Agenda Item 2

Supplementary Questions JHOSC 14 December

1. 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:

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."

Supplementary Question from Glynn Cartwright

Glynn Cartwright submitted that the transfer rate for first time mothers was actually 36.3% not 45% as stated by the Clinical Commissioning Groups and that for 2nd and 3rd time mothers the transfer rate was under 10%. He questioned whether the Clinical Commissioning Groups were serious about allowing St Mary's Birth Centre to succeed or whether they were trying to end the use of birth centres such as St Mary's altogether?

The Chairman asked the Clinical Commissioning Groups and UHL to cover these issues as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and advised Glynn Cartwright that he would receive a written answer to his supplementary question after the meeting.

Answer from CCG

The consultation document described the proposed Midwifery Led Unit at Leicester General Hospital as running as a pilot for 12 months to test public appetite for this service, with an indicative target of 500 births per year. This is the approximate number of births each year required to make standalone units viable. 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 approximately 500 births per year will be achieved in subsequent years.

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 NEPU Birthplace Cohort study (please see link to actual source of key findings https://www.npeu.ox.ac.uk/birthplace/results) states:

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

- *For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned FMU births and 40% for planned AMU births*

The figures for St. Mary's Birth Centre are below:

	2018/19			
	Women Booked for Delivery	**150**	of which:-	
Less:	Intrapartum Transfers	13	First time mothers	12
			Multiple pregnancies	1
	Women Recorded as Delivered	**137**		
Less:	Post Natal Transfers	9	First time mothers	5
			Multiple pregnancies	4
	Women Receiving Post Natal Care at St. Marys	**128**		
	Total Transfers	**22**	**Total Transfers of First Tme Mothers**	**11.3%**
	Total Transfers %	**14.7%**	**Total Transfers of Mothers Delivered Before**	**3.3%**
	2019/20			
	Women Booked for Delivery	**181**	of which:-	
Less:	Intrapartum Transfers	29	First time mothers	24
			Multiple pregnancies	5
	Women Recorded as Delivered	**152**		
Less:	Post Natal Transfers	19	First time mothers	10
			Multiple pregnancies	9
	Women Receiving Post Natal Care at St. Marys	**133**		
	Total Transfers	**48**	**Total Transfers of First Tme Mothers**	**18.8%**
	Total Transfers %	**26.5%**	**Total Transfers of Mothers Delivered Before**	**7.7%**

2. 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.

Supplementary Question from Liz Warren

Liz Warren asked if she could see the facts and figures which supported the assertion that St Mary's Birth Centre was not cost-effective?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Liz Warren would receive a written answer after the meeting.

Answer from CCG

- The average cost associated with a normal classified delivery at St. Marys is 33% higher than the average cost of a normal classified delivery at Meadows and Orchard Birth Centres.
- St. Marys births (normal deliveries) equate to a 55% loss against tariff income, compared to a 5% deficit in the other two Birth Centres.
- There is an additional circa. £20k per annum cost associated with EMAS ambulance transfers from St. Marys (based on the 48 transfers that occurred in 2019/20) which is not factored into the delivery cost comparison.

Please see **appendix 1** for table.

3. 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.

Supplementary Question from Kathy Reynolds

Kathy Reynolds asked when would firm plans be in place for permanently relocating the Neuro Rehabilitation services following the closure of Wakerley lodge.

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals", stated that Liz Warren would receive a written answer after the meeting and re-iterated his commitment to have Neuro Rehabilitation Services as a specific agenda item at a future Committee meeting.

Answer from CCG

It is important that we follow due process and do not pre-empt the outcome of the consultation process by putting firm plans in place which don't take account of what people have told us during the consultation.

Having completed the consultation it is important that the feedback and insights from people are reported on and understood 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 CCGs at their governing body meeting in early Spring.

4. 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, a copy of which is filed with these minutes.

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.

Supplementary Question from Bob Waterton

Bob Waterton referred to table 6.10 of the Pre-Consultation Business Case which set out the proposed benefits as a result of improvements in staff motivation which the Business Case stated would remain the same for each year. He questioned whether the benefits should in fact be expected to decline over time and over what period these benefits were expected to be accrued.

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and stated that Bob Waterton would receive a written answer after the meeting.

Answer from CCG

The benefit from improvements in staff motivation is considered to be a recurrent benefit, which is realised upon completion of the reconfiguration programme and then maintained. Following the new Emergency Department at the Leicester Royal Infirmary, there was a material improvement in staff turnover from approximately 15% to 6% (the Trust average is 8%), which provides confidence in the benefits described within the Pre-Consultation Business Case.

Whilst this will be reviewed and revalidated as part of the Outline Business Case development, there is no reason to believe that the benefit will decline. In addition to the new buildings the business case reflects that the buildings will be fully maintained across their life cycle.

(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.

<u>The cost of losing staff through the reorganisation</u>

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.

<u>The cost of maintenance for the life of the project</u>

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

<u>The cost of additional congestion on the roads arising from the proposed concentration of services at the LRI</u>

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.

Supplementary Question from Bob Waterton

Bob Waterton stated that the implication of a policy of low bed numbers at the Leicester Royal Infirmary over the next decade, together with the loss of community hospitals, meant that more of a burden would be placed on the community. He submitted that the answer given by the Chairman did not take account of the costs of community care and questioned whether the cost of community care should be incorporated into the calculations?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and stated that Bob Waterton would receive a written answer after the meeting.

Answer from CCG

Whilst we believe that the bed calculations and the additional beds included in the plans will stand us in good stead beyond 2024 we will, as always, keep our bed planning under constant review. If absolutely necessary we maintain the flexibility to increase bed numbers within our planned estate.

The plans to build better hospitals for the future for Leicester, Leicestershire and Rutland stand independently of other proposals. Even if we were planning to do nothing to improve and expand on the services provided in the community closer to where people live, these plans are the right ones.

However, during 2018 and 2019 we undertook separate engagement to understand what matters most to people about community services. The feedback from this work aligns with the central tenet of the overall clinical strategy for health and care services which is 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 the local community to identify services that can and should be delivered locally.

(c) The Total Net Present Cost (TNPC) results in Table 6.12 of the Pre-Consultation Business Case 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 Leicester General Hospital 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.

Supplementary Question from Bob Waterton

Bob Waterton questioned whether further detailed work on the multiplier effects could establish that the multiplier effects would significantly reduce over time due to leakages from the local economic system?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity

Reconfiguration Consultation: “Building Better Hospitals” and also stated that Bob Waterton would receive a written answer after the meeting.

Answer from CCG

The multiplier calculation used in the PCBC has been based on evidence provided from other NHS capital schemes and reviewed by NHS England and NHS Improvement and deemed to be a prudent view of the impact.

The multiplier will be reviewed as part of the Outline Business Case development which will include using benchmark information together with guidance from NHS England and Improvement, Department of Health and Social Care and The Treasury.

Whilst the Outline Business Case review may reduce or increase the calculation compared to the assumption used in the PCBC, any change in the multiplier assumption will have a relative impact on each option being assessed.

5. 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.

Supplementary Question from Lorraine Shilcock

Lorraine Shilcock stated that being pandemic ready was not just about providing more intensive care/elective care capacity but also related to the design of buildings. She asked whether the proposed design of the hospital buildings would be modified to achieve pandemic readiness and requested details of what other aspects of the £450 million proposals would help the system to become pandemic ready?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Lorraine Shilcock would receive a written answer to her supplementary question after the meeting.

Answer from CCG

We are not working in isolation of NHS England and NHS Improvement on this project. We are working closely with people from Simon Corben's NHS Estate Team on the proposals for Leicester's and the design of the building looking at all aspects including the pandemic.

Further information regarding to the proposals and the pandemic is including in an open letter written by a range of UHL clinicians available at: https://www.betterhospitalsleicester.nhs.uk/news-and-media-centre/news/our-proposals-and-covid/

6. 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.

Supplementary Question from Jean Burbridge

Jean Burbridge questioned what was meant in the reply by “Solus delivery is not an exact science” and submitted that surely the leaflets were either delivered or not. She also asked how much the CCGs paid for the solus delivery and what compensation was sought for the leaflets not being delivered to all areas the first time?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building Better Hospitals” and also stated that Jean Burbridge would receive a written answer to her supplementary questions after the meeting.

Answer from CCG

A solus leaflet distribution is one delivered by individuals or teams completely independent of any other marketing material. The leaflet is not in an envelope or addressed to a household. The total cost of the delivery was £70,600

Solus deliveries are 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.

We raised concerns from residents with our delivery partners, who provided a discount on a secondary delivery (the cost of which is included in the above total) as well as 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 a third-party 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. Our community reports from this exercise show the recall is within this range for communities across Leicester, Leicestershire and Rutland.

The net difference in footfall of 23,109 has been calculated by deducting the expected increase in patient footfall on the Leicester Royal Infirmary site by 2025/26 (407,193) from expected reduction in patient footfall (384,084).

These figures therefore take account of the fact that the Treatment Centre at Glenfield Hospital will receive the majority of planned care patients, but Leicester Royal Infirmary will receive the majority of women for maternity care.

7. 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

Supplementary Question by Sarah Seaton

Sarah Seaton asked for further detail on what was covered by the 23,109 increase in footfall referred to in part c of the answer and asked for further clarification on the net increase/reduction in footfall/traffic overall. The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building

Better Hospitals" and also stated that Sarah Seaton would receive a written answer to her supplementary questions after the meeting.

Answer from CCG

The net difference in footfall of 23,109 has been calculated by deducting the expected increase in patient footfall on the Leicester Royal Infirmary site by 2025/26 (407,193) from expected reduction in patient footfall (384,084).

These figures therefore take account of the fact that the Treatment Centre at Glenfield Hospital will receive the majority of planned care patients, but Leicester Royal Infirmary will receive the majority of women for maternity care.

8. 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

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."

Supplementary Question from Giuliana Foster

Giuliana Foster pointed out that the Pre-Consultation Business Case repeatedly stated that hospital plans were premised on new models of care and extra work in community settings and questioned whether this extra care had been quantified and costed?

The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building Better Hospitals” and also stated that Giuliana Foster would receive a written answer to her supplementary question after the meeting.

Answer from CCG

A central tenet of our overall clinical strategy for health and care services in Leicester, Leicestershire and Rutland is and always has been about delivering as much care as we can as close to where patients live as is practically possible. We are therefore committed to developing local plans that move appropriate services from the acute hospitals into a community setting. These plans are separate from the proposals for the acute and maternity reconfiguration.

We have already started discussions in local areas as the first step to developing these local plans for what local health and care services should look like. These plans would take into account the concern of communities including travel and transport, GP provision and the usage of local infrastructure, such as the community hospital.

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. We will also discuss with people the use of technology to provide certain aspects of pre-planned care in a different way. This care would be provided when it is appropriate for the patient and could reduce the stress of attending a consultation in person due to reduced travel, reduced spread of infection and would support people to self-care.

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.

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