Agenda Item 7

Briefing Paper for Attention of Health Overview and Scrutiny Committee Members in Leicester, Leicestershire and Rutland.

1. Introduction

This paper has been prepared for Health Overview and Scrutiny Committees across Leicester, Leicestershire and Rutland (LLR), including Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee. It raises concerns about serious legal and process breaches that have occurred during the process of planning health services for Leicester, Leicestershire and Rutland, within which the capital plan for University Hospitals of Leicester sits. It makes recommendations to remedy these breaches.

The paper draws upon a raft of national guidance, statutory requirements and common law and upon the advice of a Fellow of the Consultation Institute which is an authority on law and process governing consultation.

The paper expresses public concern about serious breaches of due process and their potential consequences. It asks the joint Health and Overview Scrutiny Committee (JHOSC) to act to help get the process back on track and avoid the lengthy delays that legal challenge could bring.

Its recommendations are set out in detail on pages 4-5, but in summary:

1. **LLR must have a strategic plan to set direction for the future.** It should urgently publish its proposed long term strategic plan (with all supporting documentation including impact and equality assessments and capital scheme-related documentation) for JHOSC scrutiny well in advance of formal consultation.

2. **Public confidence needs to be restored in what has been a flawed process**. To achieve this the JHOSC should seek expert advice regarding adequacy of process requirements ahead of a period of formal public consultation. In addition, the JHOSC should scrutinise the five year plan and associated capital scheme, if necessary seeking independent external expertise. The review should pay particular attention to how the plan will meet the health needs of the population and how the component parts interrelate and join with each other. The consequences of centralised hospital services must be appropriately mitigated. The JHOSC would then recommend modifications to the plan as necessary to ensure its adequacy in guiding the direction of future health services It should signal Councils' ability to refer this to the Secretary of State if the local NHS rejects its recommendations.

3. **Consultation on UHL reconfiguration should be placed in the context of a strategic plan.** Once the review process has been completed, the JHOSC should agree a plan for local consultation on the UHL capital scheme in the context of the overall five year plan above.

The consequences of failure to follow national guidance and statutory and common law requirements could be very serious. It potentially opens decision making up to legal challenge which is both costly and can delay matters.

The proposed closure of approximately 400 beds at Leicester General Hospital site, the closest acute and maternity facility for East Leicestershire and Rutland, will have an appreciable impact on these populations. It is therefore imperative that the planning process be put back on track and scrutiny committees help ensure the process from now on addresses previous shortcomings and plans for alternative provision to compensate for losses. The first step for the relevant Health Scrutiny Committees, including Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee, is to seek to ensure that Better Care Together (BCT) allows enough time to rectify the process shortcomings before embarking upon formal consultation. Enough time needs to be allowed for the public to digest meaningfully the data and options on offer well ahead of the formal period of consultation.

Key Message: There is great public concern that LLR Better Care Together Planning has been undertaken in a manner inadequate to meet requirements and this paper offers a route to resolve the shortcomings and help avoid legal challenge.

2. Background

In January 2019 a national Long Term Plan (LTP) for health was published by NHS England. Leicester, Leicestershire and Rutland was required to produce, by the end of September 2019, a draft five year strategic plan stating how national LTP recommendations would be implemented locally. The publication of all local plans, in final form, in England is expected in the coming weeks.

In 2018 BCT acknowledged it did not have a strategic plan other than the now defunct 2014 strategy but undertook to remedy that as part of its forthcoming local five year plan.

The national LTP published planning guidance requires involving the public in developing options.

However, BCT has failed to engage the public in coming up with a set of options to put to consultation. Had the legislative requirement to involve the public in developing implementation options been followed during 2019 in preparing the local five year plan, some of the previous breaches of due process could have been rectified.

It appears, however, that BCT Leadership has failed to follow national requirements and that the final version of the LLR five year plan will be published in the coming weeks with neither adequate public involvement nor due process surrounding the preparation of options. Even if the local plan had been approved by Trusts or CCGs in public Board Meetings (which they have not), local NHS leaders may not have fulfilled the statutory obligations in arriving at their finalised local LTP.

It is anticipated that Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee may be asked to endorse the new local plan as a revised long term strategic plan despite the fact that BCT has not properly engaged the public in developing that plan, including the range of implementation options required. At the time of writing, the draft plan remains unseen by any members of the public that BCT was required to involve in its preparation.

It is also anticipated that Joint HOSC will be asked to endorse consultation on a single capital programme to reconfigure services at the University Hospitals of Leicester. So far neither the public nor (to our knowledge) our local government representatives have seen any alternative options or the vitally important contingent schemes required.

If only one capital implementation option is offered, it may contravene both public law and the best practice requirements that BCT Partnership are expected to follow. NHS authorities may not

consult on issues upon which they have already made a decision since this would fail under Gunning I of the Gunning Principles of 1985 on Consultation and so render consultation unlawful (subject to review by a Judge).

The local Long Term Plan should have been prepared by properly involving the public in developing and examining both the new strategic direction and the full range of implementation options. These options should have been worked up into deliverable format especially where capital costs and /or change of location are involved and evaluated against agreed criteria and against each other before all then being put to public consultation.

BCT LLR has failed to work through this process adequately from 2016 to date.

A properly developed overall plan for LLR is now vital so that options can be considered in formal consultation by the public. Options should include alternative approaches to hospital centralisation and provision in mitigation of this centralisation where communities lose out. For example, and in order to meet its equality obligations, sufficiently strengthened community services would be needed; in Rutland and possibly East Leicestershire provision would need to be made to bring LGH ambulatory services closer to home; and acute provision would need to be made at Peterborough and elsewhere for those who cannot travel to the Leicester Royal Infirmary and Glenfield Hospital and if planned capacity at UHL is insufficient as looks likely to be the case.

KEY MESSAGE LLR does not have an agreed strategic plan following the collapse of its previous strategic plan of 2014. Future direction (local Long Term Plan) must be agreed before capital schemes to implement that direction are formally discussed.

3. Failure to follow NHS regulatory process in preparing the local Long Term Plan.

The involvement of communities and public discussion in planning change are required both to modify LLR's 2014 agreed strategic direction of acute to community and in preparing a range of implementation options which have to be worked up and rigorously compared. The impact of all options has also to be assessed and alternatives offered in mitigation. A range of choices relating to both community based services and hospital services should be made available. The full range of documentation relating to all supporting capital costs, revenue costs, health needs, impact assessments, including equalities impact assessments, underpinning assumptions and other details must be supplied to enable the public to make an informed choice.

While some engagement events have been held, they have been criticised for talking "at" rather than exploring with the public. For acute services people were presented with glossy artists' impressions of one option only and told that was what they were getting when funds were available. For community services, in Rutland the views of Leicester people on Leicester services were presented but no details of proposed solutions were discussed and discussion of community hospitals was excluded. Despite the questionnaires, interviews and focus groups reported by local Healthwatch, the public involvement in developing local solutions called for in the 2019 national LTP has not happened.

The prospect and experience of being ignored has greatly worried a number of people so, in September 2019, in the absence of proper engagement in drawing up options by BCT, Rutland people prepared a local report setting out how they would like to see the national Long Term Plan proposals applied to Rutland. BCT leads declined to engage with the public at this meeting but promised an alternative programme of engagement in autumn 2019. This did not take place.

Details relating to the ways in which current arrangements do or do not fulfil obligations around equalities and health inequalities have not been shared with the public and legitimate requests by the public for background papers have been refused. Repeated requests for the pre-consultation business case underpinning the hospital reconfiguration have been refused, including under the 2000 Freedom of Information Act. As late as January 2020, such a request was refused. This stands in stark contrast to the availability to all members of the public of the Pre Consultation Business Cases (PCBCs) for Path to Excellence in the North East and for Improving Healthcare Together in South West London. In these local health reconfiguration programmes, the PCBCs and other supporting documentation have been kept in the public domain and updated at each stage. The public of Leicester, Leicestershire and Rutland have a legitimate expectation that such information should be shared with them so that engagement can be informed and continuous. The refusal to share the PCBC contravenes guidelines on continuous engagement and opens the process to future legal challenge.

Failure to follow NHS England formal guidance for handling service and estate changes. Much has been made of the fact that NHSE has silenced discussion until capital funding for the one option has been approved. Due process for service reconfiguration requires capital proposals to be developed in the context of a strategic plan. However, UHL's capital proposals were developed ahead of the local strategic plan (the local long term plan) which has yet to be published.

Preventing Split Public Consultation. Legal requirements relating to splitting public consultations are complex and any move by local NHS leaders to consult the public formally on the hospital reconfiguration plan separate from public consultation on other aspects of the local health plan run the risk of being unlawful, under legitimate expectation. In addition, attempts to consult the public on hospital reconfiguration in the absence of the full details regarding the local health plan as a whole (which presumably will contain the interrelated schemes and mitigating provision needed in the community) run the risk of preventing members of the public from giving informed responses, likely to be unlawful under Gunning II. For instance, we understand that phase 2 of the review of community services, including plans for community hospitals, is not due to be completed until late 2020 and yet UHL board papers indicated UHL's wish to embark on formal consultation regarding hospital reconfiguration as soon as March 2020.

The legal and due process requirements placed upon CCGs and Trusts are extensive so not replicated here but are available on request. Links to some of the key documents are however provided in Appendix II for those who wish to study the detail.

KEY MESSAGE Shortcomings in process to date open the forthcoming consultation to the prospect of legal challenge.

4. Recommendations to put matters on a better course

As outlined above, the local five year strategic plan has not been developed in accordance with legal requirements since the public have not been adequately engaged in drawing up options for implementation either after the publication of the draft STP in November 2016 and before the publication of the national long term plan in January 2019 nor since the publication of the national long term plan and the drawing up of the draft local five year plan in September 2019.

As a result of this, the local plan is vulnerable to legal challenge for judicial review and/or referral to the Minister for examination by the Independent Reconfiguration Panel, entailing attendant lengthy delays.

It is important at this stage that the local plan, including the associated capital scheme, is therefore subject to close scrutiny and analysis before it can be considered fit for the future.

We recommend:

(1) The JHOSC withhold its agreement to formal public consultation on the UHL capital scheme until a number of further steps have been completed.

(2) The JHOSC invite Mr Nick Duffin, Fellow of the Consultation Institute to provide advice to the Committee in person.

(3) The five year strategic plan, the detailed documents underpinning it and the UHL capital scheme, which forms part of the long term plan for the people of LLR, be put into the public domain at the earliest opportunity and well before the start of public consultation. These should include all documentation relating to an assessment of the current and anticipated satisfaction of equality duties and health inequality duties.

(4) The JHOSC undertake a thorough scrutiny of the five year term plan, and associated capital scheme, with a view to assessing its' fitness for the future. It should draw upon the knowledge and expertise of patients and members of the public as well as health service personnel. If necessary, the JHOSC seek advice and input from independent experts able to give assurance (or not) as to the adequacy of the plan in its objective to ensure different parts of the health system operate in a joined-up way with the consequences of centralised hospital services appropriately mitigated.

(5) The JHOSC recommend modifications to the plan, if these are required to ensure its adequacy in guiding the direction of health services in the coming years and signal its willingness to refer the matter to the Secretary of State if the local NHS rejects its recommendations.

(6) The JHOSC agree a plan of local consultation on capital scheme(s) in the context of the overall long term plan once this process has been completed.

We envisage that this process could take as little as 4 months and that, for this modest delay, the prospect of a future judicial review citing breaches of due process would be significantly reduced.

KEY MESSAGE It would be a tragedy for the CCGs and UHL to fall foul of legal challenge especially in view of the substantial capital investment currently proposed for UHL. This section makes proposals to reduce the prospects of this outcome.

APPENDICES

Appendix I: Acronyms used

BCT = Better Care Together Programme responsible for LLR NHS planning since 2013, under which health service planning for LLR has taken place since 2013

CCG = Clinical Commissioning Group

DH = Department of Health and Social Care

JHOSC = Joint Health Overview and Scrutiny Committee

LGH = Leicester General Hospital

LLR = Leicester, Leicestershire and Rutland

LTP = Long term Plan for NHS published in January 2019

NHSE = NHS England

STP = Sustainability & Transformation Plan

UHL = University Hospitals of Leicester

Appendix II: Legislation and guidance

Some of the relevant sections of the legislation are thus:

S14Z2

2. The clinical commissioning group **must make arrangements** to secure that **individuals to whom the services are being or may be provided** are **involved** (whether by being consulted or provided with information or in other ways)—
    a) in the **planning** of the commissioning arrangements by the group,
    b) in the **development and consideration of proposals** by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
    c) in **decisions** of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

S242 (1B)

Each relevant English body **must make arrangements**, as respects health services for which it is responsible, which secure that **users of those services**, whether directly or through representatives, are **involved** (whether by being consulted or provided with information, or in other ways) in—

a) the **planning** of the provision of those services,
b) the **development and consideration of proposals** for changes in the way those services are provided, and
c) **decisions** to be made by that body affecting the operation of those services.

14T Duties as to reducing inequalities

Each clinical commissioning group must, in the exercise of its functions, have regard to the need to —

a) **reduce inequalities** between patients with respect to their ability to **access** health services, and
b) **reduce inequalities** between patients with respect to the **outcomes achieved for them** by the provision of health services.

Appendix III:

The involvement of communities and public discussion in planning change are required both to modify LLR's original 2014 agreed strategic direction of substantial transfer of acute beds to community and in preparing a range of implementation options to deliver that revised strategy which have been worked up and rigorously compared. The impact of all options has also to be assessed and alternatives offered in mitigation.

- **NHSE 2018 formal Guidance on Implementing Strategic Change** Due process for service reconfiguration requires capital proposals to be developed in the context of a strategic plan. However, UHL's capital proposals were developed *ahead* of the local strategic plan (the local long term plan) which has yet to be published. To date capital reconfiguration proposals have been presented as one option which may imply that a decision has been made. Links to 2018 reconfiguration guidance and 2019 Capital Guidance:

  https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

  https://www.gov.uk/government/publications/health-infrastructure-plan

- **Risks arising from Split Public Consultation** From the limited information in the public domain, our understanding is that HOSCs will be asked to consider consultation on the new builds at UHL without considering all the relevant details of the strategic plan as a whole which presumably will contain the interrelated schemes and mitigating provision needed in the community. Any consultation lacking all the relevant information would run the risk of legal challenge under Gunning II.

"The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered." (Guidance to Local Authorities 2014).

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