STP, BCT & UHL Reconfiguration Update

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Executive Summary

Context

In order to provide a vision for transformation across the whole health economy, this paper provides an update on the Leicester, Leicestershire & Rutland (LLR) Sustainability and Transformation Partnership (STP) / Better Care Together (BCT) Programme which sets the context for UHL's Reconfiguration Programme.

The LLR STP describes how the local health and social care system plans to restore its financial balance by the 2022/23 financial year through new ways of working. The STP builds on the work developed as part of the BCT programme but with clearer focus on implementing system priorities. Crucially, it makes UHL's case for national/external capital investment and access to transformational funding to support its Reconfiguration Programme. In August 2018, partners across LLR published a summary document: Next Steps to Better Care in Leicester, Leicestershire and Rutland.

UHL's Reconfiguration Programme is an ambitious and complex undertaking which has been established in order to deliver both the broader system priorities within the STP and the Trust's strategic direction and clinical strategy. It is important that the Trust Board has visibility of progress in delivering the STP, since the assumptions on transformation in the STP underpin the Reconfiguration Programme. The Trust Board therefore need to be able to provide appropriate challenge to ensure there is sufficient assurance associated with activities undertaken to achieve the desired future state.

Questions

1. What progress has been made since the last Trust Board?

Conclusion

The following progress has been made:

Sustainability and Transformation Partnership (STP)

1. A number of engagement events are planned which will take the key elements of both STP and UHL reconfiguration plans out to local communities across Leicester, Leicestershire and Rutland for comment and discussion.

Reconfiguration Programme Funding

1. The process to access the capital required to progress with our Reconfiguration Programme is continuing to plan. We have not been advised on the timescales for the announcement of the outcome of the capital bids, other than there is expected to be an announcement around the time of the Autumn Budget on the 29th October 2018.

2. The NHS England Regional Assurance Panel took place on the 10th October at UHL. The panel Chair was very complimentary about the high standard of the Pre Consultation Business Case. The meeting was very positive, and all LLR attendees were able to contribute to the discussion.

3. The plan for the completion and approvals process of the Pre-Consultation Business Case (PCBC) is outlined in the main report.

East Midlands Clinical Senate - Maternity

4. As described last month, the maternity reconfiguration proposals were reviewed and approved by the East Midlands Clinical Senate in January; however there was evidence in relation to obstetrics and neonatal care that had not been reviewed and which required consideration by the senate.

5. The East Midlands Clinical Senate met via conference call on the 28th September to review the evidence UHL had submitted. All the senate questions were fully answered by the UHL team. Following the meeting, the previous maternity senate report was updated with an addendum to reflect this latest positive panel outcome and demonstrated that the clinical senate supported the proposals.

Progress with the Business Case Approval of the Interim ICU and Associated Clinical Services Scheme

6. UHL senior leadership team attended the follow-up joint Health Overview and Scrutiny Committee (HOSC) on the 28th September. At this second meeting an updated report was written and presented to the joint HOSC that was co-authored by the CCGs and UHL which included clear legal statements as to why it would not be appropriate for a consultation exercise to be undertaken as this stage in the process.

7. After a full and frank discussion between all parties, the chair of the Joint HOSC presented a motion that the members unanimously agreed. Within the detail of the motion it concluded the committee recognised the clinical case and believed that the CCG's and UHL have now fulfilled their statutory duty to consult scrutiny.

8. As responsibility for consultation lies with the CCGs, the CCG management teams discussed and agreed the way forward at the Commissioning Collaborative Board on the 18th October (Appendix A). The Board unanimously supported the recommendations and remain committed to the decisions already made by the Governing Bodies in the approval of the Full Business Case in July 2018, but also agreed that the interim ICU scheme is included in the upcoming engagement events.

9. The ICU Full Business Case was approved at the National Resource Committee on the 16th October; we are now waiting for final approval from the Department of Health and Social Care (DHSC).

Patient and Public Involvement (PPI)

10. The Reconfiguration Programme values PPI and in particular the opportunities for co-production with UHL Patient Partners A regular update will be provided to the Trust Board on the PPI involvement undertaken within the Reconfiguration Programme; each month we will focus on a specific project and show how our Patient Partners have supported the work of the Project Boards.

11. Following the Trust Board PPI Thinking Day, the Reconfiguration team and a number of Patient Partners met on the 1st October to discuss and develop the PPI aspects of the Reconfiguration communications plan. The meeting discussed the range of opportunities that public involvement fulfils, and that it is broader than just engagement with the UHL patient partners.

12. The Reconfiguration Team agreed to describe the role that we would foresee the patient partners fulfilling within the individual projects. In the meantime, the Reconfiguration programme is a major part of the engagement events being held across Leicester, Leicestershire and Rutland in the next few weeks as described above.

Programme Risk Register

13. The latest Reconfiguration Programme risk register remains current from the latest board meeting. The highest scoring risks are detailed at the end of this report.

Input Sought

The Trust Board is requested to:

- **Note** the progress within the Reconfiguration Programme and the planned work over the coming months.

For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

   a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

   b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Described in the report]
4. Results of any **Equality Impact Assessment**, relating to this matter: [A full EIA is being completed as part of the Pre-Consultation Business Case]
5. Scheduled date for the **next paper** on this topic: [06/12/18]
6. Executive Summaries should not exceed **4 sides** [My paper does comply]
7. Papers should not exceed **7 sides.** [My paper does not comply]

Section 1: Sustainability and Transformation Partnership (STP)/ Better Care Together

1. The Better Care Together Programme will address the issue of consultation. Whilst formal consultation on the reconfiguration programme can only take place at a point where funding is agreed at a national level, the partnership has recognised that there needs to be far more engagement with the public, staff and stakeholders in the near future than there has been over the last 12 months.

2. We are committed as a system to greater involvement of patients, the public and stakeholders in the proposed changes – particularly those that are likely to result in significant changes to the way in which services are delivered.

3. As such, a number of events are planned which will take the key elements of both STP and UHL reconfiguration plans out to local communities for comment and discussion. These events are planned to take place between 5pm and 7.15pm on the following dates:

    - Monday 29 October, Loughborough Town Hall, Market Place, **Loughborough**, LE11 3EB
    - Tuesday 30 October, Peepul Centre, **Leicester**, LE4 6DP
    - Thursday 1 November, Civic Centre, Burton Street, **Melton Mowbray**, LE13 1G
    - Wednesday 7 November, Lyric Rooms, Lower Church Street, **Ashby**, LE65 1Ab
    - Wednesday 14 November, Eyres Monsell Club and Institute, Littlejohn Road, **Leicester**, LE2 9BL (drop in session)
    - Thursday 15 November at The Three Swans Hotel, 21 High Street, **Market Harborough**, LE16 7NJ
    - Monday 19 November, Rutland County Council, Catmose Street, **Oakham**, LE15 6HP
    - Monday 26 November, Sketchley Grange Hotel, Burbage, **Hinckley**, LE10 3HU.
    - Tuesday 27 November, De Montfort University – To Be Confirmed

4. The purpose of these events will be to inform communities in Leicester, Leicestershire and Rutland about the acute, maternity services and community services reconfiguration plans, set in the context of the Next Steps for Better Care Together. It will provide an opportunity for patients, the public and wider stakeholders to hear more about the underpinning detail of the rationale for the proposed changes, what it would mean in practical terms for services currently being provided from the Leicester General Hospital site in particular. It will also give the public the opportunity to raise any questions or concerns that need to be addressed as we move through the next stages of the programme and towards formal public consultation. The event will also be the opportunity to discuss specifically the consolidation of level 3 intensive care and dependent services.

Section 2: Reconfiguration Programme Board Update

Reconfiguration Programme Funding

1. The process to access the capital required to progress with our Reconfiguration Programme is continuing to plan.

2. We understand that the STP Capital Bid for £367m, which was submitted along with the LLR STP Estates Strategy on the 16th July for consideration in the wave 4 national capital funding round, has been reviewed nationally. We have not been advised on the timescales for the announcement of the outcome of the wave 4 STP capital bids, other than there is expected to be an announcement on capital around the time of the Autumn Budget. The Autumn Budget is on the 29th October 2018.
3. The NHS England Regional Assurance Panel took place on the 10th October at UHL. The key lines of enquiry were received on the afternoon of the 8th October following a pre-meeting between the NHS England panel members where they had reviewed the Pre Consultation Business Case (PCBC) and evidence bundle.
4. The themes they wanted to focus on in the meeting were understanding how our reconfiguration case was different from the one presented in 2015/16 which was much wider and included the community hospitals; understanding any interdependencies with the community hospital review; what work is already happening in UHL Trust in relation to digitisation and what pre-consultation engagement is taking place across LLR.

5. At the assurance panel the Chair was very complimentary about the high standard of the business case. The meeting was very positive, and all LLR attendees were able to contribute to the discussion.

6. A formal report summarising the panel discussion has been received, this includes a number of clarification points that we are responding to by the 6th November. Following confirmation that the panel are satisfied with our responses, the PCBC will progress through the next stages of the assurance process, as detailed in the approvals programme below.

East Midlands Clinical Senate - Maternity Update

7. As described last month, the maternity reconfiguration proposals were reviewed and approved by the East Midlands Clinical Senate in January; however there was evidence in relation to obstetrics and neonatal care that had not been reviewed and which required consideration by the senate.

8. The East Midlands Clinical Senate met via conference call on the 28th September to review the evidence UHL had submitted. The UHL representatives (Ian Scudamore, Jonathon

Cusack, David Yeomanson, Elaine Broughton and Justin Hammond) were able to fully answer the senate's questions and provided them with the assurance they required.

9. Following the meeting, the previous maternity senate report was updated with an addendum to reflect this latest positive panel outcome and demonstrated that the clinical senate supported the proposals.

PCBC Approvals Programme

10. The plan for the completion and approvals process of the PCBC is outlined below. Completed actions are marked in green on the timetable below. Dates highlighted in purple are indicative, and allow time for feedback between assurance panels. Since the last Trust Board the dates for the National NHSE Assurance Panel and the National NHSE Investment Committee have been confirmed.

Action	Lead	Completion Date
Procure support to write the PCBC	Sarah Prema	27-Apr
Strengthen Workforce Plan	Louise Gallagher	20-June
Robust activity model across LLR including Bed Bridge and activity to Alliance - 5 years +	Sarah Prema	20-June
Submit Draft STP Capital Bid	Nicky Topham	22-June
Submit Draft LLR Estates Strategy	Darren Kerr	22-June
Issue Senate papers	Justin Hammond	28-June
Clinical Senate	John Jameson	5-July
UHL Trust Board Approve Capital Bid	Paul Traynor	12-July
Submit STP Capital Bid	Nicky Topham	16-July
Submit LLR Estates Strategy	Darren Kerr	16-July
UHL robust Models of Care	Jane Edyvean	31-July
Draft 1 PCBC following Senate Feedback	Nicky Topham	31-July
PCBC support at CCG Commissioning Collaborative Board	Sarah Prema	16-Aug
Page Turn of PCBC with NHSE/I	Sarah Prema	17 Aug
Issue Papers for Regional NHSE Assurance Panel	Nicky Topham	26-Sep
Regional NHSE Assurance Panel	John Adler/ Paul Traynor	10-Oct
Respond to NHSE Regional Feedback	Nicky Topham	6-Nov
National NHSE Assurance Panel (Oversight Group for Service Change and Reconfiguration (OGSCR))	Nigel Littlewood	4-Dec
Respond to NHSE National Panel Feedback	Nicky Topham	11-Dec
National NHSE Investment Committee	Paul Watson	18-Dec
Respond to NHSE Investment Panel Feedback	Nicky Topham	15-Jan
NHSI Resources Committee	Dale Bywater	12-Mar
DHSC / Treasury/ Ministerial Approval	TBC	TBC
Commence Consultation	Richard Morris	TBC

Progress with the Business Case Approval of the Interim ICU and Associated Clinical Services Scheme

11. At the last Trust Board we reported that members of the UHL senior leadership team attended the joint Health Overview and Scrutiny Committee (HOSC) on the 4th September, however this meeting did not conclude the discussion and a further meeting was arranged for the 28th September. At this second meeting an updated report was written and presented to the joint HOSC that was co-authored by the CCGs and UHL which included clear legal statements as to why it would not be appropriate for a consultation exercise to be undertaken as this stage in the process.
12. After a full and frank discussion between all parties, the chair of the Joint HOSC presented a motion that the members unanimously agreed. Within the detail of the motion it concluded the committee recognised the clinical case and believed that the CCG's and UHL have now fulfilled their statutory duty to consult scrutiny. Despite this they also recommended that in the interest of openness and transparency the CCGs and UHL pause implementation of the planned ICU changes and undertake public consultation before continuing with the proposals.
13. As responsibility for consultation lies with the CCGs, the CCG management teams discussed and agreed the way forward at the Commissioning Collaborative Board on the 18th October. The presented paper (Appendix A) confirmed that the CCGs remain committed to the decisions already made by the Governing Bodies in the approval of the Outline Business Case in November 2017; and the Full Business Case in July 2018; and having taken legal advice do not propose to formally consult on the proposals at this late stage. The Board unanimously supported the recommendations and agreed that the interim ICU scheme is included in the upcoming engagement events.
14. The ICU Full Business Case was approved at the National Resource Committee on the 16th October; we are now waiting for final approval from the Department of Health and Social Care (DHSC). Assuming we get DHSC approval; we plan to let the construction contracts at the end of November once the engagement events have been completed.

Patient and Public Involvement (PPI)

15. The Reconfiguration Programme values PPI and in particular the opportunities for co-production with UHL Patient Partners A regular update will be provided to the Trust Board on the PPI involvement undertaken within the Reconfiguration Programme; each month we will focus on a specific project and show how our Patient Partners have supported the work of the Project Boards.

16. Following the Trust Board PPI Thinking Day, the Reconfiguration team and a number of Patient Partners met on the 1st October to discuss and develop the PPI aspects of the Reconfiguration communications plan. The meeting discussed the range of opportunities

that public involvement fulfils, and that it is broader than just engagement with the UHL patient partners. They also discussed the opportunity of including other patient and public groups who have direct experience of using specific hospital services e.g. kidney dialysis groups and the Maternity Voices Partnership.

17. The Reconfiguration Team agreed to describe the role that we would foresee the patient partners fulfilling within the individual projects, which will include the opportunity for patient partners to help project managers understand and design how involvement and communication would work best within their project.

18. In the meantime, the Reconfiguration programme is a major part of the engagement events being held across Leicester, Leicestershire and Rutland in the next few weeks as described above.

Section 3: Programme Risks

19. Each month, we report in this paper on risks which satisfy the following criteria:
    a. New risks rated 16 or above
    b. Existing risks which have increased to a rating of 16 or above
    c. Any risks which have become issues
    d. Any risks/issues which require escalation and discussion

20. The latest Reconfiguration Programme risk register remains current from the latest board meeting. The highest scoring risks are detailed below:

Risk	Current RAG	Mitigation
There is a risk that the scale of transformation required is not delivered resulting in a failure to operate out of the capacity provided within the Reconfiguration Programme.	16	Efficiency programmes have been further developed by the CMGs and therefore there is a confidence in delivery.
There is a risk that the back office, training and R&D budget allocations identified in the DCP are insufficient to re-provide all affected services.	16	Scoping Brandon Unit to assess refurbishment requirements and identifying other office options. Identifying number of staff to be displaced. Trust wide 'Agile Working' policy and approach being drafted to drive new ways of working including IT equipment and hot-desking.
There is a risk that the solutions to enable required decant of construction space either not	16	The overall program is reviewed and progressed with the space planning team, significant decant space identified in DCP (Brandon Unit, Mansion

Risk	Current RAG	Mitigation
identified in a timely manner or not available at all.		House) and planned as a project work stream. Decant space to be funded as part of DCP overall costs.
There is a risk that changes in other parts of the system such as Primary Care and Social Care create greater competition for limited workforce supply such as healthcare assistants and advanced clinical practitioners.	16	Develop LLR wide process including; Strategic Workforce Planning, OD, training and education and staff mobility. Ensure alignment with strategic and operational planning through Reconfiguration Programme and alignment with business as usual.
There is a risk that the programme capital budget allocated to equipment will be insufficient as a consequence of a change in the accounting rules.	16	Each project within the programme has a detailed equipment schedule which informs the overall cost plan. Use of specialist equipment advisors to identify if there alternative procurement methods that can help mitigate the increasing costs. The purchase of new equipment is managed within the budget alongside optimising the reuse of current equipment.

Input Sought

The Trust Board is requested to:

- **Note** the progress within the Reconfiguration Programme and the planned work over the coming months.

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

COMMISSIONING COLLABORATIVE BOARD MEETING

Paper D

Title of the report:	**Consolidation of level 3 ICU and dependent service moves within Leicester's Hospitals**
Report to:	Commissioning Collaborative Board
Section:	Public
Date of the meeting:	18th October 2018
Report by:	Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG
Sponsoring Director:	Toby Sanders, Managing Director, West Leicestershire CCG Sue Lock, Managing Director, Leicester City CCG Karen English, Managing Director, East Leicestershire & Rutland CCG
Presented by:	Toby Sanders, Managing Director, West Leicestershire CCG Sue Lock, Managing Director, Leicester City CCG Karen English, Managing Director, East Leicestershire & Rutland CCG

Consolidation of level 3 ICU and dependent service moves within Leicester's Hospitals

Background and brief summary

1. In 2014/15 University Hospitals of Leicester NHS Trust (UHL) presented plans to consolidate level 3 Intensive Care ICU) services, currently provided at each of three acute sites in Leicester, on to the Leicester Royal Infirmary (LRI) and Glenfield facilities. This was on the basis that maintaining services across three sites was unsustainable and inefficient, primarily because of a lack of suitably qualified clinicians to maintain safe services at all three.

2. At that time plans were supported by commissioners. Health Overview and Scrutiny Committees (HOSC) for Leicester City and Leicestershire County were also consulted in early 2015.

3. Leicestershire County Council agreed that the proposals would improve patient experience and outcomes and would therefore not be in the interests of residents to insist upon formal public consultation.

4. The City Council noted that UHL had determined it was necessary to proceed with the proposal without engaging in a full public consultation exercise, as they felt this was in the best interests of patients in order to provide ICU facilities after December 2015. The committee also requested periodic updates on the proposal and the consequences of the changes.

5. Rutland County Council was not consulted until April 2018 due to an oversight but, in any event, endorsed the plan to consolidate ICU at the LRI and Glenfield sites.

6. After the consultation with the Leicester City and Leicestershire County HOSCs in 2015, UHL commenced the process of obtaining capital to undertake the necessary works. This could not be immediately completed due to a national capital funding moratorium at the time.

7. In 2017 when additional funding was made available (through Sustainability and Transformation capital funding) it became possible to implement the plan and procure contractors to undertake the necessary building works.

8. Following on from securing funding in principle, the relevant Outline Business Case (OBC) to move ICU beds and dependent services (Hepatobiliary, Colorectal Surgery, Emergency General Surgery and Transplant) was approved by UHL's Board and the three CCG Governing Bodies in public meetings in November 2017. The Full Business Case (FBC) was subsequently approved by the Trust and CCGs in public board meetings in July 2018.

9. During the latter part of the summer the issue was raised with Joint HOSC as to why no formal consultation had taken place. It was argued that the removal of level 3 ICU services from the General Hospital effectively pre-judges future planned consultation of the wider reconfiguration of Leicester's acute hospital estate.

10. This matter was discussed at Joint (Leicester, Leicestershire and Rutland) HOSC meetings on 4th September and 28th September. At the first of these meetings UHL set out the clinical case for change, including the ongoing urgency.

11. At the second meeting the CCGs and UHL set out their collective position in relation to a question from HOSC as to whether or not they should now consult on the issue prior to building works commencing. The question posed by the Joint HOSC was on the basis that the length of time passed since the original proposals were put forward and approved in 2014/15 mean that the situation was not as clinically urgent as they had been originally led to believe.

12. Legal advice received on this matter was very clear in stating that this would not be possible. This is because to do so would contravene the Gunning Principles, specifically that consultation should take place while proposals are still at a formative stage. Given that decisions were taken in 2015, 2017 and 2018 this would clearly not be the case.

13. Furthermore, any elongation of the process would lead to a continuation of the current clinical risks, which remain as great today as they were in 2015. Additional costs would also be incurred to the scheme build as a result of any delay, whilst there is uncertainty as to whether the national capital would continue to be available to us.

14. At the meeting on 28th September the CCGs and UHL apologised for having missed opportunities to have kept the public and other stakeholders more informed about progress of the scheme since decisions were taken in 2015, 2017 and 2018. However, the NHS organisations stated their view that to consult at this very late stage would not be appropriate for the reasons stated.

15. The Joint HOSC considered the above and noted that the CCGs and UHL had fulfilled their obligation to consult with the respective HOSCs. The Joint HOSC also recognised the strong clinical case for change, but nevertheless recommended that a consultation should now take place.

16. Although the recommendation of the Joint HOSC is not binding upon the CCGs it is important that the commissioners properly consider their position and next steps.

Clinical case for change

17. UHL has three ICUs, one on each site. This triplication of services is unsustainable and inefficient; the biggest risk is the lack of suitably qualified clinicians to maintain safe level 3 ICU services (level 3 being the highest level of Critical Care for the sickest patients) across the three sites.

18. This is compounded by the fact that nationally and locally patients are becoming older, sicker and more complex, requiring more ICU capacity but without the doctors in training to staff that capacity.

19. For some considerable time the Intensive Care Unit (ICU) at the Leicester General Hospital (LGH) site has faced significant operational difficulties. In November 2014 the scale of the risk to the level 3 services at LGH was first highlighted and escalated within the Trust by the clinical team. The department had experienced medical staff recruitment and retention issues across all grades which meant that the future was difficult in terms of maintaining the level of ICU service provision. This was driven by:

    - Reduced dependency level for the sickest patients at LGH. This restricted opportunities for critical care staff to maintain their skills in providing care for the most critically ill patients;
    - Due to the lower acuity of patients the middle grade doctor rota at the unit at LGH could no longer be filled with suitable trainee posts
    - Changes in the way medical training for intensive care staff was structured led to the distribution of training posts to other units to ensure that they are exposed to sufficiently complex patients to meet their training requirements
    - Recruitment to substantive intensivist posts at LGH had been attempted on multiple occasions but had failed, largely due to the loss of training designation and the reduction in patients' acuity.

20. At the same time an external report commissioned in 2014 concluded that there would be substantial benefits to merging the units to create centralised larger units and that the extent of these benefits could not be overstated.

21. More recently, Care Quality Commission Inspection reports for the three hospital sites were published in January 2017 incorporating inspections of the critical care units. Critical care units at GH and LRI were rated as "good" across the board, whilst the LGH rated as "requires improvement" for the "safe" domain.

22. The report referenced some key factors particularly in relation to the quality of the environment within the LGH critical care unit:
    - A cramped layout and lack of clinical space;
    - An inability to prepare drugs away from the bedside, in accordance with best practice;
    - Side rooms that are used for the isolation of patients have no gowning lobbies;
    - There is limited space around bed areas;
    - There are no bathroom, shower or toilet facilities for patients on the unit;
    - There is a lack of storage space on the unit.

23. To ensure the continued safe service provision at LGH during the period since the issue was raised in 2014, a series of temporary actions were put in place. These include:
    - Recruiting to substantive and locum non-trainee middle grade Doctor posts to support safe provision of the level 3 service;
    - Changes in consultant anaesthetist job descriptions to support more flexible working
    - The appointment of internal locums to cover consultant vacancies;
    - Consultants acting down on shifts to cover junior doctor rota deficits;
    - The use of bank or agency staff for junior doctor or nursing vacancies;
    - Ongoing dialogue and engagement with clinicians over long term strategic plans for intensive care.

24. Above all, the service has been maintained over this challenging period because the staff have regularly gone beyond what could reasonably be expected of them to make sure that the unit remains open and safe until the level 3 service moves can be enacted.

25. Whilst the actions outlined above have helped to ensure the continued delivery of a safe service at LGH for the time being, the service remains fundamentally unsustainable in the long term. The discretionary effort displayed daily by staff cannot and should not be counted on any longer than is absolutely necessary. The daily risk is that any additional loss of key clinical staff would further destabilise the unit.

26. Conversely, the benefits of the planned consolidation of level 3 ICU will improve the workforce experience for all staff. Specifically, for the medical staff and the ICU consultants, it will mean they are no longer trying to cover three units with too few people. This in turn will give trainee intensivists better access to their educators, and will help support recruitment and retention in what is a very competitive market for ICU clinicians.

27. Further, the transfer of level 3 ICU and dependent services from the LGH will also improve the Trust's ability to accommodate demand and reduce elective cancellations by increasing the total number of ICU beds and separating emergency from elective work via the consolidation of day case activity at the LGH site.

Impact on wider plans for hospital reconfiguration

28. Concern has been expressed that the ICU and related moves are the "thin end of the wedge" and that they will make the transfer of further services from the Leicester General Hospital inevitable, thus undermining the integrity of future public consultation about these wider changes. This is not the case, although it is undoubtedly consistent with the overall strategic direction of travel.

29. The planned ICU changes have been designed in a way that does not make further changes inevitable or unavoidable. This is essential because: a) we have not yet consulted the public on further changes, and b) we do not have the funding in place for the wider scheme or have a timeframe for it.

30. The wider scheme is progressing well, including an even more substantial improvement to ICU which will see a doubling of capacity. This major hospital reconfiguration will be subject to full public consultation but that consultation is not permitted to start until the £367m capital investment has been approved in principle by Government.

31. The services being transferred in addition to level 3 ICU itself as part of these planned moves are those that rely regularly on level 3 ICU support. This includes Hepatobiliary, Colorectal Surgery, Emergency General Surgery and Transplant.

32. For information, following the planned consolidation of level 3 intensive care and dependent services, the bulk of the clinical services currently provided at the Leicester General Hospital will remain, namely:

    - brain injury unit
    - younger disabled unit
    - neurology
    - diabetes clinical service and research centre of excellence
    - gynaecology
    - maternity
    - orthopaedics
    - rheumatology
    - stroke rehabilitation
    - sports medicine
    - therapy services
    - urology
    - psychology
    - rehabilitation
    - palliative care
    - older people's mental health
    - cognitive behaviour therapy
    - personality disorder

33. The services remaining at LGH may occasionally require level 3 support and the Trust will therefore continue to provide and staff a level 3 ICU stabilisation bed at the LGH along with a transfer service. Both of these will be available 24/7. In the unlikely event of two or more patients requiring level 3 ICU support at LGH at the same time, escalation procedures will be in place to safely cope with this situation. It is important to recognise that level 2 High Dependency Unit (HDU) beds will remain at the General Hospital site.

HDUs are wards for people who need more intensive observation, treatment and nursing care than is possible in a general ward but slightly less than that given in intensive care.

Legal advice

34. Legal advice has been sought from Browne Jacobson LLP in relation to this matter, specifically in relation to whether UHL can proceed to build the required infrastructure and then move the level 3 ICU and dependent services from Leicester General Hospital without now having a public consultation.

35. From the perspective of our legal advisors, in order to answer this question, one of the first matters to consider is whether in undertaking a public consultation at this very late stage, the requirements of the 'Gunning Principles' can be met. These are:

- Consultation must take place at the time the proposal is still at a formative stage,
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response,
- Adequate time must be given for consideration and response,
- The produce of consultation must be conscientiously taken into account.

36. The simple answer to the above question regarding the Gunning Principles with regard to any public consultation is 'no', because the Trust and the CCGs have made a decision and have now approved both an Outline Business Case and Full Business Case and, indeed, a procurement process has been undertaken to appoint contractors to undertake the works. We are simply not at a formative stage.

37. The fact is that a decision was made back in 2015 that the level 3 ICU services had to move from Leicester General Hospital. Put simply, any attempt to undertake a public consultation now would be viewed as pointless because it is apparent that the decisions of both the CCGs and the Trust have been made and both the local authorities and public are fully aware of that fact.

38. To be clear, the legal advice obtained by the CCGs and the Trust is that a public consultation now would not add anything to the process as the decisions have already been made and the outcome would therefore be predetermined.

39. The Trust and the CCGs have also considered the question of whether the inability to meet the Gunning Principles now invalidates the earlier decision to consolidate the level 3 intensive care services. Again, the legal advice we have received states that the answer to that question is also 'no', because a decision was made in 2015 in the absence of public consultation and two of the local scrutiny committees were consulted at that time, while the third was consulted (and endorsed the same position) at a later time.

Risks and possible impacts

40. As explained to the Joint HOSC at its meeting on 28th September 2018, the Trust would face a significant increase in costs in the event of delay which would be unaffordable. A delay of six months has been calculated to increase costs by approximately £830,000, comprising building cost inflation and cost of changing the plan. This is because of the

interdependency of this project with the planned relocation of the East Midlands Congenital Heart Centre, the latter having a fixed national deadline.

41. However, in practical terms the delay would likely be considerably longer than this. This is due to the fact that, in order to fulfil the requirements of the Gunning principles, the CGGs and UHL would be required to resile earlier decisions – thereby returning the programme to Strategic Outline Case (SOC) stage.

42. A conservative estimate of the total length of time it would take to rerun the process to reach this point again is a minimum of 12 months. This timeframe presumes that national capital funding which is earmarked for the scheme would continue to be available to us, for which there is no guarantee.

43. As currently configured, if further delay caused the ICU at the General Hospital to become unsustainable, for example through the loss of key clinicians, the activity could not be absorbed at either the LRI or Glenfield because these ICUs are already operating at capacity. This could mean approximately 1,800 patients would therefore need to travel to acute Trusts outside of Leicestershire for their surgery. Aside from the obvious inconvenience to patients and their families, this would mean a loss of £15m to the Trust's income, weakening the Trust's financial position, while there is also not the spare capacity at other centres to absorb this volume of patients.

Plans for full public engagement

44. The CCGs and Hospital Trust have always recognised the strong desire of patients, the public and stakeholders to participate in a discussion about the wider reconfiguration of Leicester, Leicestershire and Rutland's acute hospitals.

45. At the end of August the local Sustainability and Transformation Partnership (STP), known locally as Better Care Together, published its Next Steps document. This set out local progress over the last 18 months and restated future priorities.

46. Key issues contained within that document will be subject to formal public consultation at an appropriate point in time. This will include plans for the reconfiguration of the city's hospitals, and maternity services including St Mary's birthing unit in Melton Mowbray.

47. A detailed pre-consultation business case is currently going through appropriate local and national governance processes. We are committed to putting this into the public domain as soon as it is practicably possible.

48. Unfortunately, as stated earlier, national planning guidance means that it is not possible for us to begin formal public consultation on the issues set out above until we are in a position where we have some surety over the availability of the capital needed to realise our ambitions. At the moment we are not able to give a clear indication of likely timescale for the conclusion of the process as there is not a specific national timetable for this.

49. However, we are committed as a system to greater involvement of patients, the public and stakeholders in the proposed changes – particularly those that are likely to result in significant changes to the way in which services are delivered.

50. To commence this process, the CCGs and Trust are planning a full engagement programme during late October and November to share more widely the plans for acute hospital reconfiguration, maternity services and some elements of community services.

51. These events are planned to take place between 5pm and 7.15pm on the following dates:

- Monday 29 October, Loughborough Town Hall, Market Place, Loughborough, LE11 3EB
- Tuesday 30 October, Peepul Centre, Leicester, 5pm – 7.30pm
- Thursday 1 November, Civic Centre, Burton Street, Melton Mowbray, LE13 1GH
- Wednesday 7 November, Lyric Rooms, Lower Church Street, Ashby, LE65 1AB
- Wednesday 14 November, Eyres Monsell Club and Institute, Littlejohn Road, Leicester, LE2 9BL
- Thursday 15 November at The Three Swans Hotel, 21 High Street, Market Harborough, LE16 7NJ
- Monday 19 November, Rutland County Council, Catmose Street, Oakham, LE15 6HP
- Monday 26 November, Sketchley Grange Hotel, Burbage, Hinckley, LE10 3HU.

52. The purpose of these events will be to inform communities in Leicester, Leicestershire and Rutland about the acute, maternity services and community services reconfiguration plans, set in the context of the Next Steps for Better Care Together.

53. It will provide an opportunity for patients, the public and wider stakeholders to hear more about the underpinning detail of the rationale for the proposed changes, what it would mean in practical terms for services currently being provided from the Leicester General Hospital site in particular. It would also give the public the opportunity to raise any questions or concerns that need to be addressed as we move through the next stages of the programme and towards formal public consultation. The event would also be the opportunity to discuss specifically the consolidation of level 3 intensive care and dependent services.

54. As part of this process the CCGs and Trust are committed to ongoing involvement and oversight of local HOSCs and we are currently in discussion about how we can make this as effective as possible.

Joint Overview and Scrutiny Committee

55. At the Joint HOSC meeting on 28th September the committee recognised the strong clinical case to consolidate level 3 ICU, and understood the proposals to move the service. The committee also noted that the CCGs and UHL have fulfilled their statutory duty to consult Scrutiny, and stated it would therefore be inappropriate to make a referral to the Secretary of State on these grounds.

56. The committee also noted that it is not for it to comment on whether NHS bodies have fulfilled their obligation to consult with the public, though stated it considered it to be an oversight that public consultation did not take place whilst proposals were at a formative stage.
57. The Joint HOSC requested that UHL and the CCGs provide a detailed project plan to the committee, and regular updates on the progress of the works and any variations. It also

asked for more detailed information around the sustainability of existing services at the Leicester General Hospital once the level 3 beds have been removed, and more detail around the escalation process.

58. Joint HOSC also noted the planned engagement on the wider acute hospital reconfiguration plans, and requested that formal public consultation also take place on this matter at the earliest available opportunity.

59. However, despite all the information provided to the committee by the CCGs and UHL, the committee came to the view that they were not convinced that any of the reasons given preclude the ability to carry out consultation in relation to ITU specifically. As such, the Committee recommend that the CCGs and UHL pause implementation of the planned ICU changes and undertake public consultation before continuing with the ITU changes.

Conclusion and next steps

60. The CCGs and UHL recognise that opportunities have been missed to keep patients, the public and stakeholders aware of the issues and progress made in relation to the proposal to consolidate ICU services. Both the CCGs and UHL have publicly apologised for this.

61. The only way to meet the Gunning principles and legal duties now would be to resile from earlier decisions. This may mean losing the capital funding, risk the destabilisation of the existing service with potential serious potential consequences for an indeterminate period, increase scheme costs, and require a completely new process including re-making the decisions in full – which would normally take at least 12 to 24 months.

62. Furthermore, the clinical sustainability issues cannot be dismissed just because UHL has managed to mitigate the risk successfully up until this point. The fact remains that the service remains fundamentally as vulnerable today as it was in 2015 and to not take immediate steps to resolve those issues now that the capital is available could be argued to be negligent on the part of both the CCGs and UHL.

63. However, the CCGs and UHL believe that it would be appropriate to use the planned BCT Next Steps engagement events over the coming weeks to engage in a broader discussion with patients and the public on the ICU proposals before contracts with the preferred provider are concluded.

64. These events will provide the opportunity to discuss the implementation of the plans, explain to the public the clinical need and urgency for the ICU changes, the positive improvements it will bring to our local communities, reassure people as to what it does – and does not – mean for the future of the Leicester General Hospital site and planned future consultation, and address any questions or concerns that patients and the public may have. Plans for the move will be shared at the event, with the public given the opportunity to raise any views or suggestions for how to improve what is being done.

Recommendation

The Collaborative Commissioning Board (CCB) is asked to:

CONFIRM that the CCGs remain committed to the support provided for UHL's plan in 2014/15 and the formal decisions already made by each of the Governing Bodies in November 2017 and July 2018. Specifically, this included approving the outline business case in November 2017 and approving the full business case in July 2018.

SUPPORT the specific inclusion of ICU with the planned upcoming engagement events as outlined above.