, Melton, Charnwood).

5.5.9 **Proposal 7: Hydrotherapy pools**

Respondents were asked the following questions:

- Q20 - To what extent do you agree or disagree with this proposal?

- Q21 - Please explain why you agree or disagree with this proposal.

**Q20 - To what extent do you agree or disagree with this proposal**

Most respondents were in agreement with this proposal.

The table below shows the response to question 20: 71% (3273) of all respondents agreed and 7% (330) disagreed with the proposal to use hydrotherapy pools already located in community settings

<table>
<thead>
<tr>
<th>Hydrotherapy: To what extent do you agree or disagree with this proposal?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1353</td>
</tr>
<tr>
<td>Agree</td>
<td>1920</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>987</td>
</tr>
<tr>
<td>Disagree</td>
<td>153</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>177</td>
</tr>
<tr>
<td>Base</td>
<td>4590</td>
</tr>
</tbody>
</table>
Q21 - Please explain why you agree or disagree with this proposal

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: Access - agreement - Proposal will improve access to hydrotherapy.
- Events: Access - Proposal will improve access to hydrotherapy.

In disagreement:

- Survey: Quality of care - Concern over quality of care at hydrotherapy pools.
- Events: No disagreement sub-themes were raised by event participants.

In observation:

- Survey: Access - Services should be provided locally (e.g. across the county).
- Events: General - More details about the proposal are needed (e.g. locations, data).

Key themes from other channels

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: General - Proposal will benefit more people.
- In disagreement: No disagreement sub-themes were raised in the correspondence.
- In observation: General - More details about the proposal are needed (e.g. locations, data), Cost and efficiency - Consider the running cost of hydrotherapy pools compared to their utilisation, Quality of care - Consider access to trained staff at community pools and Service provision - Consider retaining hydrotherapy pool at Leicester General Hospital.

5.5.10 Proposal 8: New maternity hospital

Respondents were asked the following questions:

- Q22 - To what extent do you agree or disagree with this proposal?
- Q23 - Please explain why you agree or disagree with this proposal.
Q22 - To what extent do you agree or disagree with this proposal

Most respondents were in agreement with this proposal.

Table 103 shows the response to question 22: 50% (2329) of all respondents agreed and 31% (1416) disagreed with the proposal to build a new maternity hospital on the Leicester Royal Infirmary site.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1072</td>
</tr>
<tr>
<td>Agree</td>
<td>1257</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>890</td>
</tr>
<tr>
<td>Disagree</td>
<td>519</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>897</td>
</tr>
<tr>
<td>Base</td>
<td>4635</td>
</tr>
</tbody>
</table>

Q23 - Please explain why you agree or disagree with this proposal

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with the proposal.
- Events: General - Agreement with the proposal.

In disagreement:

- Survey: Access - Leicester Royal Infirmary is not a suitable location for a maternity hospital (e.g. inner city, traffic, pollution).
- Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities, too centralised).

In observation:

- Survey: Communication - Consider better promotion of St. Mary’s Birth Centre to increase number of patients.
- Events: Staff - Consider the need for adequate staffing.

**Key themes from other channels**

The top sub-themes raised in the correspondence received in agreement,
disagreement and observation about this proposal were:

- In agreement: No agreement sub-themes were raised in the correspondence.

- In disagreement: Quality of care - Concern about quality of maternity services provided by large hospitals (e.g. lack of birth care, breastfeeding support, personal attitude).

- In observation:
  - General - More details about the proposal are required.
  - General - Further consultation is required or consultation process is ineffective (e.g. about services being removed).

5.5.11 Proposal 9: Breastfeeding services

Respondents were asked the following questions:

- Q24 - Please explain why you agree or disagree with this proposal.

- Q24 - Please explain why you agree or disagree with this proposal.

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal were:

In agreement:

- Survey: General - Agreement with proposal.

- Events: General - Agreement with proposal.

In disagreement:

- Survey: Quality of care - Consider the high quality breastfeeding support provided by St. Mary's Birth Centre (e.g. should not be replaced).

- Events: No disagreement sub-themes were raised by event participants.

In observation:

- Survey: Access - Breastfeeding support should be provided locally (e.g. Melton, Rutland).

- Events: Staff - Consider the need to ensure adequate staffing (e.g. well-trained staff).
**Key themes from other channels**

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: Access - Consider how to increase access and accessibility to drop-in sessions (e.g. rural mothers, parking).

- In disagreement: No disagreement sub-themes were raised in the correspondence.

- In observation:
  - General - Further consultation is required or consultation process is ineffective (e.g. should not be conducted during pandemic, not accessible, changes already decided).
  - Staff - Consider the need to ensure adequate staffing (e.g. well-trained staff).

### 5.5.12 Proposal 10: Children’s hospital

Respondents were asked the following questions:

- Q25 - To what extent do you agree or disagree with this proposal where 1 is strongly disagree and 5 is strongly agree?

- Q26 - Please explain why you agree or disagree with this proposal.

**Q25 - To what extent do you agree or disagree with this proposal where 1 is strongly disagree and 5 is strongly agree**

Most respondents were in agreement with this proposal.

The table below shows the response to question 25: 77% (3537) of all respondents agreed and 7% (343) disagreed with the proposal to create a newly established children’s hospital at Leicester Royal Infirmary.
Q26 - Please explain why you agree or disagree with this proposal

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with proposal.
- Events: Quality of care - Co-location of children's services on one site will improve patient quality of care.

In disagreement:

- Survey: Access - Leicester Royal Infirmary is not a suitable location for children's services (e.g. inner city, traffic).
- Events: Access - Consider lack of adequate parking at Leicester Royal Infirmary.

In observation:

- Survey: General - More details about the proposal are required.
- Events:
  - Estates and facilities - Consider developing child-friendly facilities to make hospital experience less stressful.
  - General - More details about the proposal are required.

Key themes from other channels

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

Table 5-10 Children's hospital: To what extent do you agree or disagree with this proposal?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1839</td>
<td>40%</td>
</tr>
<tr>
<td>Agree</td>
<td>1698</td>
<td>37%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>731</td>
<td>16%</td>
</tr>
<tr>
<td>Disagree</td>
<td>135</td>
<td>3%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>208</td>
<td>5%</td>
</tr>
<tr>
<td>Base</td>
<td>4611</td>
<td></td>
</tr>
</tbody>
</table>
• In agreement: General - Positive to have a dedicated children's hospital.

• In disagreement: No disagreement sub-themes were raised in the correspondence.

• In observation:
  
  o Children's hospital - Consider facilities for parents staying with child in new children's hospital, Children's hospital - Consider developing child-friendly facilities to make hospital experience less stressful.

  o Specific groups - Consider the needs of diverse ethnic and religious groups.

5.5.13 Proposal 11: Access and transport

Respondents were asked the following questions:

• Q27 - Do you have any concerns about being able to travel to or access any services and what would need to happen to make this less of a concern?

• Q27 - Do you have any concerns about being able to travel to or access any services and what would need to happen to make this less of a concern?

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

• Survey: General - No concerns.

• Events: General - No concerns.

In disagreement:

• Survey: Location - Proposal will reduce accessibility for patients (e.g. rural communities and county residents).

• Events: Location - Proposal will reduce accessibility for patients (e.g. rural communities and county residents).

In observation

• Survey: Transport - Consider improving public transport to care sites (e.g. free buses, hospital hopper, out of hours busses).

• Events: Transport - Consider improving public transport to care sites (e.g. free busses, hospital hopper, out of hours busses).
Key themes from other channels

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

- In agreement: No agreement sub-themes were raised in the correspondence.
- In disagreement: Location - Consider poor accessibility of Leicester Royal Infirmary (e.g. drop-off facilities, traffic, public transport).
- In observation: Parking - Consider the lack of parking at Leicester Royal Infirmary (e.g. disabled parking, cycle parking, staff parking).

5.5.14 Proposal 12: Other feedback and comments

Respondents were asked the following questions:

- Q28 - If you have any other specific comments about the proposals for acute and maternity services, or there are any alternative proposals that you think we should consider, please use this space to tell us what they are.
- Q28 - If you have any other specific comments about the proposals for acute and maternity services, or there are any alternative proposals that you think we should consider, please use this space to tell us what they are.

The top sub-themes raised by survey respondents and event participants in agreement, disagreement and observation about this proposal are set out below.

In agreement:

- Survey: General - Agreement with proposals (e.g. great proposals, benefits for patients and staff).
- Events: General - Agreement with proposals (e.g. great proposals, benefits for patients and staff).

In disagreement:

- Survey: Maternity services - St. Mary's Birth Centre should remain open.
- Events: Access - Proposal will reduce accessibility for patients (e.g. rural communities and east or south of city residents).

In observation:

- Survey: Local services - Services should be provided locally (e.g. close to home, small hospitals).
• Events: General - More details about the proposals are required and Specific groups - Consider the need of vulnerable groups (e.g. disabled patients, elderly, autistic).

**Key themes from other channels**

The top sub-themes raised in the correspondence received in agreement, disagreement and observation about this proposal were:

• In agreement: General - Agreement with proposals.

• In disagreement: General - Proposal is ineffective and requires improvement (e.g. no long-term plan, no bed planning).

• In observation: General - Further consultation is required or consultation process is ineffective (e.g. should not be conducted during pandemic, not accessible, changes already decided).

### 5.6 Conclusions on the consultation process and outcomes

The consultation process has been wide ranging and has received 5,675 responses, overwhelmingly supportive of the main proposals. Where relevant issues have been raised these have been considered by UHL and commissioners as described in the following section.
6  Response to the consultation outcomes

6.1  Introduction

This section describes the response to the outcomes of the consultation on the UHL Reconfiguration Programme proposals. It concludes by demonstrating how the proposals have been shaped to ensure that they continue to contribute to the delivery of the BCTP aims and priorities for ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

6.2  Responses to the consultation outcomes

The consultation has been wide ranging and has elicited responses from a wide range of members of the public as well as local healthcare professionals and clinicians. The responses to the consultation outcomes are summarised below.

6.2.1  Summary of clinical proposals included in the consultation

The table below summarises the clinical proposals that were included in the consultation and identifies those areas where changes to the original proposals are now proposed as a result of the consultation process.

<table>
<thead>
<tr>
<th>Consultation Question No.</th>
<th>Proposal as stated in PCBC</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2</td>
<td>Relocation of clinical services on to 2 acute sites – the Leicester Royal Infirmary (LRI) and the Glenfield Hospital (GH)</td>
<td>Proceed as planned apart from: • Brain Injury Unit (was LRI) • Specialist Neurological Rehabilitation Unit (was LRI)</td>
<td>Brain Injury Unit (now GH) Specialist Neurological Rehabilitation Unit (now GH)</td>
</tr>
<tr>
<td>3, 4</td>
<td>Relocate outpatient services from the Leicester Royal Infirmary (LRI) to the Glenfield Hospital (GH)</td>
<td>Proceed as planned apart from: • Ear Nose &amp; Throat (was GH) • Ophthalmology – (was GH) • Plastic Surgery – (was GH) • Endocrinology – (was GH)</td>
<td>• Ear Nose &amp; Throat (now LRI) • Ophthalmology – (now LRI) • Plastic Surgery - LRI • Endocrinology (now LRI)</td>
</tr>
<tr>
<td>6, 7</td>
<td>Utilise new technology to provide certain aspects of pre-planned care</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>8 - 13</td>
<td>Provide a GP Led Urgent Treatment Centre at the Leicester General Hospital (LGH)</td>
<td>Proceed as planned</td>
<td></td>
</tr>
<tr>
<td>14, 15</td>
<td>Relocate the Midwifery Led Unit from St. Mary’s Hospital and trial a</td>
<td>Proceed as planned</td>
<td></td>
</tr>
</tbody>
</table>
6.2.2 Responses to consultation with the public

The main areas where concerns were expressed in respect of the proposals were:

- Relocation of the standalone maternity unit from St Mary’s (Melton Mowbray) and trial a new maternity unit on the LGH site.

- Proposed new haemodialysis units.

- Travel and access issues.

Relocation of maternity unit from St Mary’s to Leicester General Hospital

The proposed relocation of the midwifery led unit from St Mary’s to the Leicester General Hospital received significant feedback with 41% (1909) of respondents not agreeing with the proposals. In total, 36% agreed (1678) and 23% (1048) neither agreed or disagreed.

The top three sub-themes raised in agreement were:

- **Access** - Proposal will improve access to maternity services (e.g. accessible for wider population).

- **Quality of care** - Relocation of maternity services to Leicester General Hospital will improve quality of care (e.g. access to intensive support, co-location of services).

- **General** - Agreement with proposal.

The top three sub-themes raised in disagreement were:

- **Access** - Proposal will reduce accessibility for patients (e.g. rural communities,
too centralised, closing St. Mary's).

- **Quality of care** - Consider the high quality of care at St. Mary's Birth Centre (e.g. aftercare, breastfeeding).

- **Service provision** - St. Mary's Birth Centre should remain open.

The top three observation sub-themes raised by survey respondents were:

- **Service provision** - Consider the need for access to specialist care on site.

- **Communication** - Consider better promotion of St. Mary’s Birth Centre to increase number of patients.

- **General** - More details about the proposal are required.

The consultation findings (as detailed in the Report of Findings, p51), including the geographical location of respondents have been reviewed by a group comprising clinicians, service managers, patient representatives and commissioners.

The proposed response from UHL is to proceed with the original proposals to relocate the unit to LGH on a trial basis. This provides greater equity of access for women across Leicester, Leicestershire and Rutland; offers closer proximity to acute services in the event of an emergency and offers opportunity to make the unit clinically and financially viable in the longer term.

The following were noted as key to the proposed response and to addressing the points raised by respondents during consultation:

- **Clinical Strategy** - The proposed relocation of the service at St Mary’s to the LGH is part of the Trust's overall clinical strategy and is an essential component in ensuring improved access to a greater proportion of women across Leicester, Leicestershire and Rutland.

- **Clinical Risk** - The risks associated with transfer from St Marys in an emergency are better managed if the service moves to the LGH due to proximity to acute services at the LRI. Community maternity services would remain in Melton Mowbray. We would ensure that there is support for home births and care before and after the baby is born in the local community both in Melton and across Leicester, Leicestershire and Rutland. If someone has a complicated pregnancy, care afterwards would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

- **Clinical sustainability and workforce** - The long-term sustainability of the maternity led unit is improved by relocation to LGH. This is due to improved access for more women across Leicester, Leicestershire and Rutland who
meet criteria and anticipated increase in the number of women choosing this option for birth. There are also currently significant workforce considerations, with difficulties in recruitment of midwives to support the service at St Marys. It is anticipated that this will be mitigated by a more central service at the LGH.

- **Staff at St Marys** - The staff at St Marys have a wealth of knowledge and experience. Their involvement in development of the new service at the LGH, and in how maternity services, including postnatal and breastfeeding support will be delivered in the community across Leicester, Leicestershire and Rutland and in Melton in particular, will be crucial to ensuring continued high quality of care.

- **Patient experience** - implementation of the proposals will be supported by significant ongoing improvement work in postnatal services, underpinned by the local work on the Better Births model. This will see more women in Leicester, Leicestershire and Rutland able to benefit from an expanded team of midwives who will provide continuity of care throughout pregnancy and provide postnatal and breastfeeding support in the community and in people’s own homes. These services will remain available to all women – including those from Melton.

Based on occupancy figures at St Mary’s midwifery led unit, the number of women who go there specifically for breastfeeding support is small. Across Leicester, Leicestershire and Rutland there are good rates of breastfeeding initiation and UHL would continue to support women in line with good practice with this support available in the community and in people’s own homes in Melton and across Leicester, Leicestershire and Rutland. Working with the Maternity Voices Partnership, women from all walks of life, young mums, older mums and partners, will help shape how services look in future.

- **Cost effectiveness** - the current service does not see enough patients to make it financially viable with less than three babies born there on average every week. By moving to the LGH and the anticipated increase in the number of women using the service, the proposals offer better long term financial sustainability. There is a gap nationally in midwifery-led birthing units between capacity (the number of births that can take place) and actual use, and many are under-utilised. If we can care for 500-plus women then the cost per birth, with the staffing models to support this, will prove more cost-effective and sustainable. (See note below re process of assessment for long term viability).

---

**Long term viability of a standalone MLU at the LGH**
UHL is committed to trialling a new midwifery led maternity unit on the LGH site and supporting the unit to help it become viable in the longer term. Work will be undertaken to define how the long term viability of the unit is assessed. UHL recognises the fact that the new unit is unlikely to attract 500 births in its first year and viability will, therefore, be based on a phased approach. Work will also be undertaken to develop promotional plans for the unit. Both aspects of this work will involve staff, stakeholders and patients/patient representatives.

**Proposed new haemodialysis units**

The proposal consulted upon was for two separate dialysis units in the south of the city and at the GH, but it was not specified how they would be delivered. Proposals will be developed taking into account the following:

- **Clinical strategy** - It is not considered that there were any objections to the need to replace the LGH dialysis unit and provide a dialysis facility co-located with the inpatient service.

- **Clinical risk** - None of the feedback related to clinical risk.

- **Clinical sustainability and workforce** - The model suggested was opposed by 5% of respondents within the staff category.

- **Patient experience** - The responses here were conflicting because the sub-themes people supported were also those which were opposed. This was split along geographical lines with responses from Rutland residents having most misgivings. Rutland Health Watch have previously been informed that the number of people needing treatment would not support a standalone unit in Rutland and that area is served by surrounding units in Peterborough, Leicester, Kettering and Grantham.

  Oadby and Market Harborough were also suggested as potential sites. Whilst Oadby may yet be an option, Market Harborough would involve transport for the vast majority of city patients, and it is also very close to an existing unit in Kettering. The final decision on location will be informed by the impact on service users and their views.

  Very few people from the North West of the county raised concerns. This is further evidence that the GH site must be delivered and of satisfaction with the existing unit in Loughborough.

  A full menu of home based treatments is offered and encouraged.

- **Cost-effectiveness** - The feedback contains proposals for a larger number of units throughout LLR. This would be inefficient to run and difficult to staff.
However, the UHL Haemodialysis Service are committed to exploring innovative ways of delivering dialysis. For those for whom a home therapy is unsuitable self or minimal care facilities in GP surgeries have been considered. A successful pilot in Earl Shilton has received national recognition and further proposals could be worked up to expand that in the future.

**Travel and access**

Some concerns were expressed over the impact of the changes to individuals with regards to travel and access to and from the acute hospital sites. As a result, a detailed Travel Action Plan has been developed taking into consideration the points raised during consultation. The Travel Action Plan is included in Appendix C.

The Travel Action Plan includes the footfall impact of services moving between the sites and proposes different ways of enabling staff and patients to travel without being reliant on cars. The changes identified in the Travel Action Plan have been modelled into the revised footfall numbers for each site and continue to show a decrease in footfall for the LRI of about 30% in 2024/25. This was remodelled on the basis of the services that are staying at the LRI rather than moving to GH.

There has been a significant focus in the travel planning work undertaken since October 2020. Below are some of the key actions being progressed that will assist:

- Plans to develop a new Park & Ride facility for a minimum of five years at LGH (in partnership with Leicester City Council).
- Development of a new Park & Ride facility at Beaumont Leys (in partnership with Leicester City Council) to provide additional off-site parking for GH.
- Introduction of PlusBus ticketing on the Hospital Hopper. This now makes it possible to travel by rail and then by bus to GH, LGH and LRI, on a single ticket purchase.
- Improved promotion of schemes to assist with patient travel (e.g. volunteer car scheme).
- Introduction of ANPR (Automatic Number Plate Recognition) technology on the main patient car parks at LRI and GH. This technology will assist with access issues at the LRI and remove the need for patients to estimate length of stay at the GH. As well as ANPR technology, additional temporary car parking is being created at the GH in recognition of the additional demand that will be created during the building phase.
- Promoting of the new Santander Cycles Leicester e-bike share scheme from spring. This will improve connectivity for those travelling by bus and train, by
improving connectivity between the main transport interchanges in Leicester city centre and LRI.

All of the above are detailed within the Travel Action Plan which was approved by the UHL Trust Board in March 2021.

6.2.3 Response to the consultation with clinicians

As a direct result of the consultation with clinicians and operational staff, changes are proposed to the Reconfiguration Proposals presented for consultation and summarised in Section 4 above in respect of the following services:

- Ear Nose and Throat (ENT).
- Ophthalmology.
- Brain Injury Unit (BIU) and Specialist Neuro Rehabilitation Unit (SNRU).
- Plastic Surgery.
- Endocrinology.

Ear Nose and Throat

Current proposals

The consultation proposals involved the following assumptions for ENT.

Table 6-2 ENT proposals

<table>
<thead>
<tr>
<th>Service</th>
<th>Proposed location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT (Adult)</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td></td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td></td>
<td>LRI (Balmoral)</td>
</tr>
<tr>
<td></td>
<td>LRI (Balmoral)</td>
</tr>
<tr>
<td>ENT (Paeds)</td>
<td>All services</td>
</tr>
<tr>
<td>Balance</td>
<td>GH Treatment Centre</td>
</tr>
<tr>
<td>Audiology</td>
<td>LRI and GH Treatment Centre</td>
</tr>
</tbody>
</table>
Considerations

The ENT Consultants expressed concerns regarding separating Adult, Paediatric and Emergency services from each other particularly with regard to workforce capacity and sub-specialisation.

The UHL Reconfiguration Team has reviewed any potential interdependencies that would prevent ENT from staying on the LRI site. The following were taken into account:

- **Out Patient Department** - The current ENT outpatient space at the LRI was identified for use by Gynaecology outpatients; therefore an alternative solution will need to be sought for this activity, which is likely to be Jarvis Clinic LRI.

- **Inpatient Ward space** – not affected by this change.

- **Theatre space** – sufficient Theatre space remains for all services at the LRI.

- **Workforce** – As stated above.

- **Hearing and Balance** - These services will relocate to the LGH initially to enable the demolition work as part of the Enabling Project at the LRI. ENT remaining at the LRI site requires a solution to relocate these services back to the LRI at the end of the Programme.

Revised proposals

Following comprehensive clinical engagement, the revised proposals are now for all services to remain at the LRI for the reasons set out above.

Ophthalmology

Current proposals

The consultation proposals involved the following assumptions for Ophthalmology.

Table 6-3 Ophthalmology proposals

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology (Adult)</td>
<td>Outpatient/Daycase relocate to GH</td>
<td>All services to remain at the LRI</td>
</tr>
<tr>
<td></td>
<td>Elective &amp; Emergencies (In-pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>remain at LRI</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology (Paeds)</td>
<td>Remain at the LRI</td>
<td>No change</td>
</tr>
</tbody>
</table>

Considerations

Ophthalmology provide out of hours oncall services to the Emergency Department and
Children’s Hospital at the LRI. Having out of hours on call and childrens’ Ophthalmology on one site and all the adult Ophthalmology facilities on another site would make it very difficult to provide a safe service without investing significantly in additional skilled staff and equipment.

Moving some services would mean the ophthalmology workforce would have to be split in half which would drastically slow production in a predominantly adult service. Sub specialty work (Corneal, Ocular Plastics, Glaucoma, Retina etc) is mainly the issue, all of which is led by adult Ophthalmologists who treat adults and children equally, providing surgery to those children who require it. If part of the service moves to the GH Treatment Centre the services will not be available at the LRI unless there is investment in a larger workforce (doubling up), which would not be cost effective.

On call would also need to be cross site. At present the on call consultant is delivering a theatre or a clinic during their on call time, this would mean dropping those commitments for calls on another site. Currently, all being on the same site, the on call teams can manage their day time job delivering activity and look after the emergency patients. Being local to the Childrens’ Hospital would also be beneficial with an easy rapid on call response to a child if required.

Equipment would also need to be replicated on both the sites, making it unviable.

The clinicians consider department, as a whole, to be much more productive being on the same site at the LRI, collocated with the Emergency Department and with adults and childrens’ being local to one another and with Optometry and Orthoptics available on site for refraction for clinics and eye measurements for Ophthalmic surgery.

**Revised proposals**

Following comprehensive clinical engagement, the revised proposals are now for all Ophthalmology services to remain at the LRI for the reasons set out above.

**Brain Injury Unit (BIU) and Specialist Neuro Rehabilitation Unit (SNRU)**

**Proposals**

The consultation proposals involved the following assumptions for the BIA and SNRU.

**Table 6-4 BIU and SNRU proposals**

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain Injury Unit</td>
<td>Relocate to the LRI</td>
<td>Relocate to the GH</td>
</tr>
<tr>
<td>Specialist Neurological Rehabilitation Unit</td>
<td>Relocate to the LRI</td>
<td>Relocate to the GH</td>
</tr>
</tbody>
</table>
Considerations

The BIU and SNRU sit under the Emergency and Specialised Medicine (ESM) Clinical Management Group (CMG). BIU and SNRU have a dependency with ICU as per the requirements for a medical ward and require access to ICU and the DART team.

The current BIU and SNRU locations at the LRI have been adapted as far as possible within the limitation of the space available to deliver a high quality service to patients. However, there is currently no dedicated space for the following service provision:

- Quiet space to accommodate 1:1 therapy sessions individually with Speech and Language Therapy, Neuropsychology and Occupational Therapy (cannot be shared and needed separately for each therapy).
- Low stimulus sensory assessment area for patients with PDoC on BIU.
- Dedicated areas for patients to demonstrate functional skills for independent living.
- Secure and protected outdoor space for patients for therapeutic activities and rehabilitation of patients accessible from ward for both BIU and SNRU.
- Separate area for group therapy activity for patients e.g., communication group, cognitive skills group, organised meaningful activities.
- Designated Independent Living area with attached toilet and kitchenette for patients to demonstrate ability to live Independently with a care package before discharge from.

The BIU and SNRU are unique in the specification for clinical space due to the large equipment that is used in the management of patients with disability. It is also essential that the SNRU has access to a secure garden space accessible from the ward and a large physiotherapy gym which is an essential part of the patient treatment. Access to dedicated quiet space for Occupational Therapists and Speech and Language Therapists to work with patients with cognitive deficits is also key to the delivery of rehabilitation. BIU offer rehabilitation to patients soon after ICU care and therefore adjacency and access to ICU and the DART team is critical SNRU has a dependency with ICU as per the requirements for a medical ward.

The move to GH will protect the long-term future of the BIU and SNRU and future proof against growth in demand by providing appropriate clinical space and rehabilitation facilities, including access to secure green space adjacent to the units. This is an integral part of patient recovery and rehabilitation. The space allocated for BIU and SNRU will need to provide two distinctly different clinical areas accommodating the needs of patients at the different stages of the care pathway.
The Clinical Operational Policy states that there may be potential increases in staffing in future to meet standards. However, the service have commented that whilst there may be a general impact on staff due to the relocation of services as part of Reconfiguration, there would be no more impact on workforce by moving from LGH to GH than the LRI.

**Revised proposals**

Following comprehensive clinical engagement, the revised proposals are for the BUI and SNRU to relocate to GH for the reasons set out above.

**Plastic Surgery**

**Current proposals**

The consultation proposals involved the following assumptions for Plastic services.

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery (Adult)</td>
<td>Inpts/Emergencies – LRI Outpatients/Daycase - GH</td>
<td>All to remain at the LRI</td>
</tr>
<tr>
<td>Plastic Surgery (Paeds)</td>
<td>Inpts/Emergencies – LRI Outpatients/Daycase - LRI</td>
<td>No change</td>
</tr>
</tbody>
</table>

**Considerations**

Plastic Surgery are a small team of 6 Consultants working across the LRI Adults and LRI Paediatrics along with the peripheral hospital commitments. The Consultants consider that splitting the service across two sites would mean a deterioration in the service currently provided as the Consultants would not be able to effectively support their colleagues on a different site.

**Revised proposals**

Following comprehensive clinical engagement the revised proposals are for Plastic Surgery outpatient and daycase activity to remain at the LRI for the reasons set out above.

**Endocrinology**

The consultation proposals involved the following assumptions for Endocrinology.

<table>
<thead>
<tr>
<th>Clinical service</th>
<th>Service Detail – as stated in PCBC</th>
<th>Revised Service Detail – post consultation feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrinology (Adult)</td>
<td>In-pts/Emergencies – LRI Outpatients/Daycase - GH</td>
<td>All services to remain at the LRI</td>
</tr>
<tr>
<td>Endocrinology (Paeds)</td>
<td>All services at the LRI</td>
<td>No change</td>
</tr>
</tbody>
</table>
Considerations

Endocrinology is a currently based at the LRI and largely supports the inpatient specialties that will continue to be on that site post reconfiguration. Currently they work in an integrated way with specialties across the site with regards to complex endocrine investigations, outpatients and in-patient services. Geographically co-localised with those allied specialties including chemical pathology, oncology, clinical genetics, paediatrics, obstetrics & gynaecology, ENT, ophthalmology, interventional radiology and pathology. They fulfil all the requirements of a Specialised Endocrine Unit where they currently stand at the LRI. The consequences on the education and training component of leaving endocrinology services in the Victoria building on the LRI site have been considered. Phase one of the education and training reconfiguration plans are unaffected by this. Phase 2 of the education and training plans involves the second floor of the Victoria building and further work is needed to ensure separation of these facilities from the clinical endocrinology and genetics facilities and to ensure that additional education and training space is provided. Initial work on this indicates that a good solution is likely.

Revised proposals

Following comprehensive clinical engagement, the revised proposals are now for all Endocrinology and clinical genetics services to remain at the LRI for the reasons set out above.

6.3 Equality Impact Assessment

A full Equality Impact Assessment (EIA) was included in the PCBC. This has been updated to reflect the impact of the proposed changes to the original PCBC proposals. The purpose of the EIA is to assure key decision makers and the population of Leicestershire that providers’ legal obligations concerning their duties under the NHS Act 2006 and subsequent Equality Act 2010 are satisfied.

The Equality Act 2010 protects people against discrimination, harassment, or victimisation in employment, and as users of private and public services based on nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The NHS Act 2006 determines that health inequalities must be properly, and seriously considered and respective Clinical Commissioning Groups must have regard to the need to reduce inequalities between patients in their access to health services as well as the outcomes achieved for them, by the provision of such health services. As part of this multifactorial assessment by the CCG, it has a duty to balance all its legal duties and conscious efforts are then to be taken to mitigate any potential negative impacts upon those from protected groups. The EIA is included in
Appendix D.

6.4 Conclusions on the response to the consultation outcomes

The consultation responses largely support the proposals as presented in the PCBC and the consultation document. Those areas where issues have been raised have either been revised in response to the feedback or further considered, to confirm the proposal are still appropriate, before deciding to proceed. The Commissioners' approach to responding to the consultation outcomes is summarised in the paper included in Appendix E.
7 Financial implications

7.1 Introduction

This section sets out the financial implications of the reconfiguration proposals. It identifies the anticipated capital costs and funding and the procurement route for the required capital developments.

UHL are one of the eight identified front running schemes within the National ‘New Hospitals Programme’, and as such are in the pipeline of funded schemes with allocated capital funding.

There have been a number of policy changes since the PCBC was published, which could not have been anticipated or accounted for in the budget set out in the PCBC. Work is ongoing with the ‘New Hospital Programme’ to define the impact of these changes to national policy on the capital costs, with the expectation that additional capital will need to be allocated centrally.

This DMBC reflects a step in the journey to get a HM Treasury approved Full Business Case (FBC) that allows the drawdown of capital funding to deliver the changes identified. The Outline Business Case (OBC) will ‘test’ the affordability of the scheme. Once the exact parameters of the policy change are agreed with the New Hospital Programme, the affordability and Value for Money assessments will be reassessed and updated in the OBC.

Once the OBC is approved, the FBC will be developed which will confirm the affordability and Value for Money based on final contract prices and scheme costs.

7.2 Capital costs

7.2.1 Overview of capital costs from PCBC

The estimated capital costs of the proposed developments as set out in the PCBC (based on the DHSC Healthcare Premises Cost Guides) together with the timing of the developments are summarised in the table below.
Underlying assumptions

The above cost estimates were prepared by UHL’s cost consultants Rider Levett Bucknall (RLB) and were based on the following assumptions:

- Inflation was assumed to mid-point on construction period for each individual project.

- Optimism Bias of 6% was included. This was lower than would normally be expected at that stage as a significant amount of development work (including the preparation of detailed schedules of accommodation) and review had already taken place. In addition, there were costed allowances for infrastructure which was being developed as its own project as part of the DCP.

- An element of the VAT was assumed to be recoverable which related to fees and the type of development being proposed, for new build developments this is limited, but it is more extensive on refurbishments.

7.2.2 Updated capital costs

The estimated capital costs of the developments, based on the scope of works as set out in the PCBC, have not changed. The scope of the scheme, as described in the PCBC, is still deliverable within the identified capital envelope of £453m. However, since the PCBC was developed, there have been a number of changes relating to national policy and local scope changes which may have an impact on the capital cost. These policy changes do not undermine the clinical model that was consulted on. These are summarised below.

### Table 7-1 Estimated capital costs from PCBC

<table>
<thead>
<tr>
<th>UHL DCP</th>
<th>Capital cost (Including inflation)</th>
<th>SITE</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
<th>22/23</th>
<th>23/24</th>
<th>24/25</th>
<th>25/26</th>
<th>26/27</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Projects within the scope of this PCBC</strong></td>
<td></td>
<td></td>
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<tr>
<td>LRI Maternity Hospital</td>
<td>£107,130,776</td>
<td>LRI</td>
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<tr>
<td>LRI Children’s Hospital</td>
<td>£38,959,630</td>
<td>LRI</td>
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<tr>
<td>LRI Inpatients, day case and Gynaecology outpatients relocation</td>
<td>£15,649,510</td>
<td>LRI</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>GH new build (including Treatment Centre, theatres and new wards)</td>
<td>£189,736,677</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GH Surgical admissions unit</td>
<td>£3,787,815</td>
<td>GH</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>GH Ward refurbishment</td>
<td>£2,759,619</td>
<td>GH</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Total capital cost of PCBC specific projects</strong></td>
<td>£338,024,027</td>
<td></td>
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<tr>
<td><strong>Projects outside the scope of this PCBC</strong></td>
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<tr>
<td>GH Decontamination unit</td>
<td>£8,914,332</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enabling (back office reconfiguration, demolitions and early infrastructure)</td>
<td>£19,682,950</td>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LRI ICU expansion</td>
<td>£25,896,014</td>
<td>LRI</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>LRI Infrastructure</td>
<td>£12,224,918</td>
<td>LRI</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>LRI support functions (pharmacy and mortuary)</td>
<td>£2,147,450</td>
<td>LRI</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>GH ICU expansion</td>
<td>£20,462,287</td>
<td>GH</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH Infrastructure</td>
<td>£15,603,749</td>
<td>GH</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>GH support functions (pharmacy)</td>
<td>£1,666,950</td>
<td>GH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LGH Relocation of Stroke Services</td>
<td>£2,809,879</td>
<td>LGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LGH services and IT isolations</td>
<td>£5,567,444</td>
<td>LGH</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Total capital cost of DCP</strong></td>
<td>£453,000,000</td>
<td></td>
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</tbody>
</table>

### Decision Making Business Case
Reconfiguration of acute and maternity services at University Hospitals of Leicester NHS Trust
National policy changes

- Change in national approach to commercially funded ventures (car parks and Welcome Centres).
- Impact on designs of COVID19 and pandemic proofing.
- Impact of central NHS requirements in terms of sustainability (Net Zero Carbon)².
- Impact of central NHS requirements in respect of the use of Modern Methods of Construction (MMC).
- Impact of central NHS requirements in terms of the approach to digital transformation.

Local scope changes

- System related changes:
  - Additional beds as identified in the bed bridge as being provided through in-fill beds at the LRI, will now be included as new build beds to optimise their usage.
  - An increase in neo-natal cots over those originally planned in the PCBC as requested by the neo-natal network and the NHSE/I specialised commissioners.

- UHL changes:
  - Increase in accommodation to reflect communications space and pandemic proofing.

Impact on capital costs

Because of the uncertainty over the above issues, it is not currently possible to accurately assess the impact on the capital costs. However, work is on-going with the New Hospital Programme to agree the scope of inclusion in the programme, and the potential sources of capital.

7.3 Funding for capital developments

In September 2019, the DHSC included UHL as a front runner in the Health

² The government has an aspiration for all new NHS buildings to comply with 'Net Zero Carbon' requirements. The detailed guidance is currently being developed for the government's 'New Hospitals Programme'. When the guidance is issued UHL will incorporate this into their 'Green Plan' and apply the guidance to the Reconfiguration Programme as required.
Infrastructure Programme (HIP) with a capital envelope of £453m with £450m funded through Public Dividend Capital (PDC). The HIP has now evolved into the New Hospital Programme and UHL continues to be a front runner scheme within the overall programme and allocation of PDC funding.

In addition to the original budget identified of £453m, additional budget has been identified from additional charitable funding sources and from the land receipt from the sale of parts of the LGH site to create a budget of £492m:

- £450m PDC.
- £3m Charitable funding.
- £5m additional charitable funding supported by the Charitable Funds Committee.
- £27m land receipt from LGH.
- £7m Trust Capital Contribution.

As a result of the national policy changes identified above UHL propose to request additional PDC funding from DHSC. The PDC funding will be confirmed when UHL have confirmed the scope of change owing to the policy change and submit their OBC for the Reconfiguration Programme. This is currently anticipated to be in spring 2022.

In addition, as described above, UHL anticipates additional funding being available from the capital receipt from the sale of part of the LGH site and increased charitable fundraising.

As set out above, UHL have been approved for funding by the DHSC, as a front running scheme in the New Hospital Programme. Whilst the original funding of £450m PDC has been identified, in the event that further PDC funding is not made available to fund the additional national policy changes such as the requirement for New Zero Caron and Digital, then the scope of the scheme will be reviewed again in order to fit the budget available.

7.4 Potential procurement route for capital developments

The UHL Reconfiguration Programme is one of the first wave of eight projects that comprise the DHSCs New Hospital Programme of forty new hospitals. The New Hospital Programme are currently developing a procurement strategy that will be enacted across the national programme. As such it is highly likely that the procurement will be coordinated and managed by the central NHP team.
7.5 Affordability

Reflecting that discussions are ongoing in relation to the capital envelope as described in paragraph 7.2.2 above, the affordability assessment will be updated and reassessed as part of OBC development and incorporated into the OBC submission in Spring 2022.

7.6 Value for Money

The PCBC set out that as part of their 2018 STP capital bid, UHL provided an economic appraisal of the proposed service reconfiguration and developments covered by the PCBC. This focused on a comparison of the estimated capital and revenue costs of the developments compared to the monetisable benefits, together with the identification of the non monetisable benefits. The analysis was prepared in line with the requirements of the HM Treasury ‘Green Book’ (concentrating on cash flows to the public sector only). The appraisal calculated the incremental economic costs and benefits to society of the proposed developments, over a 60 year appraisal period, and the resulting VfM ratio.

Reflecting that discussions are ongoing in relation to the capital envelope as described in paragraph 7.2.2 above, the Value For Money assessment will be updated and re-assessed as part of OBC development including a detailed economic appraisal using the DHSC’s Comprehensive Investment Appraisal (CIA) model in the OBC.

7.7 Conclusion on financial implications

The UHL Reconfiguration Programme was announced as being funded as one of the eight front running schemes within the government’s ‘New Hospitals Programme’. The cost of the scheme outlined in the PCBC was £453m. Since the approval of the PCBC, there have been a number of policy changes announced by the DHSC that require consideration in the scheme. These changes will require funding from additional PDC to be allocated from the government. In the event that the additional funding is not forthcoming or is not allocated in full, then the scope of the additional requirements will be reviewed to ensure the budget is not exceeded.

As such, reflecting that discussions are on-going with the ‘New Hospitals Programme’ to define the impact of changes to national policy, the affordability and Value for Money assessments will be updated for inclusion in the OBC submission in Spring 2022.

The delivery of the UHL Reconfiguration Programme and the wider service transformation in LLR, together with the financial implications, are a clear demonstration of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.
8 Delivering the reconfiguration proposals

8.1 Introduction

This section sets out details of the approval processes, stakeholder support and the timeline for the Reconfiguration Programme. It demonstrates that Commissioners and the UHL have appropriate plans in place to deliver the project and to realise the benefits of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

8.2 Approvals

The decision for approving this DMBC is the responsibility of the three LLR CCGs. In addition, the DMBC is supported by the UHL Board and NHSE Specialised Commissioning. The UHL Board considered the DMBC, at its meeting on 3rd June 2021 and confirmed its support. The DMBC was considered by NHSE Specialised Commissioning at its Senior Leadership Team on 3rd June 2021 and its support was also confirmed.

The DMBC was discussed at both the Senior Leadership Team for the BCT programme and the LLR Commissioning Collaborative Board before being approved by the LLR CCGs Combined Board on 8th June 2021.

8.3 Stakeholder support

The Reconfiguration Programme continues to be supported by relevant LLR stakeholders including:

- UHL.
- NHSE (Specialised Commissioning).
- LPT.
- EMAS.
- Leicester City Council.
- Leicestershire County Council.
- Rutland County Council.

It is also supported by the following neighbouring STPs:

- Cambridgeshire and Peterborough.
- Derbyshire.
• Lincolnshire.

• Northamptonshire.

• Nottinghamshire.

8.4 Programme timeline.

8.4.1 Current timetable

This outline timetable below reflects the assumption that following the approval of the DMBC there will be a single Programme OBC and FBCs developed for individual projects starting at different points throughout the life of the Programme.

Table 8-1 Programme timeline

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Approval / Completed Date</th>
<th>Forward Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td></td>
<td></td>
<td>To be obtained for demolition and new build elements before FBC submitted for approval. No major issues expected as planning authority is supportive and LGH land divestment supports the Local Development Plan for housing.</td>
</tr>
<tr>
<td>East Midlands Clinical Senate</td>
<td>5th July 2018</td>
<td></td>
<td>The Clinical Senate strongly supported the Reconfiguration Programme with the move to two acute sites on the basis of clinical sustainability and workforce needs.</td>
</tr>
<tr>
<td>Strategic Outline Case (SOC) / Pre-Consultation Business Case (PCBC)</td>
<td>April 2015</td>
<td></td>
<td>LLR Better Care Together (BCT) SOC supported by NHSE (NHSE) &amp; NHS Improvement (NHSI).</td>
</tr>
<tr>
<td></td>
<td>July 2018</td>
<td></td>
<td>PCBC acts as a SOC enabling projects to progress directly to OBC and FBC.</td>
</tr>
<tr>
<td></td>
<td>January 2020 – September 2020</td>
<td></td>
<td>NHSE / NHSI Approvals process on PCBC.</td>
</tr>
<tr>
<td>Milestones</td>
<td>Approval / Completed Date</td>
<td>Forward Date</td>
<td>Comments</td>
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<tr>
<td>----------------------------------</td>
<td>---------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Consultation</td>
<td>September to December 2020</td>
<td></td>
<td>Public Consultation on proposals</td>
</tr>
<tr>
<td>Enabling Works combined business case</td>
<td>Sep 2021</td>
<td></td>
<td>Back office, education, training and research services based in Knighton Street Offices, Knighton Street Outpatients, undergraduate centre and the hearing and balance building.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LRI ICU Expansion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LRI Infrastructure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LRI Maternity Hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LRI Children’s Hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LRI In-Patients, Day Case and Gynaecology Relocation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH New Build (Treatment Centre &amp; wards).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH STACU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH Infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH ICU Expansion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH Support Function</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GGH BIU / NRU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GH Wards; LRI Wards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LGH Isolations</td>
</tr>
<tr>
<td>Milestones</td>
<td>Approval / Completed Date</td>
<td>Forward Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>NB: the approvals timescale is acknowledged. UHL will continue to review and develop the project whilst the OBC is being approved.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Business Case (FBC) / procurement completion</td>
<td>March – Oct 2022</td>
<td>LRI ICU Expansion; Back Office Accommodation; LRI Infrastructure; GH Admissions Unit; GH Expansion; LRI Maternity Hospital; GH ICU Expansion; LRI Gynaecology Relocation; LRI Wards; LGH Isolations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dec 2023 - July 2024</td>
<td>LRI Children’s Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nov 2024 – May 2025</td>
<td>GH STACU; GH Wards; GH BIU/NRU</td>
<td></td>
</tr>
<tr>
<td>Planned start date of capital work</td>
<td>Jan 2022</td>
<td>Back office, education, training and research (Enabling Project)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March 2023</td>
<td>LRI ICU Expansion; LRI Maternity Hospital, LRI Infrastructure; GH New Build (Treatment Centre &amp; wards); GH ICU Expansion; GH Infrastructure; GH Support Function; LGH Isolations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dec 2024</td>
<td>LRI Children’s Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nov 2025</td>
<td>GH STACU; GH Wards; GH BIU / NRU</td>
<td></td>
</tr>
<tr>
<td>Planned end date of capital work</td>
<td>Nov 2022</td>
<td>Back office, education, training and research (Enabling Project)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apr-Nov 2025</td>
<td>LRI ICU Expansion; LRI Maternity Hospital, LRI Infrastructure; GH New Build (Treatment Centre &amp; wards); GH ICU Expansion; GH Infrastructure; GH Support Function; LGH Isolations</td>
<td></td>
</tr>
</tbody>
</table>
### Milestones

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Approval / Completed Date</th>
<th>Forward Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Nov 2026</td>
<td>LRI Children’s Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>April 2026</td>
<td>GH STACU; GH Wards; GH BIU / NRU</td>
</tr>
<tr>
<td>Related target asset disposal</td>
<td></td>
<td>2024 - 2026</td>
<td>Disposal phasing yet to be planned and will align to building schedule for GH and LRI</td>
</tr>
<tr>
<td>date</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Programme OBC will be developed for submission to NHSE/I in spring 2022 and conclude with the final Ward expansion projects in spring/summer 2025. FBCs will be developed following feedback from the NHSE/I approval panels, expanding on the detail of the Programme OBC.

This phased approach takes account of the sequencing required for each of the projects to meet the needs of the business, enabling the services to move in a way that minimises patient disruption.

Due to the size and scale of the Programme it is anticipated that the overall construction period will last 5 years, with completion in autumn 2026. However, this timescale is only indicative and will be subject to change if delays occur within any of the approval stages.

### 8.4.2 Critical path for implementation

There are critical interdependencies between the following UHL transformational initiatives:

- IT 'eHospital' project.
- Frailty/Models of Care and reduction in outpatient numbers (and the consequential impact on):
  - Workforce plan.
  - Estates Reconfiguration Programme.

The interdependencies are shown in the Figure below.
Implementation Interdependencies

Figure 8-1 Implementation interdependencies

- Workforce
- Digital and Technological Workforce Opportunities
- Agile Working
- Workforce
- Tomorrow's Ward
- Agila Working
- Workforce
- Consolidation & Collocation of services
- IT
- eQuip refresh
- eMDS (LR): Online Diagnostics
- Patient Pathway
- 20% reduction in new and follow-up appointments
- Paperless Nursing
- EMIS EPR
- Care in place
- Access Primary Care
- Interoperability system complete
- Radiology
- High Volume Specialties
- Co-located Health & Social Care Teams
- Cardiac Scoring
- 19 bed reduction
- Emergency Scoring
- 18 bed reduction
- Acute Frailty Services Launch
- Community MDT roll out to 31 lines across LHR
- Community Services Redesign
- 9 bed reduction
- Full Integrated
- 6 bed reduction
- Critical Care Service
- Frailty Scoring
- High Volume Specialties
- Co-located Health & Social Care Teams
- Acute Frailty Services Launch
- Community MDT roll out to 31 lines across LHR
- Community Services Redesign
- 9 bed reduction

Majority of the Reconfiguration Programme

- ICU LRI
- New Build GH
- ICU GH
- Maternity Hospital
- Children's Hospital
- Refurbished Wards LRI/GH

Projects

YEARS

2018/19

2019/20

2020/21

2021/22

2022/23

2023/24

2024/25
IT ‘eHospital’

The eHospital programme was launched in 2019 as UHL embraced an approach to becoming a digital hospital, to develop and deploy a trust wide electronic patient record (EPR) solution to HIMSS level 6 by 2022. This is in progress and is a key enabler for transformation of the way UHL deliver care and offers a range of quality, safety and efficiency benefits. In parallel, the UHL is embarking on an infrastructure modernisation programme to ensure staff and patients are able to reliably access digital solutions, and on a digital workplace programme to improve digital maturity in relation to productivity, communications and collaboration technologies.

In close collaboration with ICS partners UHL will deliver input into the LLR shared care record by September 2021 and, in advance of UHL’s new buildings being completed, a number of components of UHL’s digital vision.

These are in line with the NHSx digital blueprint and will maximise the digital opportunities available in both UHL’s new and retained estate, and include:

- Mobile and cloud first Trust wide EPR capabilities, reducing reliance on paper.
- Connected IoT and medical devices.
- Data and analytics, supporting decision making, research and population health objectives based on new and richer datasets.
- Automation and AI innovations to support new ways of working and delivering care.
- Integrated facilities, logistics and clinical workflow management.
- Support for virtual clinics and virtual wards.
- Self check in, wayfinding, patient access to records and integrated bookings.
- Online preoperative assessment and consent.

Frailty / Models of Care

The frailty model aims to deliver a 67 bed improvement (only 57 beds are required). Work has commenced and is already proving beneficial.

Workforce

UHL’s workforce plan is broken into a series of action plans. Some cover the immediate operational workforce challenges and some identify workforce transformation plans as part of UHL’s reconfiguration programme. The reconfiguration workforce action plans underpin the overarching clinical and estates
strategies and outline the significant interdependencies between projects. Each action plan has a Demand (Right Staff), Supply (Right Skills) and Actions Summary (Right Place and Time) element. These are iterative and will be developed in line with the evolving Models of Care as the individual business cases are developed.

8.5 Conclusion on delivering the reconfiguration proposals

The above demonstrates that the Commissioners and the Trust have the appropriate plans in place to deliver the project and to realise the benefits of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.
9 Overall conclusion and recommendations

9.1 Context

This DMBC is a critical and tangible step towards sustainable health and care for the people of LLR. While keeping our planned development of primary, community and social care clearly within view, we deal with the urgent need to redefine the future shape of our acute hospitals provided by UHL to ensure long term clinical and financial sustainability.

The reconfiguration of services across the three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes; while at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

This DMBC is critical in order for UHL to progress to an OBC and subsequently an FBC so that we can secure the investment needed to reconfigure our acute hospitals. It is urgent because acute services are overstretched, with staff battling daily to deliver the quality of care that they believe in and our current configuration is not financially viable. It is compelling because there is significant potential to improve services and outcomes for our patients by ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

9.2 Conclusions

The consultation responses largely support the proposals as presented in the PCBC and the consultation document. Those areas where issues have been raised have either been revised in response to the feedback or further considered, to confirm the proposal are still appropriate, before deciding to proceed.

Commissioners and the Trust have the appropriate plans in place to deliver the reconfiguration and to realise the benefits of ‘working together to provide individuals with better care, in the most appropriate setting, in a financially sustainable way’.

A summary of the reconfiguration benefits are detailed in the table below.

Table 9-1 Summary of reconfiguration benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
</table>
| Clinical | • A new single site Maternity Hospital and a dedicated Children’s Hospital at the Leicester Royal Infirmary.  
            • A new Treatment Centre, wards and theatres at the Glenfield Hospital protecting planned |
OVERALL CONCLUSION AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>elective activity and eliminating cancellations at times of peak emergency activity.</td>
</tr>
<tr>
<td></td>
<td>• Reduction in clinical risk due to the consolidation of services, resources and equipment.</td>
</tr>
<tr>
<td></td>
<td>• Enhanced critical care provision on the two acute sites allowing UHL to meet national standards.</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>• Improved outcomes for patients through increased Consultant presence and earlier, more regular senior clinical decision-making.</td>
</tr>
<tr>
<td></td>
<td>• Co-location of specialties to enable enhanced input and multi-specialty management of patients in one location resulting in more timely management with fewer hand-offs thus promoting early recovery.</td>
</tr>
<tr>
<td></td>
<td>• Reduced cancellations ensuring patients are operated on at the earliest possible point in time leading to improved patient experience and clinical outcomes.</td>
</tr>
<tr>
<td></td>
<td>• Improved patient experience from transformation and the improved clinical environment.</td>
</tr>
<tr>
<td></td>
<td>• Patient space which complies with the highest expectations of the Patient Led Audit of the Care Environment (PLACE) and delivers therapeutic spaces which aid wellbeing and recovery.</td>
</tr>
<tr>
<td></td>
<td>• Technology used to connect with patients and ensure their information is available electronically for all consultations.</td>
</tr>
<tr>
<td>Workforce</td>
<td>• Staff experience improved though the ability to concentrate resources on two hospital sites.</td>
</tr>
<tr>
<td></td>
<td>• Workforce attraction and retention improved as a consequence of enhanced working environments.</td>
</tr>
<tr>
<td></td>
<td>• Opportunity to grow specialised, teaching and research portfolios.</td>
</tr>
<tr>
<td></td>
<td>• A sustainable workforce through the consolidation and transformation of services and improved facilities.</td>
</tr>
</tbody>
</table>
### 9.3 Recommendations

The Governing Bodies of East Leicestershire and Rutland CCG, Leicester City CCG and West Leicestershire CCG are individually asked to:

- **RECEIVE** the Report of Findings
- **APPROVE** NHS East Leicestershire and Rutland CCG, NHS Leicester City CCG and NHS West Leicestershire CCG has met its statutory duties and ensured that an effective and robust public consultation process has been undertaken and will be used to inform the decisions made. [refer to Appendix C to N with Report of Findings]
- **APPROVE** Reconfiguration of acute services – moving acute services on to two of the current three hospital sites with acute services being provided at Leicester Royal Infirmary and Glenfield Hospital
- **APPROVE** New treatment centre – moving outpatient services from Leicester Royal Infirmary and Leicester General Hospital to a new purpose build treatment centre at Glenfield Hospital.
- **APPROVE** Use of new technologies – offering appointments by telephone or video call for certain aspects of pre-planned care.
- **APPROVE** Primary Care-led services – creating a primary care urgent treatment centre at Leicester General Hospital site and scope further detail on proposals for developing services at the centre based upon feedback and further engagement with the public. Services could include:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economy</td>
<td>• Recurrent improvement in the financial position of UHL and wider health economy of £18m pa.&lt;br&gt;• Reduced backlog maintenance from the current requirement of circa £77m to circa £33m, a reduction of 58%.&lt;br&gt;• Release of land for the development of 600+ housing units.&lt;br&gt;• A financially sustainable future for UHL and the wider health economy.</td>
</tr>
</tbody>
</table>
• Observation area with beds where patients can be observed when they are not well enough to go home, but don’t meet the criteria to be admitted to hospital.

• Diagnostic service - this provides appointments for people to have a test or simple procedure.

• Community outpatients service – this is treatment for people with health problems requiring a diagnosis or treatment, but do not require a bed or to be admitted for overnight care.

• Potentially extra primary care capacity - to provide family health care to people living in the east of the city.

APPROVE New standalone maternity unit – relocating the standalone maternity unit at St Mary’s in Melton Mowbray and trial a new standalone midwifery unit at Leicester General Hospital to assess its viability.

APPROVE New haemodialysis treatment units – providing two new haemodialysis treatment units, one at Glenfield Hospital and the second in a new unit to the south of Leicester.

APPROVE Hydrotherapy pools – using hydrotherapy pools already located in community settings.

APPROVE New maternity hospital – building a new maternity hospital on the LRI site, including a midwifery-led birth centre provided alongside the obstetric unit. Moving existing maternity services (services provided in pregnancy, childbirth and post-pregnancy) and neonatal services from Leicester General Hospital to Leicester Royal Infirmary.

APPROVE Breastfeeding services – enhancing breastfeeding services for mothers by providing post-natal breastfeeding drop-in sessions alongside peer support.

APPROVE Children’s hospital – refurbishing the Kensington building at Leicester Royal Infirmary to create a new children’s hospital including a consolidated children’s intensive care unit, co-
located with maternity services.

**NOTE**

**Ongoing engagement and communication** - the NHS in Leicester, Leicestershire and Rutland will continue its communication and engagement on the implementation of these decisions with patients, the public, staff and key stakeholder organisations particularly taking into account the findings of the Equality Impact Assessment.

**NOTE**

**Capital Costs** - The Governing Body is asked to note content of Part 7 of the DMBC and the commissioners will be asked to support, at a later date and subject to decisions reached on these recommendations, the business cases that will enable access to the funds set out in Part 7.
Appendix A – Consultation Document

[See separate file]
Appendix B – Consultation Outcomes Report

[See separate file]
Appendix C – Travel Action Plan

[See separate file]
Appendix D – Equality Impact Assessment

[See separate file]
Appendix E – Commissioners’ approach to responding to the consultation outcomes

Building Better Hospitals
For the future

Principles post consultation to the communities in Leicester, Leicestershire and Rutland

The Acute and Maternity Reconfiguration Consultation Report of Findings considers common themes emerging from the consultation, both from the public and stakeholders.

The Clinical Commissioning Groups in Leicester, Leicestershire and Rutland along with University Hospitals of Leicester NHS Trust recognise the importance to people of concerns they may have and ideas to improve the proposals further.

All the feedback received throughout the consultation process has been carefully considered. A number of principles, which address key themes, have been developed to support the implementation of the proposals for improvement at Leicester’s hospitals over the next five years.

A set of 20 principles which the NHS in Leicester, Leicestershire and Rutland will adhere to when implementing change.

1. **Good access to reach all sites**
   - Improve public transport to care sites and transport links (e.g. free buses, hospital hopper, out of hours buses, subsidised public transport)
   - Improve hospital transport schemes (e.g. voluntary taxi services, hospital taxi, park and ride and shuttle bus)
   - Improve facilities for cyclists (e.g. parking, cycle lanes, showering / changing facilities)
   - Work with partners to enhance road infrastructure

2. **Good access onto and around all sites**
   - Access for all including the less abled people (e.g. good signage, clear thoroughfares, separate entrance, disabled parking)
   - Improve car parking (affordable, more spaces, modern payment system)

3. **Embrace environmental sustainability**
• Provision of environmentally friendly facilities (e.g. reduce the carbon footprint, green area)

4. Across all developments adapt high quality patient communications and interactions

• Staff training in British Sign Language
• Provide for patients whose first language isn’t English
• Provide for all vulnerable groups (e.g. disabled patients, elderly, autistic, ethnic and religious groups, mental health service users and LGBT+ communities)

5. Co-design services and provide information to all socio-demographic groups throughout implementation of change

6. Focus attention beyond clinical needs (e.g. Wi-Fi, waiting rooms, catering, play area, gardens)

7. Develop solutions for those people living in rural locations—care closer to home, particularly if needed in an emergency

8. New technologies adopted and adapted to meet the patient need and choice

• Allow patients to choose the type of appointment that matches their need (patient choice)
• Consider groups who require face-to-face appointments or physical examinations or care of specific medical conditions, tests or assessments
• Consider those who cannot use technology (e.g. dementia, children, elderly, hearing problems) or who lack access to digital technology (e.g. PCs, laptops, smartphone, Internet or poor internet connections).
• Consider the advantages of virtual appointments for some patients (e.g. with social anxiety, agoraphobic, housebound, disabled).
• Consider the need for medical devices to assess patients remotely (e.g. blood pressure devices)

9. Engage communities on next steps for Leicester General Hospital

• Co-design services
• Consider diagnostic service at primary care centre including x-ray
• Consider the needs of patients with long-term conditions

10. Consider variety of locations to achieve the best access to haemodialysis treatment

11. Provide quality of care in hydrotherapy services, at the right and appropriate locations with good access e.g. wheelchair users and provide trained staff who pay attention around the service including single sex sessions

12. New Maternity Hospital providing personalised high quality care
• Adequately staffed
• Provision of perinatal care and support (e.g. mental health, breastfeeding)
• Provision of services to meet the needs of women experiencing miscarriage or fertility issues (e.g. endometriosis)
• Improved maternity access for partners (e.g. antenatal sessions, overnight stays, during COVID-19)
• Provision of facilities for new-born hearing screening
• Birth care, breast feeding support and adequate staffing of pre and post-natal care

13. High quality and sustainable standalone Midwifery Led Unit
• Develop a sustainable, cost effective new Midwifery Led Unit on the site of Leicester General Hospital, with no restrictions on long term viability of the service
• Improved access to a greater proportion of women across Leicester, Leicestershire and Rutland
• Provision of high quality care and aftercare with reduced risk of associated long journey transfer to acute clinical support
• Maintain high efficient workforce

14. Provision of community breastfeeding support
• High quality accessible (times and hours) breast feeding support, closer to home including drop-sessions
• Personal approach to breastfeeding promoting personal choice (e.g. no pressure to breastfeed)

15. Provision of high quality Children’s Hospital for children, young people and family carers
• Child-friendly facilities to make hospital experience less stressful
• Facilities for overnight stays for parents staying with child
• Right attitudes towards for teenagers and adolescents understanding their needs
• Provision of a pharmacy on site
• Facilities for children with additional needs (e.g. hoists, sensory room)
• Ease of transfers from A&E

16. Provision of adequate acute bed capacity to match need

17. Reduce clinical risk and reduce negative impact on the workforce by maintaining Ear, Nose and Throat Service at Leicester Royal Infirmary

18. Provision of a safe service in close proximity of the Children’s Hospital by maintaining entire ophthalmology services at Leicester Royal Infirmary
19. Provision of more scope for developments if there is an increase in demand for the Brain Injury Unit and Specialist Neuro Rehabilitation Unit by relocating it from Leicester Royal Infirmary to Glenfield Hospital:

- Quiet space to accommodate 1:1 therapy sessions individually with Speech and Language Therapy, Neuropsychology and Occupational Therapy (cannot be shared and needed separately for each therapy).
- Low stimulus sensory assessment area for patients with Prolonged Disorder of Conscientiousness at Brain Injury Unit.
- Dedicated areas for patients to demonstrate functional skills for independent living.
- Secure and protected outdoor space for patients for therapeutic activities and rehabilitation of patients accessible from ward for both services.
- Separate area for group therapy activity for patients e.g., communication group, cognitive skills group, organised meaningful activities.
- Designated Independent Living area with attached toilet and kitchenette for patients to demonstrate ability to live independently with a care package before discharge from.

20. Maintain Plastic Surgery outpatients and day case activity at Leicester Royal Infirmary to ensure alignment with other adult and paediatric services.

To view a copy of the Better Hospitals Leicester Consultation Report of Findings in full or in summary and to read the Decision Making Business Case please visit: www.betterhospitalsleicester.nhs.uk.

Email beinvolved@LeicesterCityCCG.nhs.uk or telephone 0116 295 0750 to request a copy of the summary document and Decision Making Business Case.