

Paper 2:
**Report on University Hospitals of
Leicester NHS Trust Full Business Case
for relocating Intensive Care Unit
Level 3 beds out of Leicester General
Hospital**

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Abbreviations

- UHL – University Hospitals of Leicester
- CCG – Clinical Commissioning Group
- Colorectal – diseases and procedures of the bowel, rectum and anus.
- ELR – East Leicestershire and Rutland
- FBC – Full Business Case
- GH – Glenfield Hospital
- General Surgery – a wide range of surgery with sub-specialities, most commonly dealing with abdominal and chest injuries and disease (Royal College of Surgeons¹)
- HOSC – health overview and scrutiny committee
- HPB – hepato-pancreato-biliary system (liver, pancreas, bile ducts and gall bladder)
- ICU – intensive care unit
- LGH – Leicester General Hospital
- LRI –Leicester Royal Infirmary
- Nephrology – medical management of diseases of the kidney
- RT – Renal Transplant
- STP – Sustainability and Transformation Plan / Partnership
- UHL – University Hospitals of Leicester NHS Trust

ICU differing levels of support as follows:

Level 0	Needs are met through normal care on acute wards
Level 1	Patients at risk of their condition deteriorating, or recently moved from higher levels of care. Needs can be met on acute ward with additional advice and support from critical care team.
Level 2	Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support for at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

¹ Retrieved from <https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/general-surgery/>

Executive summary

This report discusses the University Hospitals of Leicester NHS Trust's full business case for relocation of level 3 intensive care beds and associated services from Leicester General Hospital to Glenfield Hospital and Leicester Royal Infirmary. This was first presented to its Governing Board and placed in the public domain in July 2018; with work planned to commence in October/November 2018. The full business case raises a number of concerns set out in this report:-

1. There has been no formal public consultation about this substantial change in service delivery, involving geographical relocation of services, by either the University Hospitals of Leicester NHS Trust or by the Leicester, Leicestershire and Rutland Clinical Commissioning Groups.
2. The appendices, which contain important technical details underpinning the full business case, have not been placed in the public domain. This impedes the public's access to relevant information and the effective assessment of all the practicalities and implications of the full business case.
3. The full business case places the proposed reorganisation, across Leicester's three acute hospitals, of the Intensive Care Units and associated services firmly within the Sustainability and Transformation Plan (sometimes referred to as the Better Care Together plan). The ICU proposals are seen as part of UHL's strategy of moving from three acute hospital sites to two. However, there has been no finalised version of the Sustainability and Transformation Plan published, nor has there been any public consultation about proposals to move from three acute hospital sites to two.
4. Three clinical services, renal, hepato-pancreato-biliary and urology, hitherto operated at Leicester General Hospital, will be disrupted by the proposals set out in the full business case as they will be split across two sites – the Leicester General Hospital and the Glenfield Hospital. This poses the risk of discontinuities of services and care, logistical difficulties for patients and visitors and, possibly, clinical risks.
5. Government planning and construction recommendations for hospital buildings will not be met as the Trust endeavours to incorporate too much into

too small an area in order to contain costs. Siting the new building in a restricted space on top of existing wards means that current buildings recommendations cannot be achieved and there is a risk that the new-build wards will not be fit for long term service, patient safety and dignity and staff well-being. This is occurring in a context in which land, apparently considered surplus to requirements, is being sold off.

6. The financial accounting for staff salaries does not seem to consider future salary increases. The possible loss of staff due to the move has not been addressed in the full business case.

7. The full business case suggests that excess land at Glenfield Hospital and the Leicester General Hospital will be sold for housing development. This has not been publicly debated and there are no details in the public domain of overall estate planning or details about how land values have been determined.

8. We recommend that the proposals, which include not only a major change in service delivery but also the sale of NHS land on a site where expansion is anticipated, should be discussed by the Joint Health Scrutiny body for Leicester, Leicestershire and Rutland and should be subject to full public consultation.

1. Introduction

The University Hospitals of Leicester NHS Trust (UHL) has long held the ambition to reconfigure its three acute hospitals, Leicester Royal Infirmary (LRI), Glenfield Hospital (GH) and Leicester General Hospital (LGH) into two acute hospitals. The two remaining acute hospitals would be LRI and GH with LGH remaining, possibly, as a community hub, a midwife-led maternity unit and a Diabetes Centre of Excellence. Land at LGH and GH considered excess to requirements will be sold for housing development and the proceeds used to reduce debt.

As part of this reconfiguration and according to the Full Business Case (FBC)², made public shortly before the July 2018 meeting of UHL's Governing Board, this relocation of intensive care services is driven by the stated inappropriateness of having one Intensive Care Unit (ICU) in each of the three UHL hospital sites. This situation has resulted in over-capacity at LGH ICU and under-capacity at LRI and GH ICUs. Further complications arise from UHL's stated staffing difficulties since LGH ICU lost its intensive care teaching status. Moving all but one level 3 beds away from LGH ICU means that services requiring, according to national policy, co-located level 3 ICU must also be moved. Therefore the renal transplant ward (RT), hepato-pancreato-biliary (HPB) inpatients and urology high risk patients are planned to move to three new-build wards at Glenfield Hospital (GH). A new interventional radiology facility will also be built at GH. The new building will be sited on top of existing wards. The remaining one ICU level 3 bed at LGH will be for stabilising any patient unexpectedly requiring level 3 care before transfer to GH. As part of this phase of the overall reconfiguration, general surgery and colorectal surgery will move to Leicester Royal Infirmary. The goals of this reconfiguration, it is proposed, include to:

- reduce unnecessary patient journeys
- improve clinical adjacencies
- provide quicker, navigable, quality services (p81)

² Retrieved from <http://www.library.leicestershospitals.nhs.uk/pubscheme/Documents/How%20we%20make%20decisions/Board%20Papers/2018%20-%20Thursday%205%20July%202018/paper%20G.pdf>

In this report we draw attention to the lack of formal public consultation undertaken by UHL and to some of the errors or omissions in the FBC which could adversely affect the quality of patient care and, possibly, patient safety and so fail to achieve these goals.

2. Public consultation

English law demands that the public must be consulted before decisions and changes are made to National Health Services (Mills & Reeve 2013³). NHS England (2017)⁴ provides guidance on public consultation for commissioners of health care as follows:

Staff can better understand population health needs, and respond to what matters most to people when they involve and listen to those who need, use and care about NHS services. Patients and the public can often identify innovative, effective and efficient ways of designing, delivering and joining up services (p10)..... The examples indicate some circumstances where the legal duty to involve the public may apply and therefore where commissioners should assess this to determine the appropriate response. As it is not possible to anticipate every such situation, the list is not exhaustive (p17).... [but includes] [d]eveloping and considering proposals to change commissioning arrangements, for example:

- Changes to services, new models of care, new service specifications, local improvement schemes, etc.
- Reconfigurations involving movement of services from one provider or location to another (p18).

In a separate document, '*Planning, assuring and delivering service change for patients*' (NHS England 2018)⁵ states:

³ Retrieved from https://www.mills-reeve.com/files/Publication/1c71458e-6a71-4b88-95df-a7a575500263/Presentation/PublicationAttachment/f3a0da0b-1fbd-4081-952d-b51f14505974/Reconfiguring%20services%20briefing_October%202013.pdf

⁴ Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

⁵ Retrieved from <https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/>

There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered (p7) ...

Change of site from which services are delivered, with its consequent impact on patient, relative and visitor travel times, even with no changes to the services provided, would normally be a substantial change and would therefore trigger the duty to consult the local authority and would be likely to require public consultation (p8)

Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider. Where there is a duty for the commissioner to consult the local authority under the s.244 Regulations, it will almost invariably be the case that public consultation is also required (p11)...in practice, public consultation requirements for commissioners and providers may be satisfied with one public consultation, but it is for each organisation with a public involvement duty to satisfy themselves that the consultation properly addresses their responsibilities. Therefore both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult (p12).

There is, therefore, a clear duty by both UHL and the Clinical Commissioning Groups (CCGs) to ensure that the public have been consulted on the planned relocation of ICU and dependent services away from Leicester General Hospital.

On 25th February 2015 Leicestershire County Council health overview and scrutiny committee (HOSC), in response to UHL's report ⁶ stating that ICU reconfiguration needed to take place before December 2015 as 'the level 3 ICU service at the General Hospital will not be clinically sustainable' (p33), resolved:

⁶ Retrieved from <http://politics.leics.gov.uk/documents/s107708/The%20Future%20of%20Intensive%20Care%20at%20UHL.pdf>

- a. That the future of Intensive Care Services, as aligned to the blueprint for Health and Social Care in Leicestershire, Leicester and Rutland 2014-19 be noted;
- b. That this Committee is of the view that the proposals to consolidate level 3 Intensive Care Services at the Leicester Royal Infirmary and the Glenfield Hospital are significant and as such constitute a 'substantial variation' which would normally need to be the subject of formal consultation;
- c. That this Committee, having considered the outline of the proposals set out in (a) above is of the view that such changes would, if fully implemented as described, improve patient experiences and outcomes and, in view of this, agrees that it would not be in the interest of people of Leicestershire for it to insist upon formal consultation as this would divert resources away from the project team charged with the delivery of these necessary changes, therefore waives its right to be formally consulted on condition that the UHL Trust undertakes to:-
 - 1) provide the Committee with a detailed project plan for the relocation of services;
 - 2) provide regular updates on the progress of works and any variations to the plans; and
 - 3) to meet with the Committee or its representatives if there are any concerns raised by members of the Committee about the implementation of the proposals⁷.

On 25th March 2015, UHL presented their plans to Leicester City health overview and scrutiny committee (HOSC) and argued that there was an urgent patient safety need to close level 3 ICU beds at LGH due to under-capacity at LRI and GH, creating delays in operations, and over-capacity at LGH. UHL stated that the loss of LGH ICU teaching status for intensive care was also exacerbating difficulties in recruiting and retaining staff such that this plan would need to be completed before December

⁷ Retrieved from <http://politics.leics.gov.uk/documents/g4235/Printed%20minutes%20Wednesday%2025-Feb-2015%2014.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1>

2015 to ensure patient safety. The minutes record that the committee was assured by the UHL representative that this 'proposal was not associated with delivering the Better Care Together programme but was concerned with continuing to provide a service'⁸ (p6).

A clause from a Government publication, *Guidance to support local authorities and their partners to deliver effective health scrutiny*⁹ was cited at the meeting:

Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this (p24).

Based on UHL's argument for the urgency of relocating ICU level 3 beds from LGH to LRI and GH, the minutes record the following:

Resolved:

1. That it be noted that the University Hospitals of Leicester NHS Trust (UHL) had determined that 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.
2. That UHL continue to present periodic updates on the progress with the proposal and the consequences of the changes⁵ (p25)

It is noteworthy that Rutland County Council's health overview and scrutiny committee was not consulted at this stage. It is also important to consider that the Joint Scrutiny Committee for Leicester, Leicestershire and Rutland has not yet had the opportunity to review the FBC as the local authority guidance (DoH 2014) requires as shown below:

⁸ Retrieved from <http://www.cabinet.leicester.gov.uk/documents/g6806/Printed%20minutes%20Wednesday%2025-Mar-2015%2017.30%20Health%20and%20Wellbeing%20Scrutiny%20Commission.pdf?T=1>

⁹ Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements (see section 4 on consultation below for more detail).

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation¹⁰ (p17).

Despite the expressions of urgency in 2015, ICU level 3 beds at LGH remain open at the time of writing – over three years later. Mitigations must have ensured continued patient safety and, in this context, UHL has had plenty of time to consult the public. Clearly, plans have evolved and developed since 2015. To date, it appears that consultation since 2015 has been confined to the presentation of the plans to Rutland Adult Health and Scrutiny Committee in April 2018 and to those members of Healthwatch or UHL's Patient Partners who have attended project meetings – a very select group. Therefore, the duty to consult the public formally and more extensively as required appears to have been sidestepped.

Furthermore, the FBC acknowledges:

The STP identifies the essential need for University Hospitals of Leicester NHS Trust ... to consolidate onto two acute sites to deliver its clinical reconfiguration strategy, whilst enabling the disposal of the majority of the Leicester General Hospital (LGH) site which is directly linked to returning the Trust to financial balance (p15).

¹⁰ Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

The draft Sustainability and Transformation Plan (STP)¹¹ for Leicester, Leicestershire and Rutland was published towards the end of 2016 and was based in part on the prior Better Care Together plan. As the FBC acknowledges, the STP includes the proposal to retain LRI and GH as the two acute hospitals for Leicester, Leicestershire and Rutland. LGH ('subject to the formal public consultation which is currently expected to take place early in 2019' - FBC p80) would remain as a community hub, a midwife-led maternity service and a Diabetes Centre of Excellence. However, no finalised version of the STP has appeared in the public domain nor has there been any formal consultation regarding the future of LGH and the UHL Estate.

The FBC, first set before the UHL Trust Board in July 2018, acknowledges that the consolidation of three hospitals into two has been a long-term strategic aim that was determined before the first draft STP was formulated. However, situating the FBC so definitively within the STP means that UHL arguably stands accused of pre-empting the redrafted STP, which is yet to be made available to the public for consultation and agreement. As we next demonstrate, the lack of public consultation may have contributed to omissions and errors in the FBC that could and should have been addressed.

3.The re-siting of the renal transplant ward, hepato-pancreato-biliary surgery and urology high risk care – identified problems

The FBC discusses the relocation of renal transplant (RT) as follows:

There is recognition that the resulting site split for transplant and nephrology is only clinically sustainable over a short-term period, not least because of the pressure this will place on a small number of consultant workforce. The Trust is therefore developing separately the options to move nephrology to Glenfield Hospital, at an early stage, at low cost. This will be subject to a separate business case.....The separation of the two services is highlighted as a risk and mitigations have been established to manage this risk (pp 99-100).

¹¹ The STP is sometimes referred to as 'Better Care Together'.

We note that these mitigations are not included in the FBC. To further understand the ramifications of the above statement, we first describe the context of the existing renal transplant ward at LGH.

The renal wards and services at LGH are intrinsically linked and, to some extent, interdependent in terms of the workforce, equipment and expertise. Facilities include a renal pharmacy, a high dependency unit for nephrology and transplant patients (ward 15A), an inpatient and an outpatient haemodialysis unit, a day case area for minor procedures and the triaging of outpatients who have become unwell (ward 10 day case), two nephrology inpatient wards (wards 10 and 15N) and ward 17 which is for transplant patients and those with renal failure requiring surgery associated with renal disease such as parathyroidectomy or dialysis access surgery.

Patients are regularly moved around ward 10 Nephrology, ward 10 Day Case, ward 15 Nephrology, ward 15 Acute, ward 17 Transplant, and inpatient dialysis according to clinical need and bed capacity. Nursing personnel are also moved around the wards to meet staff or skills shortages, demands for more specialist expertise such as haemodialysis, or heavier workloads across the wards. These nurses are experienced in delivering renal-specific care to patients with kidney disease. Nephrology and transplant doctors, dieticians, pharmacists, physiotherapists and occupational therapists also work across the wards.

The on-site renal pharmacy is staffed by pharmacists who are experts in the management of renal drugs. The pharmacists who, as experts in the management of renal drugs, offer essential advice to staff and patients. Specific renal transplant drugs, for example anti-rejection medication, are dispensed by the renal pharmacy.

To circumvent possible objections to the re-siting of RT away from the nephrology wards and associated facilities, the FBC states that the relocation of nephrology to Glenfield Hospital is a 'separate business case'. When questioned at the East Leicestershire and Rutland CCG meeting on 10th July, UHL representatives said this move would happen 6-12 months after RT has been moved.

The resulting doubts, concerns and questions we have identified are listed below:

- I. The risk assessment acknowledges some separation of linked and interdependent services (p106) but the risks here are potentially life

threatening (for example, dialysis is essential for maintaining life in those patients with end stage renal disease). Specific details about how such risks are to be mitigated should be provided. For example, the FBC does not state whether the new RT ward at GH will have haemodialysis facilities. Does this mean that patients requiring dialysis (usually three times per week minimum and, for some patients urgently and unexpectedly) will be constantly travelling from GH to LGH for haemodialysis? These details may be in an appendix but the appendices have not been put into the public domain.

- II. Renal transplant will need therefore to stand apart from the shared expertise of the renal unit as a whole. This poses challenges for adequate staffing and potentially, the loss of the ability to move patients around the wards. This will reduce flexibility in bed usage at a time of rising need.
- III. Although the FBC states pharmacists have been consulted, the only mention of their input in the detailed clinical case for RT is on page 65 and refers merely to their advice on siting drug cabinets. The essential role of specialist pharmacists appears not to have been given due recognition. This needs greater clarification.
- IV. There appears to be no explanation as to what is involved in the 'separate nephrology business case', when this will be presented or the source of finance. Is it part of UHL's wider reconfiguration proposals that have been repeatedly delayed and will, according to the FBC, cost a further £336m with no promise thus far from the Government of funding? It is reasonable to expect that there could be a considerable delay in re-siting nephrology at GH to be adjacent to RT.
- V. The FBC provides no justification for reducing RT beds from 14 beds at LGH to 12 beds at GH.
- VI. P69 states, 'this new transplant solution provides enhanced clinical adjacencies' but fails to say what these are.

There are also concerns about the plans to move HPB in-patient services to GH and also implications for some urology patients. Currently HPB services are provided at LGH where the current bed usage is stated as an average of 9 elective beds and 36

emergency beds shared between general surgery and urology on out-dated Nightingale wards or in 6-bedded bays. The FBC proposal is to move HPB inpatient services to GH whilst HPB outpatient and day case services remain at LGH. The FBC goes on to state on p166 that there will be two wards at GH for HPB. One ward will have 28 elective surgery beds and the other will have 24 emergency beds with an incorporated triage/admissions area - a total of 52 beds. However, the FBC states a need for 55 beds. According to the proposals, only by sacrificing the triage area can 56 beds be achieved. Both of these wards will share one interview room.

Although urology wards will remain at LGH, the loss of level 3 ICU beds there means that urology patients preoperatively identified as needing post-operative level 3 care will be admitted to GH. Once no longer dependent on intensive care they will be transferred to the HPB wards at the Glenfield Hospital. Similarly, urology patients unexpectedly requiring level 3 ICU care will be 'retrieved' from LGH to GH and then recover on the HPB wards at the Glenfield Hospital. 2016/17 figures given in the FBC suggest the number of urology patients requiring ICU level 3 is in the region of 16 per annum.

The long-term plan is to move HPB from the new-build ward to elsewhere within GH¹². Then, as a separate business case, nephrology wards, remaining in the interim at LGH will move to the newly vacated HPB wards at GH. Due to this planned move, during construction there will be plumbing installed for dialysis in the new HPB ward.

We have identified areas of concern with regard to the relocation of HPB as listed below:

- I. Under the proposals set out in the FBC, HPB patients will be split across two different sites, with HPB inpatients at the Glenfield Hospital and HPB outpatients and day cases remaining at the Leicester General Hospital. This will result in loss of continuity for patients who are being seen and assessed in one hospital but having their operations in another. Medical staff, almost definitely, and, probably, professionals associated with medicine and the nursing workforce will be required to work across two sites. Medical notes will also need transferring across sites (until UHL becomes completely paperless)

¹² When questioned at ELR CCG board meeting on 10/7/2018, the UHL representatives stated this would be in the paediatric cardiac unit once it has been re-sited at LRI.

and thus might be in the wrong place at the wrong time causing delays in treatment and frustrations for patients.

- II. The 'outlying' of some urology patients in the HPB ward at GH poses risks of loss of continuity of care and clinical and nursing expertise (urology-specific) for patients.

4. Planning and design concerns

We have also identified here some of our concerns with the overall planning and design of the new facilities which, we would argue, pose risks to patient wellbeing, safety and dignity and also compromise staff comfort:-

- I. For renal transplant, the ward bays' toilet and showering facilities will be ensuite and remain on a ratio of 1 facility for 4 patients. However, the proposed arrangements do not conform to HBN 04.01 section 5 which recommends a minimum of one shower with toilet and at least one separate toilet and wash basin in each bay – a ratio of 1 to 2 (i.e. one facility for two patients in a four bedded bay). The FBC acknowledges this but states that to include a second toilet will mean a loss of bed space, a window and a daytime social area. In the event of one patient using the communal shower/toilet, a second patient needing the toilet at the same time will be directed to a toilet in the other bay (likely to be occupied by the opposite gender) or in one of the single rooms. This single room toilet might be occupied by the opposite gender or be an isolation room where entry puts either the occupying patient or the entering patient at risk of infection. This becomes particularly pertinent when considering that some post-operative transplant patients need to pass urine very frequently and urgently once their indwelling urinary catheter has been removed and/or when patients are trying to find toilets during the night. There is an enhanced risk of falls and compromised patient dignity. UHL professionals have agreed this arrangement but, it would seem, patients have not been consulted.
- II. There is the further concern of the proposed later move from LGH to GH of the remainder of the renal unit to wards to be later vacated by HPB and adjacent to RT. As this move is being classed as a separate business case there is no detail but it would seem that two HPB wards and a triage area cannot be reconfigured to accommodate two nephrology wards, a nephrology high

dependency unit, a renal pharmacy, an inpatient dialysis unit, space at the bed side for dialysis equipment and for storage for the fluids and other consumables required for dialysis.

- III. The design does not meet Department of Health plans for 50% single rooms. The FBC proposes 30% single rooms. This arrangement has been agreed by UHL professionals but, again, there is no mention of patient preferences.
- IV. The recommended bed area in ICUs is 25.5m² but none of the proposed bed areas achieve that standard as they range from 20 m² to 23.9m². This means that none of GH ICU beds, described by UHL as designed to provide a 'super ICU', will meet the current recommendations and their fitness for long-term future use becomes debatable.
- V. Much emphasis has been placed on natural lighting. Although sun-reflective glass will be used, there still remains the element of overheating in the wards as the proposed artificial lighting alone will also generate heat. Given the impact of climate change and the heat wave conditions forecast for future summers, it would be sensible to incorporate air conditioning or other heat-mitigating features in the new-build design as recommended in HBN 00-01 section 1.19¹³.
- VI. There is to be just one 'retreat/interview' room planned for the two HPB wards with 7 non-specified areas, which could also be used. There appears to be no provision of a 'retreat/interview' room for RT. We suggest this is insufficient as RT and HPB both deal with very acutely unwell patients and often very anxious significant others. A space for quiet and confidential discussions with staff is essential for privacy and dignity – especially when dealing with distressed and vulnerable people.
- VII. Throughout the FBC there are further deviations from Healthcare Building Notes and references to proposed mitigations and derogations that demand more explanation or the due release of the detail, stated as being in the relevant appendices, into the public domain. These are significant as they are

¹³ Health Building Note 00-01 retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf

likely to entail a reduction in the quality of the building and the facilities through which care is provided.

VIII. If building has not commenced by November 2018, planning permission will need to be sought again. What is the cost? What is the risk that this will happen?

IX. It is not clear in the full business case to understand how the land at LGH and GH has been valued and so difficult for the public to assess whether this represents the best value.

X. The FBC papers presented at the UHL Trust Board meeting on 5th July 2018 do not include the technical appendices. This means that members of the public assessing the FBC are unable to access all the necessary information

5. Workforce planning and staff

I. Although workforce planning has been given consideration, there is no mention of the possible loss of staff that will find their daily commute longer and more expensive (although there will be some members of staff who will gain). There might be a loss of experienced staff from the specialities for personal, logistic and financial reasons.

II. The financial plans imply a static number of staff with no wage increases over the forthcoming years¹⁴.

6. Conclusion

I. There has been inadequate public consultation. Instead, a recent presentation to one health overview and scrutiny committee and presentations to the other two health overview and scrutiny committees (HOSCs) in 2015 are being taken by UHL as sufficient evidence of public approval. This is despite the fact that the 2015 agreement by the HOSCs to proceed was given in a set of circumstances that have clearly since changed and the joint HOSC has yet to

¹⁴ Details of NHS staff pay increases for 2018-2021 can be viewed at <https://www.bbc.co.uk/news/health-44413436>

be consulted. UHL has paid 'lip service' to public consultation by consulting a few patients and a handful of Healthwatch or Patient Partners members.

II. This FBC clearly fails to meet the UHL stated goals of:

- reduce unnecessary patient journeys
- improve clinical adjacencies
- provide quicker, navigable, quality services.

III. Three clinical services, renal transplant, hepato-pancreato-biliary and urology, are going to be split across two sites for an indefinite time. There is a danger that this will cause discontinuities in services, staff and patient inconvenience, complicated logistics and impaired patient satisfaction and possible clinical risks.

IV. The plans, involving-new build wards, fail to meet recommended hospital building standards in a number of respects and this raises doubts about the long-term fitness for purpose of the buildings. These deviations appear to have resulted from UHL's position of having insufficient space to meet the required standards since the proposal is to build on top of existing buildings rather than on land which they wish to sell off. There may be further deviations or associated problems in the appendices to the FBC but these are not in the public domain.

V. There has been no public consultation or clarity of detail in the proposals to sell of Estate land for housing; especially considering that this land could be utilised for buildings which will meet building recommendations.

VI. The FBC appears to overlook the impact of potential staff pay rises. It does not consider loss of staff due to increased travel costs and/or transport difficulties.

Although our list of concerns is not an exhaustive appraisal of the FBC, it is, we suggest, sufficiently wide-ranging and detailed to alert to the risks of not properly consulting the public. Such a public consultation would draw in professionals, patients and their families with different skill sets who could equally well offer useful comments and concerns about parts of the FBC that are beyond our own knowledge

and skills. It would be more cost-effective to rectify errors and omissions at this stage than later, when patients have moved onto the wards. A formal public consultation would also identify other concerns residents in Leicester, Leicestershire and Rutland may have about the proposed changes to their services.

7.Recommendation

We recommend that the proposals, which include not only a major change in service delivery but also the sale of NHS land on a site where expansion is anticipated, should be formally considered by the joint health scrutiny body for Leicester, Leicestershire and Rutland and should be subject to full public consultation.

Report compiled by Dr Janet Underwood (Health Policy Research Unit, De Montfort University), Dr Sally Ruane (Health Policy Research Unit, De Montfort University) and Mrs Kathy Reynolds (Leicester Mercury Patients' Panel).

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