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REPORT TO:	**HEALTH & WELLBEING SCRUTINY COMMISSION**
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DATE:	**2ND March 2017**
SUBJECT:	**Sustainability and Transformation Plan – UHL Acute Hospital Sites**

Introduction

1. The STP identifies 5 key priorities / strands of work for the health community in Leicester, Leicestershire and Rutland over the next 5 years:

    1: New models of care focused on prevention, moderating demand growth

    2: Service configuration to ensure clinical and financial sustainability

    3: Redesign pathways to deliver improved outcomes for patients and deliver core access and quality

    4: Operational efficiencies

    5: Getting the enablers right

2. This paper focuses priority 2 'Service configuration to ensure clinical and financial sustainability', and our intention to consolidate care onto two acute hospital sites subject to consultation. However, there are several interdependencies between the strands of work above, particularly given the relationship between demand (for hospital services) and capacity (such as beds). Therefore, this paper will summarise all strands / priorities while focusing on service configuration.

Current Service Provision and Sustainability

3. Services are currently provided on 3 acute sites: the Leicester General Hospital (LGH), Leicester Royal Infirmary (LRI) and the Glenfield Hospitals (GH).

4. Leicester is unusual in having three big acute hospitals for the size of the population we serve. Historical development rather than best clinical practice gives us our current configuration. This creates problems:

    a. Our specialist staff are spread too thinly, making our services operationally unstable;

    b. We duplicate and triplicate services across sites,

    c. It is expensive to run.

5. Over the last two decades there has been significant and sustained underinvestment in the acute estate relative to most acute hospitals.

6. Many planned elective and outpatient services run alongside our emergency services and as a result when emergency pressures increase it is elective patients that suffer delays and last minute cancellations.

7. Evidence indicates that patients, and particularly elderly patients, spend too long recovering in large acute hospitals and potentially deteriorating as a result, when they would be better served by rehabilitation services in their own home or in a community hospital.

8. We want to adopt a “Home First” principle where there is an integrated care offer for people living with frailty and complex needs. Our focus will be to ensure that people can remain in their own homes. When this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to enable them to get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

9. As a result UHL will need to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing in hospital acute care that cannot be provided in the community. By focusing our resources on two sites we can improve our outcomes for patents for example through increased consultant presence and thus earlier, more regular senior clinical decision-making

What does this mean for the General Hospital?

10. Subject to the formal public consultation, the plan is that acute services will be moved to the LRI & GH. The Leicester Diabetes Centre (as well as potentially some connected services) will remain at the General and will continue to expand to become the pre-eminent diabetes research institute in the UK.

11. The General will also continue to be home to other health and social care services. The Evington Centre will remain providing community beds for Leicester, incorporating a stroke rehabilitation ward. Joint health and social care teams delivering services in people’s homes will continue to have a base at the site. Leicester City CCG are also considering using the LGH site as a centre for a primary care hub

providing extended hours and GP+ services, ambulatory services and diagnostics.

What does this mean for the Royal Infirmary?

12. The Royal Infirmary will continue to be our primary site for emergency care. The Royal will see consolidated women's hospital for maternity and gynaecology services and the completion of the new Emergency Floor.

13. A key component of our overall reconfiguration is the creation of two super ICUs, one at the Royal and Glenfield.

14. The East Midlands Congenital Heart Centre at the Glenfield will move to the Royal as part of the investment to create a properly integrated children's hospital. If congenital heart surgery is ultimately decommissioned then these facilities will be designed in such a way that they can be re-used for other services.

What does this mean for the Glenfield?

15. The Glenfield will grow and become more specialised as services move from both the General and the Royal.

16. The first of these moves in May 2017 will be the vascular service so that we can create a complete cardiovascular centre. Renal services, including transplant, will also move to the Glenfield.

17. We also intend to locate our planned ambulatory care hub which will provide outpatient and day cases up to 23 hours at the Glenfield.

What will change to enable the acute reconfiguration?

18. The redesign of services is an essential component of the delivery of reconfiguration. The hospitals will focus on care for patients those essential needs must be provided in an acute setting.

19. In order to do this, we need to make it safe to reduce our inpatient beds capacity, through the provision of alternative pathways and out of hospital services, the themes covered by the other strands of work within our STP, as mentioned above in the introduction They are:

    - **Strand 1 New Models of Care focused on prevention and moderating demand growth:** the focus of this strand is using new models of care to bring about system wide transformation, moving our efforts upstream to reduce dependency and moderate the demand on hospital services. This will be achieved through a redesigned urgent and emergency care offer, the development of integrated placed based teams, ensuring primary care is resilient and improving the effectiveness of planned care. The impact of this will be about bending the demand curve for acute hospital admissions and bed days as well as reducing high cost placements in health and adult and children social care and impact on other public sector service.

- **Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality:** over the last two years through our Better Care Together Programme we have started the journey to redesign pathways across a number of clinical workstreams. This work will continue under the STP. This also includes our work on prevention, Long Term Conditions; Cancer; Mental Health; Learning Disabilities and Continuing healthcare and personalisation.

- **Strand 4 Operational Efficiencies:** the focus of this strand is about becoming more efficient at the things we currently do for example theatre utilisation and working collaboratively to reduce costs in areas where we have functional duplication. This includes back office functions across providers and commissioners and medicine optimisation. This incorporates the steps we are taking to implement the Carter Review recommendations. In terms of service configuration, a key element of this work is also focused on improving the efficiency of hospital beds, which involves reducing the amount of time patients spend in hospital unnecessarily, which will allow us to safely reduce the number of beds we need in some services, aiding our new / proposed configuration.

20. Integration – both as an underpinning theme and a programme of work within strand 2 - is central to our plans. We started our integration journey through our Better Care Together and Better Care Fund programmes which have resulted in the development of home based beds and the integration of some health and social care services that help to support more patients in their own home.

21. Within our STP, we go much further - integration of services will involve fundamental transformation in the way local health and social care services will work together at scale, providing integrated care in the community. We will take this further through a number of workstreams, including:

    - Multidisciplinary Integrated Locality Teams (ILT)
    - Integrated cardio respiratory community teams
    - End of Life (EOL) specialist care
    - Integrated falls service

22. Our proposals around multidisciplinary integrated locality teams are particularly exciting – we will develop and implement a model of integration that wraps around the patient and their GP Practice extending the care and support that can be delivered in community settings through multidisciplinary working. The outcome of this new way of working will mean fewer patients will need to be admitted to hospital owing to more care and support being delivered in the community.

23. Our vision for integration also includes working more closely with the hospital specialists, the voluntary and community sector, clustered around groups of general practices within identified placed based communities. These are designed to improve health outcomes and well-being, increase citizen, clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

24. In terms of strand 4 (which includes work to ensure we make best use of our hospital bed stock), we are building on a number of existing best practice improvement projects on efficient flow and discharge process including the SAFER bundle, integrated and streamlined discharge processes and improved sign-posting. Readmission improvement projects developed throughout 2016/17 will continue into 2017/18 delivering further reductions in the demand on inpatient bed capacity. The programme is also likely to work with community beds to reduce the overall composite length of stay across LLR. A particular focus will be on reducing unnecessary variation within the way different wards and their teams practice.

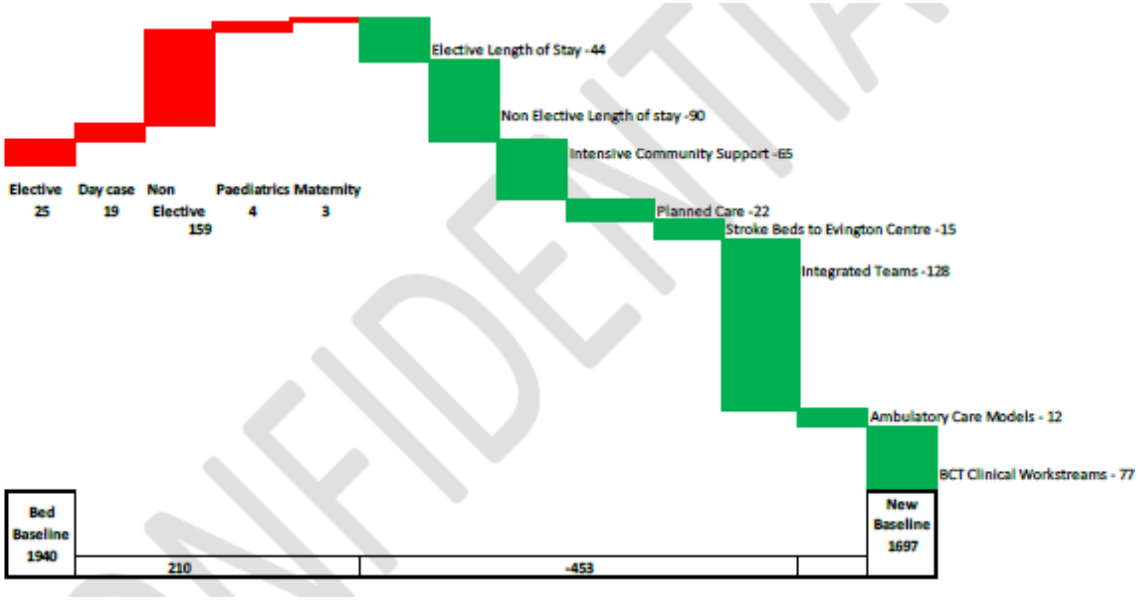
25. In addition to schemes that are active in 2016/17 additional projects targeting Ambulatory Emergency Medical patients and Same Day Surgical discharge rates will also contribute to reduced demand on inpatient acute wards.

26. Our ambition (for hospital length of stay) has been defined by benchmarking our performance against relevant peers and where the Trust has longer length of stay the opportunity to improve to the upper quartile (top 25%) has been used.

How will change be enacted and to what timescales?

27. In order to consider the impact of the above changes and the impact of any efficiencies planned, work has been undertaken to understand the future acute bed capacity requirements. The following bed bridge describes the outcome of this modelling which will take acute beds from the current level of 1940 to 1697 by 2020/21.

28. The assumptions underpinning the bed bridge below are being updated as further work is being done to sense check the likely impact of each of the interventions along with the associated timescales. In addition to the changes shown, we are currently considering utilising spare community capacity for sub-acute purposes. This is in order to ensure that we utilise existing estate and minimise investment in new acute estate, whilst ensuring that UHL has access to sufficient beds to operate effectively and can consolidate onto two acute sites. Final decisions will be taken in conjunction with the community beds strategy described in the next section, Elective Length of Stay



29. In terms of current timing / phasing assumptions, we expect to see some of the benefits of the various strands of work realised as early as 17/18. However, given the system (and our acute hospitals in particular) is currently out of balance when it comes to demand and capacity, any early gains will actually restore balance i.e. we need to reduce bed occupancy. Moreover, as alternative services will take time to become fully established, it is likely that demand will be moderated more heavily in 18/19 and onwards – therefore, the timing of any bed reductions will be aligned with this (albeit across a number of years against a gradual trajectory).

Costs & Sources of Funding

30. Financial recovery is directly linked to site consolidation. By moving acute services to the LRI and GH from the LGH, acute reconfiguration is expected to deliver gross annual savings of £25.6M by 2020-21.

31. Significant capital investment is needed to deliver this change and whilst UHL has planned some investment from internally generated capital, it is not possible to fund all of the required investment in this way and as a result some external funding is required.

32. The constraints on capital availability nationally have led us to reduce our capital requirement for reconfiguration to a minimum. All funding solutions available to the Trust have been explored with two preferred main options emerging:

    a. the Trust can seek funding in the form of interim capital support loans from the Department of Health

    b. the Trust has explored and identified PF2 as a potential suitable alternative for the financing of suitable projects with substantial new build, namely the Planned Ambulatory Care Hub and Women's Hospital. The Trust is currently in the process of exploring this in more detail.

33. The reconfiguration projects are designed to address clinical and financial sustainability inherent within the current configuration and

will, in the areas affected, modernise facilities and make better use of the remaining estate footprint.

34. Each project is independent but related in that they will collectively change the overall way in which some services, particularly inpatient services, will be delivered with the aim to reduce the number of bed days and number of emergency admissions experienced by the patients.

35. A number of projects have been established in order to deliver the acute reconfiguration. The table below details of the projects, with their costs, from 2017-18.

Individual project cost and profile	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
LGH					(28,350	**(28,35**
Emergency Floor - BAU in STP		0	0	0		0
Reprovision of clinical services	6,600	10,000	10,00	5,00		31,6
Vascular Services	0	0	0	0		0
ICU Service Reconfiguration	12,906	0	0	0		12,9
Planned Ambulatory Care Hub	1,728	2,880	19,00	34,00		57,6
ITU LRI	503	7,000	8,300	0		15,8
Women's services	1,966	3,277	22,28	38,00		65,5
Childrens' Hospital	2,577	11,000	4,000	0		17,5
Theatres LRI	1,058	3,500	6,400	0		10,9
Entrance LRI	0	0	2,000	10,00		12,0
Wards/Beds LRI	500	5,800	7,000	7,50		20,8
Wards/Beds GH	552	5,746	5,500	5,50		17,2
Other reconfiguration projects	1,000	3,000	4,500	9,00 0		17,5 00
TOTAL ACUTE HOSPITAL	**29,389**	**52,203**	**88,98**	**109,00**	(28,350	**251,2**

36. A summary of the budget is shown below. We are requesting support from the DH of £114m, and proposing to pursue PF2 for £97.3m with a commercial venture on the Welcome Centre, located at the LRI:

	Oct STP
	£m
Reconfiguration capital expenditure programme	**363.0***
Spent/Approved to date	(62.9)
Capital Funding Requirement	**300.1**
Internally funded	(47.8)
External funding requirement	**252.3**
Site disposal	(28.4)
Welcome centre	(12.0)
PF2	(97.3)
DH funding requirement	**114.6**

Return on Investment

37. The STP reported position delivers an ROI of 10.2% with an investment payback of 11.4 years.

38. The core savings from reconfiguration arise from a reduction in structural estates and facilities costs which have been verified by Ernst & Young as directly attributable to the strategic scheme.

39. In addition, further CIP (CIP = Cost Improvement Programme) has been identified and is attributable to a post-reconfigured environment that is over and above the structural estates and facilities costs as described above. The STP reported position has been based on £10m of CIP being attributable to a post reconfigured acute footprint as well as the release of the structural estates and facilities costs.

40. Having undertaken a further review of the CIP opportunities within a post reconfigured acute footprint there is scope to increase this CIP amount by a further £5m. This will be delivered through the following:

    a. Greater efficiencies due to alignment and streamlining of clinical pathways;

    b. Greater efficiencies due to improved clinical adjacencies and the associated efficient use of medical and nursing workforce;

    c. Greater opportunities to maximise efficiencies within elective pathways and the opportunities that exist within purpose built functions such as PACH;

    d. Consolidation of multi-sited functions onto one site ie Women and Childrens services.

    e. The inclusion of this additional £5m of CIP within a post reconfigured acute footprint results in an ROI of 12.6% and a payback of 9.8 years.

Recommendation

41. The Health & Well Being Scrutiny Commission are asked to:

    a. note and discuss the content of this paper

    b. advise whether there is any additional assurance they require on UHL's acute reconfiguration programme.