Paper 3

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

To: Dr Janet Underwood
Chair of Healthwatch Rutland

6 November 2020 (by email)

Thank you for your letter of 8 October with regard to the acute and maternity services configuration at Leicester's hospitals.

Outlined below are the answers to the questions you have raised in your review document.

Bed numbers

1. Given that, despite efficiency plans etc the waiting list will only reduce by 3013 patients by 2023/24, should the plans be modified to better meet demand and reduce waiting times?

The Pre-Consultation Business Case beds model has been designed to ensure that University Hospitals of Leicester and the Leicester, Leicester and Rutland health economy are able to meet the national key waiting times standards (such as treatment within 18 weeks). The overall waiting list position is dependent on the size of the trust and the population (e.g. within London, one major Acute Trust has a waiting list of over 100,000, but can still meet key waiting list standards).

2. What are the current and projected numbers for inpatient activity?

A) Taking into account what we have learnt over the last 18 months from the original Pre-Consultation Business Case to this final version and recognising our new opening bed position, the projected bed requirement is 2,333 beds by 2023/4. This is the unmitigated number i.e. without efficiencies factored in.

In calculating this we took the following into account:

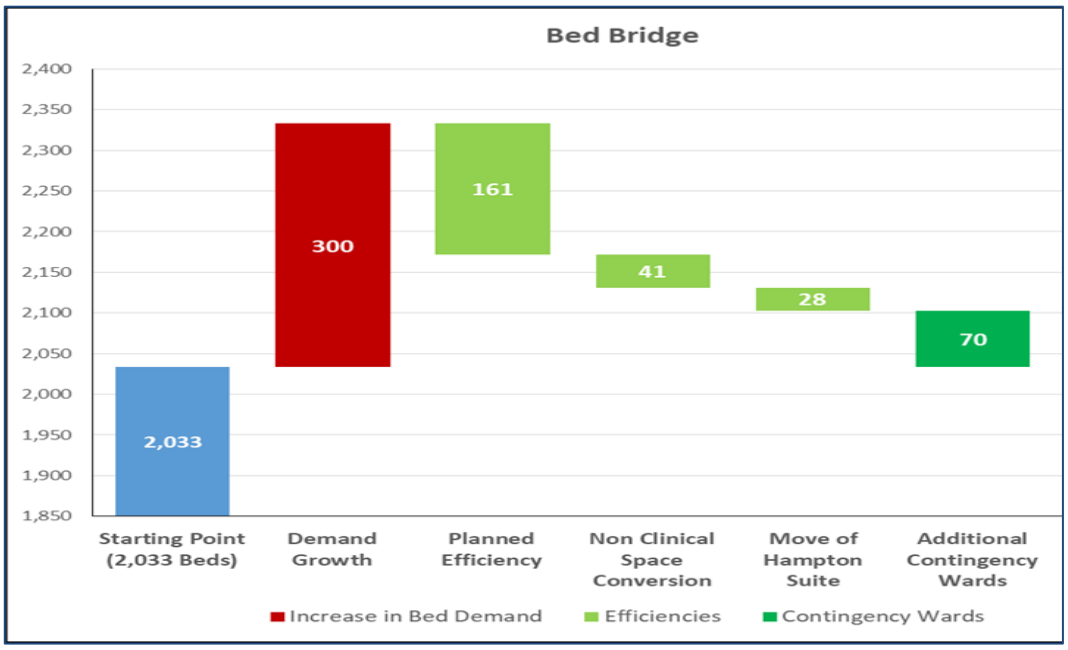
- Opening bed position as of winter 2019 is **2,033** beds.
- Activity growth assumptions have increased from **1.4% to 3%** in line with those contained in the LLR system Long Term Plan. Emergency activity across the UK has grown between 2% and 6%, with the majority of peer Trusts showing a growth rate of c4%. Whilst UHL has noted year on year growth rates of between 4-5% in the first 2 quarters of 19/20, this includes significant pathway changes which have influenced the growth rate. To mitigate against the impact of these pathway changes UHL has modelled and applied a growth rate of 3%. This growth rate is also higher than most of our regional peers have included in their plans.
- Occupancy levels of **93%** for electives, 93% day case and **90%** emergency which will allow more flexibility to improve flow. Noting that the BMA review of the busiest months over winter 2017/2018 suggested that an 85% non-elective occupancy level is unachievable, (British Medical Association, "Beds in the NHS" 2018), we have applied a more realistic occupancy rate of 90% for emergency. Our efficiency plans are targeted to improve flow to enable us to reduce our non-elective occupancy rate.

The impact of this change in occupancy levels and growth assumptions means the unmitigated **bed gap is 300** beds at its highest during peak winter months in 2023/4. Conversely during summer months the bed gap reduces significantly.

To bridge the gap we have two types of intervention; the first is designed to increase actual physical bed capacity above the current baseline of 2,033 whilst the second will reduce the number of beds required through improvements to clinical pathways and changes to length of stay, (LoS).

As a result, over the life of this plan we will both increase the actual bed stock by 139 beds (approx. 4 wards) and decrease the requirement for beds by a minimum of 161 through pathway and LoS improvements. Taken together these interventions bridge the gap.

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



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

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

It is important to recognise that for planning purposes we have deliberately taken a conservative approach to the modelling and used the minimum efficiency expectation to define our future bed requirements. In other

words if we over achieve against what GIRFT / Model Hospital and our own internal assumptions indicate, there is potential for a beds upside and or reductions in occupancy.

The high level breakdown of efficiencies is shown in the table below. The detail scheme by scheme is set out in appendix below.

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

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

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

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

Transfer of services: The Royal Infirmary is home to the 'Hampton Suite', a therapy led reablement ward. Given the nature of the patient cohort, this service could be equally successful if based at the General Hospital. The move would free up **28 acute beds.**

Additional contingency: Taken together the conservative efficiency improvements and the increase in physical beds amounts to 230 beds worth of capacity over and above the 2019 opening position of 2,033 beds. This leaves a potential residual gap **of 70 beds** if, for example, efficiency improvements are actually at

the lowest calculated and / or activity growth is greater than 3%. As such the Trust will, if necessary, address this in later years through CRL funding for what equates to 2.5 wards.

The variables impacting the future bed requirements for an acute Trust are numerous. Equally, for a Trust of the size of Leicester even the smallest change to activity / efficiency projections makes a significant difference to bed requirements. For example a half day improvement in length of stay releases 38 beds worth of capacity. Conversely a 1% increase in activity would result in the need for 76 more beds. (For more detail on the upside and downside scenarios see appendix).

That said we are confident that the current model aligns with the direction of the NHS Long Term Plan, insomuch as there are no heroic assumptions over bed reductions; a conservative approach to efficiencies and a pragmatic approach to the creation of extra capacity.

3. What is the impact of Covid-19 on RTT and what are now the projections for numbers on the waiting lists?

A) COVID-19 has had a significant impact on the RTT position in particular due to the reduced elective work during wave one. As an organisation we focused on ensuring we still maintained treating urgent and cancer demand. To do this we used the national guidance of categorisation of these patients. We have now been able to start to improve this positon by working closely as a system to ensure we are utilising all resources in the most efficient way, this includes the independent sector and Alliance sites. For the non-admitted patients we were able to control the waiting list size by using alternative solutions to treat patients such as a large shift to virtual clinics. We have also seen a significant reduction in referrals from GPs which has meant we have not seen the full effect of waiting list growth to the requirement to reduce our activity through wave 1 of COVID-19. Overall we are still predicting a growth in waiting lists through winter, but we are expecting to recover this through Spring/Summer 2021.

4. What is the timing of extra bed provision as the building work will take several years to complete?

The timing of the extra bed provision will be concurrent with the overall development.

Travel

1. Can more recent data be provided than 2014/15?

See below for response

2. How have the travel times been calculated, at what time of day and in what road, weather and vehicle congestion conditions?

See below for response

3. What are the possible mitigations being suggested for those in Rutland who are the most negatively impacted, other than 'go elsewhere'?

See below for response

A) The Travel Impact Assessment is a modelling tool used to indicate likely impacts and where additional considerations may be required. The data used was the only complete data that was available at the time.

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The Travel Plan is the document that provides the detail and which informs travel requirements, this has been published on the consultation website. This document was updated in 2019 and included surveys undertaken with the public, patients and staff. This document provides the baseline from which the new Travel Action Plan is being developed.

The Travel Action Plan is being produced in partnership with an independent transport consultancy (Go Travel Solutions) with involvement from a wide range of stakeholders from across LLR including Healthwatch Rutland. Those areas that were highlighted in the travel impact assessments as being adversely impacted (e.g. with longer travel times to access services that are moving as a result of the Acute Reconfiguration Plans) will be included in the travel considerations.

Going elsewhere

1. Will alternative hospitals be able to accommodate this potential influx of patients given their own demand pressures?

A) In producing the Pre-consultation Business Case (PCBC) the CCGs were required to discuss proposals for Leicester's hospital with NHS partners on the borders of Leicester, Leicestershire and Rutland. They received letters of support, which form Appendix AE and can be viewed on the consultation website: https://www.betterhospitalsleicester.nhs.uk/key-documents-and-links/

Maternity

1. What is the accuracy of time distances between post codes and do these times reflect peak or off-peak road congestion times and weather conditions?

Please see response above relating to travel.

2. The PCBC states that an MLU will conditionally remain at LGH. Will the new LRI Maternity unit be built with sufficient capacity to accommodate extra women should LGH be closed?

A) Yes, the new Maternity Hospital would provide sufficient capacity to accommodate women should the Midwifery Led Unit at the Leicester General Hospital site not have sufficient number of births.

3. Which year will be the 'pilot year' for an MLU at LGH?

A) The development of a standalone Midwifery Led Unit to Leicester General Hospital is dependent on the outcome of the consultation. If the consultation indicates that expectant mothers would use the unit then it would open within approximately twelve months of the new Maternity Hospital opening at the Leicester Royal Infirmary. It is proposed that the trail period for the centre is twelve months to see if it is viable with a minimum of 500 births per year. There are no plans to close St Mary's Birthing Unit prior to the new Unit opening

4. Why are the data for LE15 9 and PE9 incomplete?

A) Please refer to the answer provided in the Travel section above.

Haemodialysis

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1. How many Rutland patients will be negatively impacted in terms of travel times by the relocation of the haemodialysis unit?

A) The consultation includes proposals for two new haemodialysis treatment units in addition to the current units in Loughborough and Hamilton. When we have evaluated the feedback from the consultation we will understand from residents of Leicester, Leicestershire and Rutland the impacts of the proposals and where the public feel a new unit should be. It is at this point that a decision will be made. It is only at the stage, when we know where the new unit would be placed, that we can fully answer this question.

2. *What are the reasons for not retaining a haemodialysis unit at Leicester General Hospital if it is to become a Community Hub?*

A) UHL has engaged with patients using the haemodialysis service. It is as a result of those conversations that we have reached the current proposal to develop two new haemodialysis treatment units located at Glenfield Hospital and other somewhere to the south side of the city. The consultation provides the opportunity for current service users and public to tell us where the new unit should be.

3. Could a haemodialysis unit be a viable option in Rutland as part of 'care close to home'?

A) Rutland is placed so that it is possible to be served by dialysis units in Leicester (Leicester General Hospital or Hamilton), Peterborough or Grantham. Enhanced provision within Northamptonshire may also be beneficial. A menu of dialysis options discussed with people needing dialysis includes peritoneal dialysis and home haemodialysis. Both options and transplantation have been taken up by many patients in Rutland.

4. If the two new haemodialysis units are to be at Glenfield Hospital and south of the city and no satellite unit provided in Rutland, will there be sufficient capacity for Rutland patients to use the Hamilton dialysis unit if it is nearer for them?

A) Yes, this is offered now and would continue. However, as previously stated, the location of additional haemodialysis treatment units will only be known after the feedback from the consultation has been evaluated and a final decision made.

Care close to home

1. Should the public be expected to comment on the consultation survey before the results of Community Service Redesign work (specifically in relation to services and beds at Rutland Memorial Hospital), upon which it seems to be predicated, are known?

A) While this consultation does not include community services such as Rutland Memorial Hospital, we recognise that no part of the health service works in isolation from another part. We believe that care and treatment provided by all NHS and social care services need to wrap around the individual – which means meeting the needs in as responsive and holistic way as possible. Our Model of Care, published in the Consultation Document, sets out the principles for the four stages of care – self-care, help and empowerment, primary care, integrated neighbourhood teams and care for the acutely unwell is consistent with the principles of the NHS Long Term Plan. Our acute proposals are an integral part of this Model of Care and are at an advanced stage. The public have been asking to be consulted on them for quite some time. After we received an indication that £450 million would be allocated to transform services, it was critical for

us to give people their say on the plans in a timely way, so that we do not risk losing the money and the opportunity for improving care for local people.

With regard to the future of community services in Rutland, we had hoped to engage with Rutlanders – as well as other communities – during the earlier part of the year to together develop local plans for what local health and care services should look like in their area. This plan 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. This is a central tenet of our overall clinical strategy, which is to deliver as much care as we can as close to where patients live as is practically possible

This hasn't been possible in the way we had hoped because of Coronavirus. However, we are committed to picking up these conversations in earnest in the coming months. In the meantime, and to reassure you, I want to be clear that the CCG does not have any plans to close Rutland Memorial Hospital. Rather, our expectation is that discussions will focus on working with the local community to identify services that can and should be delivered locally through the refurbishment of the hospital or the development of new facilities, potentially in partnership with other local public sector bodies, should that be deemed to be preferable or more viable.