Agenda Item 2

Leicestershire County Council

LECESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – MONDAY 14 DECEMBER 2020

QUESTIONS SUBMITTED UNDER STANDING ORDER 34

The following questions are to be put to the Chairman of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee.

1. Question by Godfrey Jennings

In light of the Covid pandemic and limited awareness among the general public of the Better Hospitals for the Future consultation and that no community provision assurances have been given do you not think an extension of the consultation period should be considered?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following response:

"When looking at the current circumstances the world finds itself in, then in order to fulfil our duty and to continue to exercise our functions we have adapted our processes to achieve that objective. The use of technology to hold meetings, share information and promote the consultation has enabled a wider reach across communities. This activity has been combined with off-line activities to reach communities not digitally enabled. We are able to measure the majority of our activities confidently. This demonstrates that the vast majority of adults across Leicester, Leicestershire and Rutland will have had the opportunity to be aware of the proposals, often through multiple channels, and participate in the consultation process if they wish.

We are confident that our activities to date and the approach we have taken has allowed us to meet both our statutory and common law duties. Therefore we see no reason to extend the consultation period, which will close on 21 December 2020."

2. Question by Glynn Cartwright, Melton Mowbray

I, along with many others, am deeply concerned that the UHL Acute and Maternity Reconfiguration consultation process itself contravenes the Gunning Principle of those being consulted having sufficient information to respond appropriately to what is being asked of them.

Given that the proposals signify a particular loss of services to the communities of Melton Mowbray and Rutland specifically and generally to North East Leicestershire, East Leicestershire and South Nottinghamshire areas:

a) What steps have been taken to ensure information has been adequately provided in these population groups, about which exact services are going to be lost, especially with those who are not able to access online meeting facilities or use the internet frequently?

Reply by the Chairman:

The NHS bodies involved in this decision-making process have been quite clear what acute services they intend to move, why and the impact of the change, which means the Gunning Principle referred to has been met.

NHS England and Improvement run a thorough assurance process on all service reconfiguration programmes which are undertaking public consultation and, throughout this process, the CCGs have been advised by Gerard Hanratty of Browne Jacobson, who is a solicitor specialising in public law and service reconfiguration advice for the NHS. This ensures the CCGs have been advised on their compliance with both their statutory duties and common law obligations, including those set out in the Gunning Principles.

When looking at the current circumstances the world finds itself in, then in order to fulfil their duty and to continue to exercise their functions the CCGs had to adapt their processes to achieve that objective.

The pandemic has shown how technology can be used to involve and engage the public on a range of issues. The CCGs have adapted and adopted new ways of working including the use of technology which has enabled them to reach more communities. This is in addition to off-line communications and engagement activities in order to reach people not digitally enabled.

To reach people the CCGs have used a variety of both online and offline tools and techniques. These are set out elsewhere in the papers for this meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee and the Committee will further scrutinise the issue during the meeting.

b) Can you confirm the areas that have received a leaflet to their home addresses regarding the proposals, and explain why there has not been a leaflet provided to ALL households in LLR as promised, even at this late stage in the consultation process?

Reply by the Chairman:

The CCGs have undertaken solus door drops of an information leaflet to residential properties 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were sent a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, the CCGs are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors.

This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

However, it is important to recognise that the door-drop is only one small part of the overall awareness activities CCGs have undertaken, details of which can be found elsewhere in the papers for this meeting and the Committee will seek further reassurances during the meeting regarding this issue.

c) Can you outline the reasons the Clinical Commissioning Group have gone ahead with a consultation of this magnitude, during the restrictions of a global pandemic, when engaging with the issues at hand is more challenging for those whom it impacts, and many are more focussed on the problems caused by Covid 19?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following answer:

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

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

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

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

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

Intensive Care:

One of the biggest challenges faced preparing for the first COVID peak was to create enough adult Intensive Care Unit (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 its capacity in line with the peak, largely as a result of converting every available space with the right oxygen supply into makeshift ICUs and by suspending children's heart surgery so that we could convert children's ICU, into adult ICU.

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

In the reconfiguration plans it is said that UHL will create two 'Super ICUs' at the Royal and the Glenfield doubling capacity to over 100 ICU beds. Had these been in place at the time of the pandemic UHL's response would have been very different; they would have had enough ICU capacity with plenty to spare.

Children's Heart Surgery:

As mentioned above, UHL knew that COVID would require them to care for very many more adult patients on ICU. Mercifully children were 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 the Glenfield into an adult ICU. On balance we took the decision based on what would save the most lives, knowing that our children would still have their surgery albeit not in Leicester and as a consequence we could care for more of the terribly sick adults whose only hope was sedation and ventilation.

However in our reconfiguration plans we are going to create a standalone Children's Hospital at the Royal; the first phase completes in spring 2021. Had the Children's Hospital been built we 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 we were able to continue was for those emergency cases that without an operation within 24-72 hours would have been likely to die. In terms of cancer cases where patients are often immuno-compromised there was the added concern about bringing them into a hospital with positive COVID patients and the impact that this could have if, in their already poorly state they picked up the virus.

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

Impact on staff:

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

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

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

d) Can you explain why the removal of the postnatal facility along with the trial of the LGH birth centre is not specifically mentioned in the consultation documents, using misleading language of "relocation", instead of closure, which prevents people from understanding fully the impact of the proposals being consulted on?

Reply by the Chairman:

I have sought a response from the Clinical Commissioning Group/UHL and they have stated the following

"Our proposal and the consultation documents do include the relocation of the midwifery-led unit at St Mary's Hospital to Leicester General Hospital, where it will be accessible to many more women. While we are proposing to move the midwifery-led unit, we would maintain community maternity services 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. If someone has a complicated pregnancy, antenatal care would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

If the consultation shows support for a standalone midwifery-led unit run entirely by midwives, it would need to be located in a place that would be chosen by enough women as a preferred place of birth and ensures fair access for all women regardless of where they live in Leicester, Leicestershire and Rutland. It would also need to be sufficiently close to more medical and specialist services should the need arise.

This is important since it will provide more reassurance to women who may need to be transferred to an acute setting during or after birth. Transfer rates in labour and immediately after birth, according to the Birth Place Study, is currently 45% for first time mums and 10% for 2nd, 3rd or 4th babies.

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead we are looking for evidence that a clear trajectory for 500 births in subsequent years is likely to be achieved.

If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL."

e) Bearing in mind the future of St Mary's Birth Centre has been discussed for over 20 years (ref Ian Scudamore) and more particularly in the last 8-10 years, when did the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee first scrutinise the proposals?

Reply by the Chairman:

At its meetings on 14 December 2016 and 4 September 2018 the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee touched upon issues relating to St Mary's Birth Centre and the UHL Acute and Maternity Reconfiguration plans as part of scrutiny of the Sustainability and Transformation Plan/Partnership (STP). The Committee then began looking in more detail at the reconfiguration plans including the proposal to close St Mary's Birthing Centre at its meeting on 24 January 2020, and then held a further meeting on 15 October 2020 where explanations were sought regarding the proposals in relation to St Mary's Birth Centre.

f) At that time did the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee consult with any members of the public, in particular in the affected areas, for their views of the proposals?

If not why not and do you normally make decisions for the public on proposals of this magnitude without asking for their views?

Reply by the Chairman:

The consultation on the UHL Acute and Maternity Reconfiguration plans, including the plans for St Mary's Birthing Unit, is being run by the Clinical Commissioning Groups. The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee is a consultee therefore it is not required to carry out consultation with the public on this particular issue. The Committee has not made any decisions regarding the UHL Acute and Maternity Reconfiguration plans. The Committee's role is to scrutinise the way the consultation process is carried out and feed its own views into the consultation. However, the public are welcome to submit comments and questions to the Committee regarding UHL's reconfiguration plans and the Committee will raise those comments and questions with the CCGs/UHL on the public's behalf.

g) What was the outcome of the scrutiny of the proposals undertaken by the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee?

Reply by the Chairman:

The Committee has submitted comments both positive and negative to the CCGs and UHL regarding the Acute and Maternity Reconfiguration proposals and raised some areas of concern. The details of the issues raised are

recorded in the minutes of Committee meetings which can be found on the Leicestershire County Council website:
http://politics.leics.gov.uk/ieListMeetings.aspx?CommitteeId=1182
However, this scrutiny process is still ongoing and there has been no final outcome.

h) Is the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee acquainted with the paper written recently by Dr Ruane of DMU which suggests the suggestion of closing the SMBC in favour of a new birth centre at LGH is not sustainable?

Reply by the Chairman:

The Committee is aware of the paper written by Dr Ruane and it has been included in the agenda pack for this meeting.

3. Question by Louise Wilkinson

I stayed at St Mary's from the 28th September to 1st October, during this time the staff at St Mary's literally helped me to keep my baby alive through breastfeeding. I required hourly face to face support from the staff in St Mary's and would not have been able to feed my baby had I not been receiving post-natal support on the ward. How can you claim that mothers will be able to access the same level of post-natal support through community care and watching online videos after the closure of St Mary's? In the same situation would I be able to call a mid-wife to my house every hour during the night to help me feed?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following response:

“There is the full expectation that short term postnatal stays for uncomplicated pregnancies and births will be provided in both the proposed standalone midwifery led unit and in the birth centre running alongside the proposed new Maternity Hospital at Leicester Royal Infirmary. Taking this into account, and from looking at the details of patients using the facility, it is clear that in the overwhelming majority of cases it is more appropriate for those new mums to be recovering at home, away from the risks, including from infection, of being in a communal inpatient areas. From there they will be able to access support including from family and experience the essential mother and family bonding in familiar surroundings. Access to care can either be delivered in that home setting or through community-based drop-in type services.

Of course, we recognise that some mums require additional inpatient postnatal care for clinical reasons, either maternal or neonatal and, where this is the case, it is important that they are cared for in an appropriate medical environment. Under our proposals this would be provided from the new maternity hospital at Leicester Royal Infirmary.

Sadly we do not believe that it would be possible to provide this kind of service from a community location. Most significantly this is because of the requirement for around-the-clock 24/7 medical cover."

4. Question by Louise Wilkinson.

I live on Craven Street, please can you explain to me why I have not received a leaflet to my home explaining the planned changes and consultation process?

Reply by the Chairman:

The CCGs have undertaken a solus door drops of an A5 information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were set a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, we are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors.

This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

Industry standards dictate that feedback from these telephone calls would expect to establish a level of positive recall of between 40% - 60% to substantiate that deliveries have been completed to the standards expected. We are still receiving the community reports from this exercise, but at the moment the recall is within this range for communities across Leicester, Leicestershire and Rutland.

However, the door-drop is only one small part of the overall awareness activities the CCGs have undertaken. These are set out elsewhere in the papers for this meeting of the Joint Health Scrutiny Committee and the Committee will seek further reassurances regarding this issue during the meeting.

5. Question by Louise Wilkinson

At 22 weeks pregnant I had to travel by car to Leicester General Hospital as I was suspected of going into early labour- the journey took me over an hour. Please can you explain to me, if it's not acceptable for women in the city to travel to Melton Mowbray, why is it acceptable for women in Melton Mowbray to travel to the city, where there is increased traffic, surely this will add to the congestion?

Reply by the Chairman:

Reviews of maternity services have identified that the standalone birthing centre at St Mary's Hospital in Melton Mowbray is not accessible for the majority of women in Leicester, Leicestershire and Rutland. It is also under-used with just one birth taking place approximately every three days, despite attempts to increase this number. This means the unit is unsustainable, both clinically and financially.

The CCGs/UHL believe underutilisation of the unit may, at least in part, be due to concerns over the length of journey from Melton Mowbray to Leicester should mum or baby experience complications during the birth, as well as its relative inaccessibility to the majority.

The proposal would see the relocation of the midwifery-led unit at St Mary's Hospital to Leicester General Hospital, subject to the outcome of the consultation. While it is proposed to move the midwifery-led unit, community maternity services in Melton Mowbray would be maintained. It would be ensured that there is support for home births and care before and after the baby is born in the local community. If someone has a complicated pregnancy, antenatal care would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

Access at Leicester Royal Infirmary site where it is proposed to develop the new Maternity Hospital would actually be easier in future. This is because it is proposed to provide approximately 100,000-day case procedures and 600,000 follow up appointments done each year in a different way e.g., carried out closer to home in the community which is what patients say they want. More appointments will also be done remotely, over the phone and via the internet. Others will move to the new Treatment Centre at Glenfield Hospital

UHL are also creating extra parking spaces on site at both Glenfield and the Royal Infirmary so access and parking would be easier.

6. Question by Liz Warren

Has the Clinical Commissioning Group seen or asked for any evidence to support UHL's assertion that St Mary's Birth Centre is not cost-effective? If there is evidence can the Joint Committee request the CCG/UHL to publish it?

How can UHL justify the 500 births a year requirement for the midwifery unit at the General to be considered viable?

Reply by the Chairman:

I have put these questions to the Clinical Commissioning Groups and they have provided the following response:

"The Clinical Commissioning Groups have worked closely with UHL to develop these plans and supports the Pre-consultation Business Case, which was approved by the Clinical Commissioning Group Governing Body. The plans have also been independently reviewed by NHS England, as well as clinicians locally and regionally to test their appropriateness.

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 opposed 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 in Midwifery Led Birthing Unit's nationally 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 costs per birth with the staffing models to support this will prove cost effective and sustainable.

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead they are looking for evidence that a clear trajectory for 500 births in subsequent years is likely to be achieved.

If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL."

The Committee will further scrutinise this issue during the meeting.

7. Question by Kathy Reynolds

Neuro Rehabilitation services were for many years provided in Wakerley Lodge in the grounds of LGH. It was a 1980's purpose built centre with plenty of space both indoor and outdoor for therapy, wider corridors and moving space for wheelchairs, purpose designed bedrooms, bath/shower areas with hoists, a “gym”, and a central communal area for social and occupational activities. By 2016 it had been allowed to fall into such a poor state of repair that the patients were moved out on a “temporary basis” into Ward 2 at Leicester General Hospital, they are still there. This is a conventional ward, cramped for space and having none of the special facilities of Wakerley Lodge. Over the last few years, therapists have performed heroics with their disabled patients in these conditions. Is the Joint HOSC satisfied that the services formerly provided to severely disabled people at Wakerley Lodge Neuro Rehab Centre have been adequately considered in the reconfiguration plans for UHL? There is little evidence in the PCBC document to suggest it has. Does it not suggest the needs of these disabled people are of little import to those leading the reconfiguration?

Reply by the Chairman

I have sought reassurances from the Clinical Commissioning Groups and they have provided the following answer:

“The Reconfiguration team has worked with the Neurological Rehab and Brain Injury services concurrently and both were in agreement that to remain on an acute site that has access to ICU support was of paramount importance. The growing dependency between the two units within recent years also led to the request that the services be co-located as interdependencies between the two patient cohorts has benefits for the patient groups.

At the time of writing the Pre-Consultation Business Case the space identified at the Leicester Royal Infirmary site would allow for both services to provide facilities which would allow for the appropriate delivery of care that is necessary for the patients. However the clinical team during the consultation have been exploring whether the Glenfield might be a better option, because of the opportunity to access more open space to support rehabilitation. The clinical services along with patient representation will be involved in the design development.

The plans are being thoroughly reviewed as part of the process to ensure the users of the service get facilities that meet their needs. The final decision, taking on board the learning from the consultation, will be presented as part of the decision making business case for consideration by the CCG at their governing body.”

It is important that the assurances are followed up, so scrutiny will continue to review this service in our ongoing work programme.

8. Question by Bob Waterton

(a) The methodology underpinning the Total Net Present Cost calculations appears to be missing from the appendices to the PCBC. Please could you provide the methodology which has informed the 'bottom line' (ie the Total Net Present Cost) in Table 6.12 on page 163 of the PCBC. Specifically I wish to know precisely which costs and benefits have been included, what values have been assigned to each of these costs and benefits and how you have arrived at those values. In addition, I would like a clear statement on the period over which each of the costs and benefits have been assessed.

Reply by the Chairman

The Trust has used the Comprehensive Investment Appraisal Model as mandated by the Department of Health and Social Care. This identifies a methodology which is described in and consistent with the HM Treasury Green Book appraisal and evaluation in Central Government.

In line with the Treasury Green Book, costs have been discounted by 3.5% for the first 30 years and 3% thereafter to reflect the time value of money. Therefore the Net Present Cost of an additional item of expenditure is less than the total cost if it expended over a number of years beyond the present year.

Please see the Treasury Green Book for more detail on the modelling methodology – link below.

https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent#

Costs and Benefits

The financial modelling in all options uses the UHL 2019/20 recurrent Forecast Outturn as the “baseline” which was submitted to the CCG in September 2019 representing activity, workforce and finance assumptions for the 2019/20 financial year.

For each of the three options, this baseline was then adjusted for the financial impact of each option. These adjustments are described in Table 6.9 on page 161 of the PCBC with further detail provided below:

1. The clinical and overhead savings identified in the first six items in table 6.9 incorporate savings identified as a direct result of Reconfiguration and changes in models of care.

a. Option 3: savings are described in detail, including the underlying assumptions, in the table in pages 4-6 of Appendix AB.

b. Options 1 and 2: same themes as Option 3 with different values calculated due to still maintaining services across three acute sites and inherent inefficiencies.

Detailed as per excel spreadsheet provided.

2. Estates and Facilities savings represent the savings from vacating the Leicester General.

a. Option 3: outlined in the table in page three of Appendix AB.

b. Option 2: same value as Option 3 whereby the financial impact between maintaining 2.25 and 2 sites was considered minimal.

c. Option 1: Pro-rated to represent 50% of savings could only be achieved.

3. Estates and Facilities costs represent additional costs to maintain the new build and larger area at the LRI and Glenfield. These costs are similar in nature to cost savings from vacating the Leicester General and are detailed in the excel spreadsheet.

In addition to the specific costs and benefits described above, the options within the PCBC includes Societal and non-cash releasing benefits as reflected in table 6.10

The Net Present Value of Savings and Benefits as summarised in Table 6.12 in the PCBC are detailed below:

Area	Option 1 £m	Option 2 £m	Option 3 £m
Efficiencies	441	543	729
Estates Efficiencies	102	203	203
Non Cash Releasing Benefits			
Improvements in Staff motivation as a result of better facilities and care pathway also proxy for quality of care	41	83	123
Societal Benefits			
Carbon Emissions	2	2	2
Impact of ALOS reduction on economy	21	21	21
Multiplier impact on economy	350	440	456

Appraisal period

The appraisal period for each option was over a period of 67 years reflecting construction time and a 60 year period post construction. Costs for each

option have been identified in relation to Construction and Lifecycle costs for buildings and equipment.

(b) Please could you tell me if, when valuing the costs and benefits of the project, the following have been included in your costs:

- the cost of not having enough beds;
- the cost of additional travel time; details included in PCBC;
- the cost of the additional care which will be required of family members and friends from models of care which entail more care given in the patient's own home;

Medical care

the cost of losing staff through the reorganisation;

- the cost of maintenance for the life of the project;
- the cost of additional congestion on the roads arising from the proposed concentration of services at the LRI;
- the cost of out of hours care for deteriorating patients at the General Hospital following interim moves;

- the cost of not having enough beds;

Reply from the Chairman

The Pre-Consultation Business Case (PCBC) includes detailed bed modelling to take into account activity, growth in demand and the reconfiguration of services. All options have been evaluated on the same number of beds with the assumption, in line with bed modelling, that the Trust will have provide sufficient beds through Reconfiguration.

<u>The cost of additional travel time</u>

There is cost breakdown of additional travel time shown in the travel impact assessment in the PCBC Appendix X

<u>The cost of the additional care which will be required of family members and friends from models of care which entail more care given in the patient's own home</u>

The PCBC does not assume that there are any changes to models of care that require additional care of family members and friends.

The cost of losing staff through the reorganisation

In line with Trust policy, the Trust will look for all redeployment opportunities for staff which are impacted by the reconfiguration and changes in models of care. A transitional cost of £2 million per annum has been assumed for 5 years which will be used for any reorganisation costs.

The cost of maintenance for the life of the project

Lifecycle costs have been allowed for in the option appraisal of £623 million (£188 million discounted).

The cost of additional congestion on the roads arising from the proposed concentration of services at the LRI

The reconfiguration results in service moves from the Leicester General and across the two sites at LRI and Glenfield Hospital. The net impact of the reconfigured estate results in less patient activity at LRI and is therefore likely to result in less congestion.

The cost of out of hours care for deteriorating patients at the General Hospital following interim moves.

This was factored into the interim ICU business case previously.

(c) The Total Net Present Cost results in Table 6.12 show relatively small differences between the options (for example, it is £448,000 between Options 1 and 3). Please could you tell me, therefore, what the variances are around the TNPC for each of the options shown in Table 6.12 since significant variance is likely to eliminate the small differences between the option totals. Could you also, please, explain the level of confidence you have in the estimates for the Multiplier effects on the economy and for 'Improvement in Staff Motivation' since both of these are given the biggest number for Option 3 but both are very difficult to measure; different assessments may, again, eliminate the small differences between the TNPC option results.

Reply by the Chairman

The difference is £448 million not £448,000 which is a significant difference between the options.

The significant part of this difference is the cash releasing benefits of £389 million. This difference is caused by the need to maintain a significant element of multi-site working in Option 2, as more services would remain on the LGH site. These are broken down in table 6.9.

The multiplier effects relate to the level of capital investment and how that then has a consequential impact on the local economy. The higher the investment, the bigger the effect. The calculation has been based on evidence provided from other schemes and reviewed by NHSE/I and a prudent view has been taken on this. Further detailed work will take place in producing the OBC.

The staff motivation is a qualitative view quantified in relation to sickness absence and vacancies. Following the new Emergency Department at the LRI, there was a material improvement in staff turnover from approximately 15% to 6% (the Trust average is 8%) which provides confidence in the benefits within the PCBC**.**

It is important to note that the Total Net Present Cost is one consideration in the options appraisal. Other factors are taken into consideration in determining the preferred option including Value For Money and strategic fit. In terms of strategic fit, clinical sustainability underpins the PCBC to ensure safe patient care which is challenging whilst operating on three acute sites. Whilst the Treasury advises that all benefits and costs are quantified which is difficult and some elements do remain qualitative.

9. Question by Lorraine Shilcock

The WHO have been predicting the increase in pandemics for a few years now. Due to many reasons worldwide. Covid will not be the only pandemic in the next 40 years. There is a lack of pandemic preparedness in the Pre-Consultation Business Case. There are no plans for redesign of new developments in design and capacity to future proof these new buildings to cope with pandemics. Will this increase costs and by how much?

Reply by the Chairman

Whilst not explicitly spelt out, the current proposal will respond well to a future pandemic. For example, the plans include:

– a doubling of Intensive Care Unit capacity. During the peak of the Covid-19 pandemic UHL had to use some theatres, and move children's heart intensive care to Birmingham for a period of time. UHL needed in excess of 70 Intensive Care beds at the peak; the scheme will provide over 100 Intensive Care beds.

– In addition, the development of the new treatment centre allows UHL to split a lot of planned care from the emergency care. This means that at times of peak emergency pressure UHL can maintain their planned activity.

New buildings also have a more generous footprint. This will make it easier to separate flows of people and goods around the new buildings.

10. Question by Jean Burbridge

Can you estimate the percentage of the 440,000 households in Leicester, Leicestershire and Rutland to which a Solus leaflet drop was arranged actually received the leaflet (Building Better Hospitals)

Please clarify the size of the leaflet -was it the A4 6 page “Summary Document? What percentage of the total delivery was checked by GPS? Who was the 'Independent Third Party who telephoned random households to “backcheck” delivery and how many households gave answers?

Reply by the Chairman

The CCGs have undertaken a solus door drops of an A5 information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were set a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, we are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors.

This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

Industry standards dictate that feedback from these telephone calls would expect to establish a level of positive recall of between 40% - 60% to substantiate that deliveries have been completed to the standards expected.

We are still receiving the community reports from this exercise, but at the moment the recall is within this range for communities across Leicester, Leicestershire and Rutland.

However, the door-drop is only one small part of the overall awareness activities the CCGs have undertaken. These are set out elsewhere in the papers for this meeting of the Joint Health Scrutiny Committee and the Committee will seek further reassurances during the meeting.

11. Question by Sarah Seaton

Please could you tell me what your calculations are in terms of:

(a) reduction in footfall and car movements on or around the site of the LRI once the departments moving off the site have moved (eg elective care);

(b) the increase in footfall and car movements on and around the site of the LRI as departments are moved to the site (eg the larger maternity provision);

and

(c) the net position.

Reply by the Chairman

The footfall to each site has been calculated using actual activity data with the baseline of 718,289 from the year period 2019/20. The figures are overall footfall and do not distinguish the mode of transport used. The following data is provided as part of the sustainable travel solutions in the Travel Action Plan.

a. Reduction in footfall to the Leicester Royal Infirmary in year 2025/26 once departments have moved off the site is forecast as 384,084

b. Increase in footfall to the LRI in year 2025/26 once departments have moved on to the site is forecast as is 23,109 taking the numbers up to 407,193

c. The net difference in footfall is 23,109

12. Question by Ann Cowan

(a) What proportion of the £24m to be cut from Prescribing and Continuing Healthcare will be applied to cut Continuing Healthcare (CHC) from patients who by definition are eligible? Page 94 of Appendix C states "A saving of 2% per annum for CCGs focussed on Prescribing and Continuing Healthcare costs equating to £24m"

I have some personal experience of CHC funding and know only too well that without it, personal finances rapidly run out, leaving local authorities with large care bills.

(b) Can you provide a breakdown of the £48m cuts proposed by "Transformation savings relating to Community Services Redesign, Planned Care and Urgent Care Transformation of £48m"? Additionally please provide a breakdown of the "£26m of savings which are still to be identified which will be delivered through transformation in the latter years of the plan (from 2021/22 onwards)" just 4 months away. (Page 94 of the LLR 2019 plan)

Reply by the Chairman

The Clinical Commissioning Group state as follows:

"The world has changed over the last 9 months. We are now working in a different environment and therefore we need to revisit our plans from 2019, to ensure that they are still appropriate given the learning of the NHS during the pandemic. This will include reviewing services and finances. A new Operational Plan will be developed in 2021.

A central tenet of our overall clinical strategy for health and care services is and always has been about delivering as much care as we can as close to where patients live as is practically possible.

We have already started discussions in some local areas as the first step to developing plans for what local health and care services should look in communities across Leicester, Leicestershire and Rutland. These plans would include discussions relating to GP provision and the usage of local infrastructure, such as the community hospital, to deliver a greater range of services locally.

We are committed to continuing these conversations over the coming months. Our focus will be on working with each local community to identify services that can and should be delivered locally through the development of new local services , potentially in partnership with other local public sector bodies, should that be deemed to be preferable or more viable. When we have developed the plans as an outcome of these conversations, we will be able to quantify the care that will be provided in the community and the cost of delivering this care."

13. Question by Giuliana Foster

Can you quantify the extra amount of care which will be undertaken in the community by 2025 as a result of changing hospital use and new models of care and how much it will cost to deliver this care in community settings'?

Reply by the Chairman

Please see my response to question 12 above.

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