Better Care Together in Leicester, Leicestershire and Rutland
Questions and Answers

People have asked a range of questions about Better Care Together and proposals to improve services including those at the hospitals in Leicester.

The questions along with the answers have been brought together. We will continue to add further information as further questions are raised.

Better Care Together

What is Better Care Together and is it different from the Sustainability and Transformation Partnership or STP?

The three NHS Trusts and three clinical commissioning groups in Leicester, Leicestershire and Rutland, working alongside a range of other independent organisations, voluntary and community sector providers and local councils, combine to look after a population of more than one million people. They are doing this through Better Care Together which is the Sustainability and Transformation Partnership in Leicester, Leicestershire and Rutland.

What are the Better Care Together partners doing?

All the Better Care Together partners are working together to improve services for local people. Together we are working to keep more people well and out of hospital through better public health and prevention of illness. We want earlier detection and management of disease. We also want to support more patients at home and in their community.

We are working to provide improved care in a crisis from NHS 111 to 999 – including responding to urgent and emergency care need for people experiencing a mental health episode.

We are also improving the route that people take through the care system so it is joined up.

Better Care Together Consultation

When is consultation going to start?

Where a public consultation is required, as is the case for our proposals for the hospitals in Leicester, we are not allowed to go out to public consultation until we have the funding agreed and the Pre Consultation Business Case is approved.

This is because one of the tests for consultation is the assurance that what is being consulted on is deliverable; this includes the allocation of funding.

We will only be able to go out to consult once we have been allocated the funding and our pre consultation business case has been approved, at this time we don't know when this will be.

How is it real consultation if you are already bidding for money and have designs?

We will be consulting on a proposal. We genuinely want to hear people's views on our proposals. In order to bid for money we have to have proposals so the government can see our ideas are affordable.

We don't have designs just artists impressions of what the different hospitals sites could look like.

Why aren't you allowed to go out to formal consultation until national funding is announced?

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We will only be able to go out to consult once we have had been allocated the funding and our pre consultation business case has been approved, at this time we don't know when this will be.

We've heard all this before and nothing changed, so what is different this time?

The government has stated that it will invest in a couple of large schemes every year; University Hospitals of Leicester are one of a small number of hospital Trusts who are seeking this level of capital money. Nationally, the availability of funding has been very limited due to austerity, but we have done everything possible to ensure we are in the best possible position to get funding.

What's plan B if this doesn't work or happen?

We will continue to bid for capital whenever it becomes available. We are confident it's a case of when, not if. In the meantime, we will continue to provide our services as best we can within the buildings that we have.

Where's the voice of patients in all this?

We are actively engaging patients in our projects. We will ensure co-production of appropriate design with patient groups and partners as we progress our plans. We had recent experience of this when Vista and Age Concern were involved in the design to create dementia and visually impaired friendly environments in our Emergency Department.

We have spoken with patient and public involvement groups about our plans and listened to their views.

There have been two major periods of engagement on Better Care Together including this proposal, in the past four years. The first was in 2015, when thousands of local people were reached through a publicity campaign. More than 1,000 respondents completed a detailed questionnaire about the future of healthcare including acute and maternity reconfiguration. The insights were analysed and informed the development of the Sustainability and Transformation Plan or STP – a plan outlining how care will improve for people in LLR.

Our early proposals were shared with the public in November 2016 within the draft STP. This was followed by a period of engagement from January to March 2017. We reached over 10,000 people through publicity, events, and targeted meetings, digital and social media.

Feedback from the public identified a number of areas where more work was required. They included the need to maintain the acute bed capacity and access to maternity services within any proposals to reorganise the acute hospitals in LLR and create a new maternity hospital.

We were also asked to consider the better use of technology and in particular to create a single patient record that all health and care professionals could access.

People wanted us to recognise that local areas are different and there is a migration of LLR residents outside of the counties as well as a migration of residents from other counties into LLR acute services.

In October and November 2018 further engagement with the public was undertaken. A series of events was undertaken across Leicester, Leicestershire and Rutland. The purpose of these events was to inform communities about the acute and maternity services and community services reconfiguration plans. The events provided the opportunity for patients, the public and wider stakeholders to hear more about the underpinning detail of the rationale for proposed changes, what it would mean in practice terms for service currently being provided. They also gave the public the opportunity to raise any questions or concerns.

All of the feedback received through the engagement continues to influence our plans leading to this consultation.

We will continue to engage in 2019. Once we are able to consult we will actively encourage further involvement from patients and the public to tell us what they think.

The NHS does not belong to a political party or to a party in power. The NHS and its assets belong to the people. Therefore, can you please inform the public whether any estates are being sold off - as requested by Naylor Report - and if it is, why is that the public are not consulted?

Land will only be disposed of when it has been declared surplus and is planned through a comprehensive estates strategy.

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We will only be able to go out to consult once we have had been allocated the funding and our pre consultation business case has been approved, at this time we don't know when this will be.

What land are you selling at the Glenfield and why?

The land at the Glenfield we propose to sell (known as the paddocks) currently services the needs of some horses and there are no healthcare services provided on them. We could use the money from that sale to reinvest in health services for local people.

If there is a delay in an announcement - would you do the same as now and railroad through changes

The proposed changes around Intensive Care Unit are because of there is a clinical need for change – we will be consulting in depth around the bigger configuration.

If the powers at be hold the funding then you will just railroad through changes and you won't consult - how will it be different than the Intensive Care Unit issue?

There was a clinical need for the Intensive Care Unit changes. We are committed to consulting on the acute and maternity reconfiguration once we have been given the approval for the funding.

Have you consulted MPs on your plans?

We have, since 2015, shared our long term plans with local MPs. We will continue to do that and hope to gain their full support for the plans we have developed to improve local health services and hospitals for local people.

What opportunities do the public have to influence your plans if you've already done so much work on them?

Whilst we have done work to inform the pre-consultation business case, once we have an outcome of the consultation process, we will plan to undertake detailed planning on which we will engage with the public.

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We recognise there is always more engagement needed with the wider public and we are committed to doing this will be looking for opportunities to meet with groups, hold events and use social media more in 2019 to engage people in our plans.

All of the feedback received through the engagement continues to influence our plans leading to this consultation.

Will you change your plans through consultation if the public share ideas that could improve your plans?

All views obtained through consultation will be considered within the context of the proposals. At the end of consultation we will be developing a decision making business case which will articulate how we have taken account of the publics' views. It is really important to us that our plans reflect the needs of the local population, whilst taking account of health economy.

What assurances can the public have that you are going to co-produce your plans with them?

We strongly believe that we get a better outcome if we co-produce plans with the public. This is evidenced in our new emergency floor where we involved interested parties (Vista Blind and Age UK), patients and the public in the design of the new facilities – especially the frailty friendly areas and the new dementia suite.

Reconfiguration Plans

Do you need to sell land at the Glenfield and General Hospitals in order to get the capital funding?

No. However, in our plan we have to show that and that we no longer need for healthcare facilities will be sold off to generate money to reinvest in healthcare (in line with the recommendations in the Naylor Review published in 2017).

How confident are you of securing the funding?

It is obviously hard to say, however we should be hopeful given we have already received £50million for a new Emergency Department and £30million for the upgrade of our intensive care units at the Glenfield and Royal Infirmary.

We hope that the public will support us so that we can get the much needed investment in our local health services.

Will the Trust involve the public in some type of co-production around the new buildings they are talking about?

Yes. When we get approval for funding, and following the consultation we will further involve the public in taking our plans forward to reality.

Where is there space at the Royal?

We propose to build the maternity hospital on the space currently occupied by buildings adjacent to the new Emergency Department (Knighton Street office and Outpatients). These buildings are old and not fit for purpose. We also do not provide any patient facing services from these buildings.

The other services planned for the Royal Infirmary site will be housed in the Balmoral and Windsor Buildings into space vacated by the Children's services moving into Kensington once the maternity hospital is built.

When will all of these changes start?

We cannot make any changes until we have consulted and we cannot consult until we have been told that we are being given the funding and our Pre Consultation Business Case is approved.

Do you currently pay rent for your buildings?

Our buildings located across the General, Royal Infirmary and Glenfield Hospital sites are all owned by the NHS.

We hope the funding materialises, but what happens if you only get some of it, or none of it?

The £30.8million we have been allocated for the move of the level 3 intensive care unit beds and associated surgical services is independent of the funding for the rest of the reconfiguration

programme. We do not have an alternative plan and as such, if we do not receive all of the funding, we would progress with our plans at a slower pace.

The plan looks good and is certainly ambitious; where will the funding come from?

We are applying for funding from central government, and will wait to be advised what the source of funding will be.

Based on recent performance figures, the new Emergency Department doesn't seem to have helped you achieve the 4-hour standard. How can you reassure people that these new buildings will improve other standards, such as cancelled operations?

Our plans are to bring services together in better clinical configurations such as having a dedicated Children's Hospital and a Maternity Hospital, which will reduce duplication of staff and mean that services are located in better clinical configurations. Having a dedicated Treatment Centre at the Glenfield Hospital site will accommodate most of the elective services; this will help us reduce the likelihood of having to cancel operations especially due to winter pressures, as the Royal Infirmary will have most of the Emergency services.

Rural communities are concerned about the centralisation of services. Where is the evidence that it is the right thing to do?

Our proposals for community based services are that home based services will be more localised, not centralised. We are developing plans to create more capacity in integrated neighbourhood teams that include community nursing, therapy, social care, and mental health working more closely with GP practices to provide co-ordinated care and which will be delivered at a local level around populations of 30K – 50K.

Not all services can be provided effectively in all localities within the workforce that we have in health and social care. We want to develop a model of care that offers accessible community based services in rural areas, where this makes sense clinically and in terms of resources, with some services being concentrated in the main acute hospitals. We are still working on the model for community services, which includes a review of the evidence base, and will be engaging more on our plans for this in 2019.

How can you deliver safe and effective care in people's homes with the current financial constraints you have?

There is evidence from other parts of the UK that better home based care can prevent the need for hospitalisation or support shorter hospital stays, which can be cost effective. Our strategy is to invest more in home based and community based services where this makes clinical and financial sense. We are currently reviewing the balance of expenditure on home based and bed based care and coming up with proposals to strengthen home based care , which we will be running further engagement on in the New Year.

Do you have any plans to partner with private organisations/ businesses in your plans?

At this time we have no plans to partner with private organisations; however we will be guided by central government in terms of how they propose to provide us with the funding.

Do your plans take into account that we are an ageing population?

Our plans are based on the local demography, which does take account of the aging population.

Beds

Have you considered the need for more beds?

Of course; we have an ageing population. We have done lots of work and looking at demographic work, frailty etc. However do not judge a healthcare system by the number of beds it has. A good healthcare system keeps people well and out of hospital.

However we do need more intensive care beds and our plan sees an increase from 49 beds to 100.

Are you taking beds away?

No. Our final plans see an increase in beds – on our wards and in our intensive care units.

Intensive Care Unit

If you're moving Intensive Care off the General site isn't this the thin edge of the wedge to close the General?

No. Once we've consolidated Intensive Care and solved the on-going clinical risk, the other services at the General (e.g. elective orthopaedics) could stay as they are indefinitely. We don't want them to because it doesn't make clinical / operational or financial sense, but they could. In any event the long term plans for the General will be subject to full, formal public consultation just as soon as we are allowed to do that.

Why haven't you consulted on the Intensive Treatment Unit moves?

When our clinicians first raised the issue about the sustainability of ICU at the LGH, we wanted to act quickly, such was the level of concern, and so we consulted the City and County Health Overview and Scrutiny Committees and asked them to support our stance of not entering into formal public consultation on the plan. They did support that, recognising the clinical urgency. Then of course the money dried up and we were left with a plan, a big clinical risk but no way of addressing it… until now. We're in a position to finally address the Intensive Treatment Unit sustainability issue. Any formal consultation will further delay the scheme and increase the costs.

Why has there been a delay in ITU

Disappointingly Leicester's Hospitals were unable to progress these plans until national capital funding became available again in Spring 2017 and an outline business case was approved by CCG Boards in November 2017, with subsequent Full Business Case approval in July 2018.

The CCGs and UHL have been planning to close down Intensive Care and other services at Leicester General and to move them elsewhere. This is an obvious threat to Leicester General Hospital. Why was it that public opinion was not sought earlier and public consultation before it was too late to influence what is happening?

Leicester's Hospitals first presented plans to consolidate Level 3 Intensive Care Unit - currently provided at all three sites, on to Glenfield Hospital and Royal Infirmary in 2014/15 - on the basis that maintaining the service on all three sites was unsustainable and inefficient.

Plans at this time were supported both by Commissioners (organisations who buy health services for the local population) and Leicester and Leicestershire Health Overview and Scrutiny Committees.

The Trust started to progress plans for the scheme without public consultation further to outcome of discussions with Health Overview and Scrutiny Committees and clinical commissioning group. Disappointingly Leicester's Hospitals were unable to progress these plans until national capital funding became available again in Spring 2017 and an outline business case was approved by Clinical Commissioning Group Boards in November 2017, with subsequent Full Business Case approval in July 2018.

Leicester's Hospitals and the CCGs have apologised for having missed opportunities to have keep the public and other stakeholders more informed about the progress of the scheme since decisions were taken in 2015, 2017 and 2018; however we have stated that to consult at this very late stage would not be appropriate.

Following these service moves the bulk of clinical services currently provided at the General will remain, including the provision of Level 2 ICU. The planned ICU changes have been designed in a way that does not make further changes inevitable or unavoidable; although the scheme is consistent with the overall strategic direction of travel.

Why don't the proposed new intensive care units meet current guidelines on space and number of private rooms?

The HBN 04-02 you refer to gives "best practice" guidance and the new units will provide better space and facilities than we currently have.

Why haven't you consulted on the big reconfiguration plan?

We're not allowed to go to formal consultation until the government has agreed to the funding in principle.

It's frustrating because as we've said this isn't a secret, but on one level you can understand the logic, i.e. if we go out to promote the new hospitals and then the money doesn't materialise, the government will take the rap for it. So, instead we're upping the level of engagement (which is different to formal consultation), as a way of trying to keep the public and staff enthusiastic about the vision for our hospitals.

Why are you cutting the number of beds when everyone knows you never have enough?

We're not. The plan is from this winter onwards we increase the number of beds by about 50 as well as eventually doubling ICU capacity. (The original plan 2016 saw us cutting beds but we pretty soon realised that this was unrealistic).

How certain are you that you'll get the cash?

We're confident but it's not guaranteed. We think we're on the list of schemes nationally that could be backed and so what we're focusing all our efforts on is making the case as watertight and compelling as possible… ultimately the decision is with Department of Health / Treasury… we've just got to make sure that there's strong support for the vision.

Leicester General Hospital

Why do you have to close the General?

We're not closing it; it stays as a healthcare site just not as an acute hospital.

There are three hospitals in Leicester as a result of history rather than design. For the last decade our clinical teams have been telling us that it's nigh on impossible to run effective services when people and kit are duplicated and triplicated across three hospitals. Staff and patients are bounced

between the three, clinical services that ought to be next to one another are separated which hinders team working and it's clearly expensive to run.

To be honest, if money were no object we would ideally like to go from three hospital sites to one, with every service ideally located under one roof but that would be prohibitively expensive and so the next best option is to consolidate acute services on to two sites, whilst retaining some non-acute services at the General.

Why is this all being done in secret?

It's not. Our plans were first published in public in 2015, then updated in 2017, and have been covered in the media and presented at stakeholder events around the City and Counties. The overwhelming feedback through all of that was 'you've been talking about this for more than a decade, why don't you just get on with it?'

Councillors in Leicester, Leicestershire and Rutland requested to hold a full public consultation on downgrading of Leicester General Hospital. Why is it not done?

We are not allowed to go out to public consultation until we have the funding agreed and the Pre Consultation Business Case is approved for our entire plan.

What is the future of the Leicester General Hospital?

The General will still be a healthcare setting with a number of services still delivered. It will just not look the same as it does today. The land that it not used for health care facilities will be sold for housing and the money raised invested in hospitals in Leicester.

What is a community health hub and what will be provided on the General site?

The Evington centre, run by Leicestershire Partnership NHS Trust will remain on the General site. This will house the city stroke rehabilitation service.

The Leicester Diabetes Centre will stay at the General and we propose to leave the imaging service on the site as a direct access facility for patients referred by their GPs for x-rays. The City Clinical Commissioning Group is considering the location of urgent access GP care adjacent to the imaging centre; and longer term, the provision of GP services to service the new housing development.

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What land are you selling off at the General?

We are proposing to sell off the land on Hospital Close (currently residences) and some of the estate where the existing General Hospital sits. Some of the General site will be retained – for example the Diabetes Centre of Excellence, the imaging hub and some outpatient accommodation for future GP services. The Evington Centre will also remain on the site.

Where does the income go from the housing development?

The money from the sale of the land will come back to Leicester's Hospitals and this will be used to part fund the new hospital reconfiguration. The housing developer has to pay some money directly to the council to support public needs, this includes the roads surrounding the development, as well as consideration of the needs for schools and health services.

How will you make sure you get value for money for the public purse from the land sale?

Within the NHS there is specific guidance - Health Building Note 00-08 - Estate code, which provides detailed processes for the sale of land and property to ensure the most effective way in which to achieve value for money through disposals, including sharing the sale details with other public sector organisations.

Is it a good idea to sell off the land when the needs are rising for more health services?

Land will only be disposed of when it has been declared surplus and is planned through a comprehensive estates strategy. The Trust has more developable land at the Glenfield Hospital.

Is there going to be affordable housing?

The development opportunity of any surplus land has yet to be confirmed through a master planning exercise. However through the normal planning process with the local authority it is usual that a mixed development is required. These details would be produced by any future developer in conjunction with the planners.

Will there be key-worker housing for staff?

The type and style of any development will be made as part of the planning process. However the NHS is keen to support the inclusion of some key worker accommodation.

How will the facilities and environment be better for me as a consequence of the changes?

The services we relocate will be provided from either new build facilitates, or from refurbished accommodation. They will be designed to be fit for purpose, bright, airy and provide improved accommodation – more space, en-suites etc.

Do you only get the funding if you sell off the land at the General?

Yes, the funding rules were very clear, that we need to apply the outcome of the Carter review and identify land that isn't being used so it can be considered for housing. This is a national target that every NHS trust has to comply with, even if they don't want funding.

Maternity

Why are you closing St Marys? How have you tried to get more women using it?

Our plan is to close St Mary's Birthing Centre because it is so under-used and not in the most ideal location in the county to best serve the most mums. There is currently only one birth every 2 ½ days there and this has dropped in recent years.

We have actively been promoting St Mary's to all mums as one of our three birthing units, as is the home birth option. Regrettably, the number of births at St Marys has still continued to fall and we need there to be 500 births a year to make it sustainable.

We also know that it is not in the right location for the majority of mums – again a result of history rather than design

When will it close?

If through public consultation the decision is to close the unit, then we would not close until we had opened the new Maternity Hospital at the Royal Infirmary.

However, if there is a material change to the fabric of the building or if there are unforeseen staffing issues, either of which might challenge the safety of the service, or if the number of births dropped further, then we may have to seek support to close it sooner.

If we can't provide a safe service there it could lead to its closure without further consultation, and we would seek support from the Health Overview and Scrutiny Committee to do this. Even if such closure were necessary, then the alternative midwifery led birthing options – home births – birthing centres - would continue to be available.

Why are 500 births significant? What have been the figures over the past years and what is projected?

When considering the financial viability and sustainability, looking at births alone is not reflective of the wider value. The model of providing 24 hour cover for 130 births as oppose to 500 is more expensive per birth. In a bigger unit midwives have more opportunity to maintain skills and students will receive a more meaningful learning experience. There is a gap nationally in Midwifery Led Birthing Unit's between capacity (the number of births that can take place) and actual use, all of which are underutilised. If we can care for 500+ women then cost's per birth with the staffing models to support this will prove cost effective and sustainable.

How come with the number of births going up that you want to close the birthing unit in Melton?

The number of births at St Marys has dropped every year, last year there were only 131, and therefore this tells us that women are making a choice not to use the centre. However, in the consultation we are proposing to open a Midwifery Led Unit for 12 months at the General Hospital site, if we get over 500 births per year we will know that this is a service women want. At this stage nothing will change until we have been out to consult with the public about our proposals.

How many babies are born at St Mary's Birthing Centre each year?

Since 2008:

- 2008: 237
- 2009: 277
- 2010: 260
- 2011: 254
- 2012: 252
- 2013: 240
- 2014: 195
- 2015: 162
- 2016: 181
- 2017: 127

There is no evidence that big maternity hospitals provide better/safer care, so why do you want to axe the midwifery led birthing unit in Melton?

The bigger maternity units are obstetric led with alongside birth centres, in these birth centres 150 choose to have their babies at the Royal Infirmary and 800 at the General Hospital.

Melton Birthing Unit is safe for a certain criteria of women, as is home birth and alongside birth units. If women have risk factors then it is safer to deliver in an obstetric unit. We plan to give the public the option of relocating the stand alone facility to a location that is accessible to a greater number of women in Leicester, Leicestershire and Rutland.

We are not planning to close St Mary's on the grounds of safety or better care, but for sustainability and accessibility as only 131 women chose to deliver there last year.

How many women go to St Mary's Birthing Unit for after care, and what will they do if you close it?

In the last 12 months 384 women transferred into St Mary's Birthing Centre after giving birth in another hospital.

We plan on providing postnatal clinics and breast feeding clinics and the offer of telephone support. With the implementation of better continuity and personalised care the midwife can assess the on-going postnatal care needs. If women identify they need more support at home we have trained support staff that can provide this in their own home. If they have medical needs or their baby needs observation this will be accommodated within the service

How do the new reconfiguration plans support Better Births?

There will still be the same choices for women available; choice is about pathway of care not venue. We know that continuity of care is important to women and it is something we plan on developing further, and many of the continuity pathways are not affected by estate, it is however more likely to be successful with the single site as staff will be on one site and more available to see the women in their team.

We would continue to provide continuity to home births and if the public want the stand-alone unit at the General Hospital the pathway we are developing for Melton will work there as well. Women will continue to have personalisation in their choice of pathway.

Will the midwifery led birthing unit you plan at the General provide postnatal and breastfeeding care for mums?

We are not planning to have post-natal beds at the stand alone unit at the General Hospital as this is not a recognised model nationally for birth centres. We will provide postnatal, breastfeeding clinics and drop in's as part of these planned changes and we are developing models of care for the future.

Renal

Where is my dialysis going to happen if not at the Leicester General Hospital?

None of these plans affect the outpatient dialysis service and the unit at the General will remain. There are however issues with the current dialysis building; it is relatively crowded and there aren't enough individual rooms. Talking to patients and their friends and family, it is clear that easy access to inpatient and daycase facilities are important. Furthermore, the current location of the three dialysis units in Leicestershire results in a lot of travelling for people living in the west of the county.

Taken together, that means that the model of outpatient dialysis needs to be thought about but is not part of this plan.

If transplant is moving, what will happen to renal services?

This is, of course, a concern and subject to consultation the Trust is developing plans to move the in-patient renal service at around the same time that Transplant moves. This is right because the services are so interdependent. It makes perfect clinical sense for nephrology and transplantation to be at the Glenfield irrespective of the Intensive Treatment Unit bed move. People with kidney disease suffer disproportionately with heart and blood vessel issues. Looking after kidney inpatients alongside these other specialties affords us the opportunity to further improve the care we provide.

Are you consulting on renal services?

Yes, this will follow, but we will strongly project the clinical view that for smooth patient care renal inpatient services will best be provided at the Glenfield irrespective of the ITU bed moves.

You're splitting the service, are you making it less safe?

For this reason the trust has worked up plans for consultation that will see renal services move to the Glenfield. Extensive plans are being developed by the multi-disciplinary team (doctors, pharmacists, occupational therapists, nurses, dietetics, etc.) to manage the risk of splitting the service for a short period of time. Ultimately the joint service will be improved by being alongside cardiac services and vascular surgery.

Transport and access

How are you going to accommodate more parking?

For the Glenfield site the plans include the construction of a new multi-storey car park, for the LRI we will make provisions for maximising our current car parking capacity, but we envisage some future flexibility in the provision we currently purchase from external providers.

How many additional spaces will there be?

This will be subject to the outcome of our travel studies and plan that we are in the process of commissioning. It will be available for the consultation.

Are you planning on consulting on travel services for people considering the ageing population?

We will be using an independent company to carry out a full travel plan which will take account of all the users of the hospital sites, this plan will include public transport and will make recommendations about the best ways to support people to access the sites. This plan will be developed by a specialist company with expert knowledge and will take account of everyone's needs.

Hospital environment

The hospital sites are already big and very busy and hard for people to find their way around, how are the plans taking account of this?

We know that when people visit hospital they are anxious and worry anyway so the quality of the patient environment will be improve and be more welcoming and suitable for patients, their relatives and visitors and for staff. This will start when people arrive, particularly by car with

additional accessible car parking being created being created at Glenfield and Leicester Royal Infirmary. Welcome Centres will also be invested in to improve the experience of people getting around a very busy and complex building. Facilities developed through the building will mean that access is safe and easy to get around.

Staffing

How are you going to staff these new hospitals when there is a national shortage of nurses?

Our evidence of new facilities (Emergency Department and Vascular) shows that it is actually easier to attract staff to work in modern, purpose built buildings, so we are confident that this will help us to not only recruit staff but to also keep them.

Alongside all of these plans, it is crucial that you get your staffing right. How are you doing to improve recruitment alongside these plans to develop?

There are assumptions in our plan that improved facilities and less fragmentation of our services will have a positive impact on recruitment and retention particularly for nursing and medical staff.

We have seen improvements already in our ability to recruit to our new Emergency Department as well as a reduction in sickness levels. Analysis of the Emergency Department after the move also saw a demonstrable reduction in turnover and we therefore also expect to see a benefit in terms of improved retention.

We are also assuming that there will be more efficient working practices as we will realise the benefits of paperless offices and similar services provided on a single site. This will mean we can cope with a level of increased demand without increasing our staffing.

As part of a Leicester, Leicestershire and Rutland wide attraction and retention group we are also working on joint plans to improve our employer brand and promote the benefits of working in our local community. This work includes working with schools and education providers to market NHS careers and opportunities for apprenticeships.

We are maximising the opportunities that apprenticeships has afforded us in terms of introducing new career routes into healthcare professions such as nursing and healthcare scientists.

We are also expanding new roles into the service to do tasks which are suited to different roles such as Physician Associates and Nursing Associates. We are working closely with our local universities to develop pathways into the NHS. De Montfort University for example have introduced a second cohort of children's nurses that will begin to provide a new source of newly qualified nurses each March to supplement the cohort that comes out each autumn with the first graduates in March 2019.

Will you have enough staff to run the services you're looking to move/ expand?

There are many external issues impacting on our ability to recruit nurses in particular, such as Brexit and the removal of the nursing bursary. We recognise through our modelling that there will still be gaps in our nursing workforce to meet current demand, so we are taking the actions above to redress this.

As part of the reconfiguration programme we are developing workforce plans for each service in conjunction with clinicians to ensure we can develop robust and sustainable models of care. Each workforce plan looks at cover day, night and at weekends and will be developed to include new ways of working. There will be workforce efficiencies as services are re-profiled and we maintain services over a more sustainable footprint. Digitisation will also release some workforce benefits. We have also acknowledged through our experience of the Emergency Department and the move of our Vascular services that engaging with staff at all levels as early as possible is a critical factor is

managing any moves. A process of cultural audits and capturing the hopes and fears of the staff from services impacted by the changes we are planning are already well underway and action plans developed to address the concerns of staff. This early intervention will also reduce uncertainty and should lead to improved retention and improve our chances in recruiting successfully.

As we already mentioned above, we are working closely with both De Montfort and Leicester Universities to develop new pathways from apprentices, nurse associates, degree pathways for adult, child and midwifery fields of practice, as well as advanced practice programmes and masters level courses. Innovative solutions in areas like Paediatric Intensive Care have looked at using learning disability nurses and we have recently shared our experience nationally.

Although there are acknowledged shortages of qualified staff in areas like nursing, we have bucked the trend locally with midwifery and diagnostic radiographers where we have managed to recruit and retain again working with local universities, but also engaging midwives in developing new models of care and emphasising the value of professional and personal development with an on-going commitment to education and training.

Other services at Leicester Hospitals

What about dermatology outpatients – will that be moving from the General?

Yes, dermatology services will eventually move to the Treatment Centre on the General Hospital site.

What is going to happen to Neuro-Rehab?

In our plans this service will be moving to the Royal Infirmary.

Engagement

The events you coordinated in October and November 2018 didn't cover all communities in Leicester, Leicestershire and Rutland. What are you doing to reach other people?

In addition to the public events we are hosting in October and November 2018, we will also be undertaking a programme of outreach work.

The outreach work will take two differentiated approaches. We will reach out to communities particularly those comprising and/or representing people with protected characteristics to understand the potential impact of the proposals. We will particularly work through voluntary and community sector agencies and local support networks to involve these communities.

In addition, we will coordinate manned drop-in sessions situated in community venues where there is a reasonable footfall e.g. libraries. This will allow 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.

We will also be promoting the activities and discussing the proposals via the media – newspapers, radio and TV. We will also be communications via our website and on Twitter and Facebook.

Services in the community

The strategic aim is to keep more people at home for longer and this will require training and recruitment of staff. What steps have been taken in this regards, bearing in mind that the skills required will be akin to those of the 'District Nurse' (a capacity to work independently)?

We recognise the significant workforce challenges to deliver this transformational change to the way that we care for our population. Training will be a key part of this strategy and as our plans become clearer we are developing workforce plans that will support us to have the required workforce. Recognising shortages in the current workforce we will design new roles, train and develop existing staff and support all providers through an organisational development programme to support new ways of working. The details of these are still being worked up.

What happens to people discharged when they do not have housing or safe housing. This is a community issue?

We would not discharge patients to an unsafe environment and have a number of agencies we work with to support discharge. One of them is the Housing Enablement Service which has been supported by the Better Care Fund.