Appendix 1

executive summary

September 2006

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For further information, including the Working Papers referred to in this Executive Summary, please see the Making Leeds Better website www.makingleedsbetter.org.uk

1. Introduction

The Making Leeds Better Vision

Our vision is for a future where people who need health and social care get the best possible care and treatment in modern facilities closer to their own homes.

Care and treatment that until now have only been available in hospitals will be provided by doctors, nurses and other health and social care staff working in the community.

Staff will be able to take advantage of the latest developments in medical science, technology and clinical practice – free from the limitations of old building and outdated ways of doing things.

When people do need hospital care they will get it in modern facilities truly fit for the 21st century.

In the summer of 2004, partners in the Leeds Health and Social Care Community agreed to work together to make major improvements to health and social care services in the city. The first demonstration of this shared commitment was the submission to the Department of Health of a strategic outline case (SOC) for a new Children's & Maternity Hospital in Leeds. The proposals for a new hospital described in the SOC depended on far-reaching changes that would transform the delivery of health and social care across the city.

When the SOC was approved in July 2004, the partners established a programme – known as 'Making Leeds Better' – to work with the public, patients and staff to develop proposals for better health and social care services. Making Leeds Better aims to radically change health and social care in Leeds, focusing on providing more and better care for people closer to home and building a new Children's & Maternity Hospital. We aim to diagnose and treat people sooner, avoid admission to hospital where appropriate, and care for people in up-to-date facilities.

Making Leeds Better is a far-reaching and complex programme of change management, overseen by a Programme Board with members representing public and patients, voluntary organisations, local government, staff side organisations, universities and health and social care organisations. Governance arrangements for the Making Leeds Better Programme have been set up according to the recommendations of the Office of Government Commerce (OGC).

The Making Leeds Better Programme is managed in line with the Office of Government Commerce's *Managing Successful Programmes* approach. A Department of Health Gateway Review of the Programme praised our focus on care pathways, engagement of stakeholders and programme management approach.

Measuring the success of Making Leeds Better implementation will be managed and monitored by adopting the Department of Health's benefits realisation process. This focuses on benefits for patients and services users, clinicians and organisations providing care.

NHS statutory organisations and the Council are not expected to give formal approval at this stage to the proposals set out in this document, but to support the work that has been done to date and to agree the next steps required to develop deliverable and affordable options for formal public consultation beginning in spring 2007. Public consultation will focus on the proposals for major changes in the location of services outlined in this document and will follow a period of intensive engagement with the public to inform the options for consultation. The proposals for the new Children's & Maternity Hospital and other new buildings on the St James's Hospital site will require formal approval by statutory organisations as part of the outline business case (OBC) approvals process in 2008.

2. Aims of Making Leeds Better

	The Making Leeds Better Aims	
1	**Involve the public, patients & staff in making the vision a reality**	We have focused from the outset on wide engagement with the public, patients, staff, partner organisations and stakeholders across Leeds and surrounding health communities so that all requirements and issues of concern are addressed prior to formal consultation. Patients, voluntary sector organisations, clinical leaders and representatives of the Trade Unions staff side are members of the Making Leeds Better Programme Board which has overall responsibility for steering the Programme. Service users, patients, clinicians and managerial staff are involved in care pathways development.
2	**Radically redesign care pathways to provide better access to high quality care closer to home**	In line with the Government's White Paper *Our health, our care, our say*, we want to care for people in or close to their own homes, improve access to services, diagnose and treat people earlier, reduce health inequalities, tackle over-hospitalisation and reduce excessive lengths of stay. Our main focus has been on: children's and maternity care pathways; adult care pathways that will have the biggest impact on reducing hospitalisation; providing better care for patients in primary or community settings; and non-pathway services where efficiencies can be made by implementing best practice in demand and capacity management.
3	**Build a new Children's & Maternity Hospital**	We want to significantly improve services for children, women and their families by building a new Children's & Maternity Hospital through the private finance initiative (PFI). The outline business case (OBC) is also likely to include other new buildings to facilitate the relocation of services from the Leeds General Infirmary (LGI) to the St James's site.
4	**Build new premises in the community**	We want to develop the infrastructure needed for services to transfer from acute hospital settings to primary and community settings. New community health centres and child & family centres will be built through the LIFT (Local Improvement Finance Trust) mechanism.
5	**Focus acute and complex care on the St James's site**	We want to improve the quality and safety of services for patients and make best use of specialist clinical staff by focusing acute and complex hospital care onto a single main site at St James's University Hospital. Implementation of care pathways, more day case surgery and development of new premises in the community will allow the number of beds in the acute hospital to be reduced. This will provide the opportunity to locate all acute and complex care on one site.
6	**Develop a Strategic Services Plan which is deliverable & affordable**	We can only deliver improvement for patients if our plans are realistic and affordable. The key tests of deliverability and affordability are whether: ▪ Resources (both financial and workforce) can be transferred to primary and community care to enable the step changes in provision required. ▪ We can achieve financial balance and pay for PFI and LIFT new builds. ▪ Estate solutions can be implemented in time to allow staged investment in primary care and reduction in acute hospital services – including beds – as services are transferred to community settings.

Please see Working Paper: Programme Aims, Governance & Management

3. The Case for Change

Leeds is one of the most prosperous cities in the UK, recently voted the UK's Favourite City and Britain's Best City for Business. Primary, community and social services in the city have seen many developments over the last few years, with investments in services that keep people fitter for longer in their own homes and prevent unnecessary admission to hospital. When people do go to hospital, the Leeds Teaching Hospital Trust provides excellent health care to the people of Leeds and specialist services across West Yorkshire.

But, like other health and social care economies we need to respond to changes in the expectations and needs of the people who use our services, to advances in medical science and technology, and to national policy. Also, in Leeds there are some specific drivers for change that we want to address through Making Leeds Better.

The Drivers of Change in Leeds

- **Build a new Children's & Maternity Hospital** to provide clinically safe, dedicated facilities for children and mothers.
- **Invest in primary and community services** so that we can improve health and wellbeing and reduce our reliance on hospital care.
- **Tackle inequalities in health** by improving access to health and social care services.
- **Consolidate complex care for adults at St James's hospital** to improve clinical safety and quality; and to enable better use of healthcare resources across the city.

The MLB programme has the full support of Leeds City Council and the engagement of senior officers and elected members. This recognises the commonality of the Council's wish to 'narrow the gap' between those people who have benefited from the prosperity generated within the city and those people who have yet to benefit. MLB will complement and accelerate the Council's regeneration plans and ambitions for Children's and Adult services.

Please see Working Paper: Case for Change

4. Better Care for Children & Adults

The Making Leeds Better vision is entirely consistent with the direction of travel outlined in the Government's White Paper *Our health, our care, our say*. The *Your health, your care, your say* consultation, which underpinned the proposals set out in the White Paper, revealed support for more community services. At the culmination of the consultation (the Citizen's Summit in Birmingham involving a thousand people) the majority of participants supported the provision of more services in the community, even if this meant that some larger hospitals would concentrate on specialist services and some would merge or close.

The research carried out for the White Paper also showed that the public in general and people with long-term conditions – such as diabetes or heart disease – support the idea of services which help to maintain the health and independence of people with long-term conditions. People with long-term conditions think this will help to reduce their need for more expensive residential care and medical help in the future. They are particularly keen to see more joined-up social care and health services, such as through single needs assessment and use of care managers.

The Making Leeds Better proposals also include improvements for children's and maternity services provided in community-based settings. As with adult services we recognise that many children and pregnant women could be cared for in community facilities closer to their homes. New care pathways are being developed that will improve the quality and consistency of care for women and children; and many outpatient appointments and other care will be provided in community-based Child & Family Centres.

We expect the result of these community developments to reduce emergency admissions to hospital by around 6,400 (about 8%) a year. In addition, around 115,000 outpatient visits (about 15%) and 55,000 diagnostic appointments (about 25%) that currently take place in hospital would be provided in community healthcare facilities by 2012.

Making Leeds Better is about creating opportunities to look after people better and improve their health outcomes. By ensuring more effective use of resources across the city and reducing the inefficiencies inherent in delivering complex and specialist care from two hospital sites, Making Leeds Better will provide the platform for more investment both in primary and community services so that people can receive care more locally and in a new Children's & Maternity Hospital.

Our ambition for community-based care has been driven by a focus on care pathway development. This ensures that patients and clinicians benefit from a more systematic approach to providing care, which support safe, high quality and equitable care and treatment.

The Care Pathway Approach

- Ensure care pathway development is **led by clinicians**, with strong **involvement from patients and the public**.
- Develop care pathways that **improve access** for significant numbers of patients – to help reduce inequalities in health – and underpin services with health promotion.
- Ensure proposed service changes meet **clinical governance** requirements, follow **national clinical guidance** and are driven by the **Ten High Impact Changes** endorsed by the Department of Health.
- Ensure pathways address **national and local priorities** such as reducing waiting times to 18 weeks from referral to treatment and supporting GP commissioners to meet local needs.
- Secure **greater integration** within pathways between health and social care services. The pathways are based on multi-professional, multi-agency care, including services provided by Leeds City Council.
- Underpin services with appropriate **teaching, research and development**.

In Leeds, we have been able to begin implementation of many of the care pathways, building on excellent schemes that have already been developed in parts of the city. Making Leeds Better has provided the impetus for these care pathways to be implemented across the whole city so that all patients can benefit.

4.1 Better Care for Children

There are over 180,000 children and young people between the ages of 0-19 in Leeds. This represents around a quarter of the whole population of the city. Due to falling birth rate and demographic changes, the number of young people has been falling in the recent past. But, more recently, this fall has stabilised. In some parts of the city – particularly in the inner city and in black and minority ethnic (BME) communities – the number of young people is growing. As a result of this demographic trend, around 13% of children and young people in Leeds are from BME communities.

Making Leeds Better has at its heart the desire to improve services for children. Better services will come, not just from a new Children's & Maternity Hospital, but also from development of community-based services, improved delivery of care through redesigned care pathways and new Child & Family Centres based in the community. These changes focus on normalising and localising services, such as outpatients, within community settings and providing a wider range of more local services and treatments to minimise the need for children to go to hospital.

New pathways have been developed for a number of children's health conditions (asthma, epilepsy, enuresis, constipation, diabetes) and are being developed for children with complex needs. The service is also being improved for children who need acute assessment, and we have identified some underpinning changes that are needed to support these new care pathways.

4.2 Better Care for People with Longer-term Needs

A significant number of people who either live at home or who have become patients in Leeds hospitals suffer from debilitating long-term conditions. Consultation carried out by the Government for the *Your health, your care, your say* White Paper showed that people with longer-term or more complex health and social care needs want services that will help them to maintain their independence and well-being and to lead as fulfilling a life as possible.

By Government estimates, over one third of people in England have longer-term health needs and every decade, from aging of the population alone, the number of people with long-term conditions will increase by over a million. For Leeds, this means around 250,000 people with longer-term needs, growing by over 15,000 every decade. The number of people with severe disability will also increase, partly due to the increased survival of pre-term babies.

Over two-thirds of NHS activity – and around 80% of costs – relates to the one-third of the population with the highest needs of these kinds,. The Government concluded that this will have significant resource implications for health and social care unless we change our current approach.

Recent national surveys show that we still need to do more to empower people with long-term health and social care needs through greater choice and more control over their care. Health and care services still do not focus sufficiently on supporting people to understand and take control at an early stage of their condition. As a result, resources are wasted, medication goes unused, people's health deteriorates more quickly than it should and quality of life is compromised.

Making Leeds Better has focused on six longer-term conditions that affect a significant number of people in the city.

Focus of the Care Pathway Work for People with Longer-Term Needs

- Neurological conditions (particularly stroke)
- Diabetes Type 2
- A fractured hip following a fall
- Chronic obstructive pulmonary disease (COPD)
- Coronary heart disease (CHD)
- Dementia

The aim in developing care pathways for people with these conditions has been to provide better health and well-being; support for those in greatest need; convenient access to high-quality services; and care in the most appropriate setting, closer to home.

Successful support for patients with these conditions requires the effective marshalling and deployment of health and social care services. In addition, social care services commissioned or provided by the Local Authority play a crucial role in promoting self-care and assisting carers in maintaining patients in community settings who would otherwise have to be admitted to hospital.

4.3 Better Maternity Care

Women want birth to be a normal experience, with ante-natal care and post-natal support provided as close to their homes as possible. Our proposals for maternity care therefore aim to provide easy access to services, particularly to support women in hard to reach groups and to further enhance parenting skills and meet the public health needs of the population.

Aims of the New Model for Maternity Services

- Develop an evidence-based, women-centred and streamlined service.
- Promote public health, enhance choice, reduce health inequalities and tackle social exclusion.
- Implement national policy such as the Maternity Standard of the National Service Framework.
- Respond to recommendations from Confidential Enquiries.
- Consider the changing workforce and development of support worker roles.
- Enhance partnership working with statutory bodies and voluntary agencies

4.4 Better Urgent Care

Leeds experiences around 220,000 patient visits to its accident and emergency (A&E) departments each year. This is higher than the national average for a city the size of Leeds. MLB aims to provide fast and convenient services for patients with urgent health care needs, focusing providing more locally and ensuring that services fit well with the vision set out in the Government's White Paper *Our health, our care, our say*. We are working to provide safe and high quality alternatives to hospital – such as rapid response services in patients' own homes, walk-in centres and minor injuries units – except for patients with the most serious healthcare needs.

In addition to the current support provided by social care services to maintain individuals in community settings, the Local Authority has contracted a number of transitional and respite care beds to provide an alternative to urgent hospital care in those instances where the care network of a vulnerable individual breaks down.

4.5 Better Managed Care

Our work on managed care is being developed to support delivery of the Department of Health's target to ensure that no patient waits more than 18 weeks from referral by their GP to treatment. The 18 week access target is different from previous access targets because it is the first to include all stages that lead up to a patient's treatment, including the outpatient consultation, diagnostic tests and elective procedure. Consequently, the 18 weeks target shifts the focus of management from individual stages of the patient's journey to managing a whole care pathway. Achieving the 18 week target will require significant reductions in the average waits for all stages along the pathway – tackling the longest waits alone will not be enough.

Aims for Patients who need Managed Care

- Speedy access to high quality care and treatment, including access to diagnostic tests.
- Care in the best possible settings, close to where people live, where it is safe to do so.
- An appropriate choice of provider, treatment, time and place.
- Information & support to make an informed choice.

Achievement of the 18 week access target requires us to focus on specific surgical specialties. For Leeds, these will include orthopaedics, ear nose & throat (ENT), urology, gynaecology, plastic surgery and general surgery. To deliver this ambitious aim, patients and service providers will have to work in partnership to develop innovative means of increasing rates of day case surgery and enabling more patients to be admitted on the day of their operation and discharged much sooner afterwards. This will enable patients to minimise the time they have to spend in hospital.

Please see Working Paper: Better Care for Children & Adults

5. Modelling Capacity for Efficient Service Delivery

Planning new services on the scale of Making Leeds Better is complicated and requires detailed modelling for the future. The approach to modelling future capacity within the Leeds health economy has been underpinned by five basic principles: implementation friendly, pathway driven, transparent, bottom up and demand led. The basic modelling process was to understand the service, create a baseline, adjust for future changes and then vary assumptions to create a range of capacity options.

We modelled capacity at the hospital level for specified number of areas: inpatient and day case beds; operating theatres; outpatient clinics; the emergency department; and radiology. For community and social care services we modelled only the service changes identified, including the impact of the care pathways, movement of paediatric medical outpatients into community settings, and movement of some adult outpatients and radiology into community settings.

Demand for health and associated social care continues to change over time. We have assessed the effect of six factors: population change; the impact of Leeds PCTs' plans to develop services to care for people closer to home, such as rapid response services; the impact of the care pathways; commissioning changes identified by PCTs outside Leeds; the future for specialist hospital services; the impact of patient choice; and the impact of independent sector treatment centres.

To assess the impact of efficiency gains, we identified specific issues of current performance and sought to show how these could be improved. Efficiency changes include pooling of hospital beds, theatres and clinics to promote more flexible use of capacity; removing pre-operative stay so that patients come into hospital on the day of surgery; increasing the rates of day case surgery across all adult surgical specialties; reducing length of stay in line with best practice recommended by the new care pathways; assuming patients are discharged when they are fit rather than when it is convenient for staff; changing the new to follow up outpatient ratios for all consultants to the upper quartile performance in each specialty.

For pathway capacity modelling, we used the following approach: *Pathway resources = resources for 1 patient x number of patients*. Resources are expressed in terms of number of rooms or whole time equivalent staff. We used simulation software to model the way patients use beds and the emergency village. The simulation creates a series of 'virtual' patients from a given admission profile and length of stay distribution for each patient group. This approach copes well with seasonal and cyclical demand patterns. We used Excel based capacity and demand models for theatres (elective and acute separately), outpatients (first and follow-up separately) and radiology.

Please see Working Paper: Modelling Capacity for Efficient Service Delivery

6. Developing the Workforce

The benefits for patients and service users of the changes proposed by Making Leeds Better will only be achieved by our staff – clinicians and managers – and others working in the non-statutory sectors. Critical to delivery will be our ability to develop our existing staff to fulfil new roles, and to recruit and retain new staff identified as necessary to deliver the health and social services being planned.

There are currently over 30,000 staff employed delivering health and social care services in Leeds – approximately 1 in 10 of the working population. The three largest MLB partner organisations – Leeds Teaching Hospitals Trust (LTHT), Leeds PCTs and Leeds Social Services – employ the majority of these staff, but Making Leeds Better will also impact, in differing degrees, on staff employed by primary care contractors (GPs, Dentists, Optometrists, Pharmacists), on those employed by Leeds Mental Health Services NHS Trust, and on staff employed in nursing and residential homes, in the voluntary sector, and on carers.

To deliver the investment in community services proposed by Making Leeds Better, we expect the numbers of community-based clinical staff to increase by around 15-20%. This takes account of additional staff needed to deliver the new care pathways and provide 'generic' services (such as intermediate care and rapid response) that support the Making Leeds Better aim of caring for people close to or in their own homes; and we have also increased staffing levels to the national average to counter the historic underinvestment in community services in Leeds. The increased numbers in community staff would not apply equally across all staff grades: we expect to see staff in specialist grades supported by more staff in 'lower' grades with NVQ type qualifications.

For LTHT, we expect staffing numbers to change to reflect the increased investment in community-based services and the centralisation of hospital services on the St James's site. Although there will be fewer hospital beds needed in future as more patients are cared for in community settings, the level of need of patients cared for in hospital will be proportionately greater. Overall, we predict that, by caring for more patients in community settings and delivering hospital services more efficiently on a main hospital site at St James's, fewer staff would be needed in the hospital sector.

The service redesign work at the heart of Making Leeds Better has asked: who should do what?. This has also prompted some changes in the professional mix of staff – in both hospital and community.

New Professional Roles

- Extended roles for nursing staff – such as Nurse Consultants or in prescribing – which not only relieve medical staff of some tasks but also provide career development opportunities for nurses.
- New roles – such as Assistant Practitioners and Midwifery Support Workers – to support professionally registered staff.
- A 'New Type of Worker' to provide personal care and low level clinical tasks for people at home, who currently are often visited by both social service employed and health service employed carers.

We expect that most of the new community workforce will be created by training and developing staff currently employed in the Leeds health and social care economy. Some of the new skills required will be relatively straightforward, for instance requiring the provision of specific training in a technique or procedure; others will require more substantial action. Training programmes may be required to enable staff to adopt entirely new roles – for instance, Midwifery Support Workers may be recruited from the existing workforce, but will need an extensive training programme to

develop them. Some staff will need to relocate, such as where services currently being provided in hospital settings move fully to community based facilities. Given that the changes proposed by MLB take us up to 2012, we expect any workforce reductions to be managed through natural turnover or deployment of staff.

Plans for training and development of staff will be supported by the workforce development arm of the Yorkshire & Humber SHA (formerly the Workforce Development Confederation) and the two Leeds universities (the University of Leeds and Leeds Metropolitan University). In support of MLB, the Leeds Health and Education Sector Partnership (HESP) is about to commission a major piece of analysis and modelling work to understand and inform the planning of education, teaching and training requirements. We are also working closely with both universities to ensure that the Making Leeds Better proposals continue to support excellence in teaching and research.

Please see Working Paper: Developing the Workforce

7. The Children's & Maternity Hospital & Better Healthcare Facilities

7.1 Why We Need a New Children's & Maternity Hospital and a Single Hospital Site

Hospital services for children are currently provided at both St James's and the Leeds General Infirmary from eight different buildings, with two accident and emergency departments, at least 12 different outpatient areas, a day hospital, 15 inpatient wards and three intensive care units. This results in risks to clinical quality and safety, a poor patient experience and duplication of services leading to inefficiencies. The main clinical risks for children needing hospital care come from having to be transferred between hospital sites or from having to be cared for on a site remote from their main specialty.

Facilities for children of different ages are inadequate. Some children and even more young people are treated as inpatients on adult wards; and many children are still seen in mixed adult/paediatric outpatient clinics. Parents have complained vociferously about the poor quality of patient experience caused by the state of the accommodation and distribution of services for children across and within Leeds hospital sites. A new purpose-build Children's & Maternity Hospital would provide facilities for children and parents that are built around their needs.

Hospital-based maternity services are currently provided from both the St James's and the Leeds General Infirmary sites. Bringing these services together would increase the availability of consultant obstetric support to midwives (as this is currently spread across two sites). The links between maternity services and neonates (new born babies) and between neonates and many children's services are critical. Any solution for children's hospital services must also include maternity services – hence the proposal for a Children's & Maternity Hospital.

The split site issues that apply to children's services apply equally to **adult services**. Clinical care for adults is delivered from all of Leeds Teaching Hospitals Trust's sites – many of which contain facilities considerably older than the patients they treat. Centralisation of clinical teams and facilities on one site would ensure that all patients with complex or urgent health needs get the care and treatment they need with minimum delay. In addition, as hospital care becomes increasingly specialised, integrating services on one site would ensure that we make best use of specialist medical and nursing expertise and continue to improve the quality of our health services.

Please see Working Paper: Case for Change

7.2 Better Hospital Facilities and a New Children's & Maternity Hospital

LTHT Current Estate Profile

- Operates from six hospital sites, two major acute hospitals, three peripheral hospitals and one specialist hospital.
- Land area of approximately 59 hectares; buildings with an internal floor area approaching 500,000 m^2.
- Bed capacity approaching 3,000 beds, of which around 2,600 beds are currently in operation.

In response to this 'case for change', the strategic outline case (SOC) proposed a single acute site at St James's, with new build for children's & maternity and cardiac & neuro services. The Jubilee Wing at the Leeds General Infirmary (LGI) and all peripheral hospital sites were planned to be used, with the Jubilee Wing focused on the delivery of outpatient, diagnostic and day-case services. The old-style Nightingale wards at the LGI would be replaced with modern wards at St James's that provide better dignity and privacy for patients. As well as improving the quality and safety of patient care, consolidating complex care for adults on the St James's site would allow us to manage services more efficiently and provide the opportunity we need to free up funds for investment in primary and community services.

Since the SOC was published, we have modelled in detail the bed, theatre and outpatient clinic capacity needed in LTHT. Beds have been grouped into pools of similar specialties for bed management purposes, allowing more flexible use and further reducing the overall number. We have assumed that most hospital outpatient activity, therapy support and diagnostics will take place away from the proposed single acute site at St James's. The configuration of clinical specialties by site has then been reviewed to identify which clinically appropriate estate option gives the best opportunity for an affordable solution from a workforce and estates perspective. At this stage, a variant on the SOC proposal best meets these criteria because it maximises the use of existing buildings, provides the minimum new build requirement and maximises potential savings by reducing workforce costs (by reducing on call, rotas and duplication of services).

The SOC variant option proposes a single acute site at St James's, with new build for children's & maternity, cardiac & neuro services and A&E. The Jubilee Wing at LGI, part of the Seacroft site and Wharfedale Hospital would continue to be used. However, compared with the original SOC option, we propose to provide more hospital services from St James's and the Jubilee Wing, with orthopaedic services transferring from Chapel Allerton to the Jubilee Wing, and most of Seacroft and Chapel Allerton being available for community-based facilities.

The proposal is that beds will be grouped into pools of linked specialties and used flexibly and more efficiently than currently. The table below illustrates the changes from the 2006 position to 2012/13. Fewer beds are needed for most specialties in the future because of the impact of new community-based services and more efficient delivery of hospital care. The figures include critical care beds.

Bed Pool	Wing	2012/13	2006/07	Change
Acute Medicine	Gledhow/Beckett	672	836	-164
Surgery	Chancellor/Lincoln	492	597	-105
Oncology	New Oncology Wing	216	217	-1
Neuro / Cardiac	New build	288	297	-9
Paediatrics	New build	248	289	-41
Maternity	New build	99	150	-51
Day case	Jubilee/Wharfedale	72	81	-9
Musculoskeletal	Jubilee	54	90	-36
Grand Total		**2,141**	**2,557**	**-416**

The capital value of the SOC variant option is estimated at £625m, which is equivalent to an annual estate running cost of £44m. This compares with a capital cost of £627m to build the original SOC proposal (this is higher than the capital costs assumed in the SOC due to further development of the proposals and inclusion of around £200m for 'optimism bias' – see box below).

Key Assumptions Used in Providing Capital Costs for the SOC Variant Option

- Proceeds from the sale of most of the LGI site and part of Seacroft could be used to part fund the capital costs of refurbishment. The balance of the capital (other than PFI) requirement would be borrowed, with interest incurred, but it is assumed that interest could be repaid from within existing Trust resources.
- The capital costs for new build and refurbishment are based on benchmark rates for the New Oncology Wing (NOW) scheme and advice from the NOW quantity surveyor, but do not reflect any detailed review of actual requirements.
- An optimism bias allowance of 67% has been added onto refurbishment costs and 50% onto PFI costs. This is a contingency to reflect likely costs on completion and is based on a standard formula now in place for all capital schemes.

The next stage is to develop a robust and supportable outline business case (OBC). The OBC is one of the most important approval stages for major capital projects, and we must be able to demonstrate that a rigorous process has been undertaken to assess and test the options and ensure the selection of the most favourable. We need to develop a Preferred Option for the OBC that is robust enough to withstand the rigorous evaluation undertaken by initially the Strategic Health Authority, followed by the Department of Health and HM Treasury. They will take a view on the strength of the Preferred Option and the process for its determination, including the outcome of our engagement and consultation on the service proposals driving the capital solution. The outcome of the OBC stage forms the basis of the procurement process and with it the subsequent shape of any Private Finance Initiative project.

We are aiming to build the new Children's & Maternity Hospital by 2012.

Please see Working Paper: The Children's & Maternity Hospital and Better Hospital Facilities

7.3 Better Facilities for Primary & Community Care

PCT community-based services currently operate from, or are provided within, a range of premises across the city. These include 50 PCT owned health centres and clinics and a number of premises owned by GPs, Leeds Teaching Hospitals, Leeds Mental Health Trust, Leeds City Council and the PCT's voluntary and community sector partners.

In Leeds, in common with many parts of the country, the condition and functionality of the existing estate is variable. Many facilities fail to meet patient and staff expectations, with quality and access often being below an acceptable standard. Fortunately, this is changing, as the Leeds LIFT (Local Improvement Finance Trust) is delivering an ambitious community and GP premises replacement programme.

Four LIFT community health centres are already built and a further eight are under development. In total, this equates to almost £90m of investment in better community health facilities for local residents. These new health centres are providing services which previously were not available locally. For example the Armley Moor Health Centre provides minor surgery and community gynaecology services.

Armley Moor Health Centre
£6m capital cost
Opened November 2005

East Leeds Enhanced Primary Care Centre
£7m estimated capital cost
Estimated completion date July 2008

We have a good understanding of the community estate needed to house the transfer of services from hospital to community settings. Around 115,000 outpatient visits (about 15%) and 55,000 diagnostic appointments (about 25%) that currently take place in hospital would be provided in community healthcare facilities by 2012. So far, we estimate from our capacity modelling that around 50 clinic rooms would be needed to provide these outpatient and diagnostic services. We need to do further detailed work on the impact of new care pathways on the community estate.

The current proposal is for the development of three Child & Family Centres (one already exists at St George's in Middleton) and around three community healthcare 'hubs'. These hubs would house outpatient and diagnostic services, alongside some community services needed to support the care pathways and early discharge of patients from hospital. Additional community capacity will be provided first by ensuring full use of existing and planned community facilities, particularly LIFT buildings that have been designed with Making Leeds Better in mind. Consideration will also be given to using hospital estate (such as Seacroft Hospital) and/or sharing facilities with other organisations such as the Local Authority. Where insufficient capacity is available from these facilities, further LIFT buildings would be commissioned.

For costing purposes, given that further work is needed to refine the community estate capacity requirements, we have been cautious and assumed that all new capacity will be provided by new build. In reality, we are likely to have a mix of new build and better use of existing capacity.

Please see Working Paper: Better Facilities for Primary & Community Care

7.4 Developing Travel & Transport Solutions

The Making Leeds Better proposals for hospital and community healthcare services involve the relocation of some services from hospitals to local community settings and also between the two main hospital sites. Travel and transport has been a major theme during our engagement with the public and patients. Finding a place to park at our hospital sites can be difficult, and public transport to our healthcare facilities is not always convenient. MLB provides the opportunity to tackle these travel and transport issues as we design in detail the new hospital facilities at St James's and consider options for location of community health centres.

The proposals for the hospital estate assume the centralisation of acute and complex care on the St James's site, with the Jubilee Wing at LGI used for diagnostics, outpatients and day-case surgery. As these services are currently spread between the two hospital sites, the proposals will mean shifts of services in both directions. We expect around 200,000 inpatient admissions, outpatient visits and A&E attendances at the LGI to take place at St James's in the future; this is around 30% of the 660,000 current patient visits to LGI. We expect around 170,000 outpatient visits, diagnostic appointments and day-case admissions at St James's to take place at the Jubilee

Wing in the future; this is around 30% of the 560,000 current patient visits to St James's. Overall, due to the impact of developments in community-based services, we expect around 100,000 fewer patient journeys to hospital in 2012, with 130,000 fewer visitor journeys. This is around 10% fewer patient and visitor journeys by 2012.

Making Leeds Better provides us with an opportunity to work collaboratively with Leeds City Council and METRO to develop some solutions to these transport issues to ensure that travel in 2012 is easier than in 2006. Leeds City Council and METRO have agreed to work with us to develop an understanding of numbers of patients and staff travelling by each mode of transport and then to map the implications on travel times of the MLB proposals. This mapping will inform options for the location of community healthcare hubs, development of car parking plans for NHS healthcare sites, and discussions with METRO about public transport routes. We aim to have some options developed for public consultation in spring 2007.

Please see Working Paper: Travel & Transport

7.5 Investing in Information Management & Technology

Increasingly, clinicians rely on Information Management and Technology (IM&T) to access information to help them care and treat patients effectively. Therefore, IM&T systems across Leeds must fully support the MLB care pathways and other proposed service changes. Our vision of integrated IM&T systems that care pathways across organisational, professional and geographical boundaries is also enshrined within the NHS National Programme for IM&T (NPfIT). From an IM&T perspective, the vision of MLB and the National Programme are the same.

The National Programme's IM&T solutions are expected to bring enormous benefits. Clinicians will have better information and support through access to patient records and diagnoses 24 hours a day, seven days a week. Referrals will be more efficient and appropriate, with swift access to test results. Electronic discharge summaries can improve follow-up care for patients when they leave hospital. Safety in prescribing and monitoring prescriptions can be increased, with warnings about possible conflicts in treatment. The IM&T services can also provide news about changing trends in diseases.

Patients and service users will also benefit from clinicians having the the right information about diagnosis and treatment available when and where it is needed. For example: immediate treatment can be given in an emergency as the patient's medical record can be accessed electronically; PACS (the picture archiving and communications system) can provide faster access to medical imaging services and results, often resulting in quicker diagnosis and/or earlier discharge from hospital; and fewer appointments and operations will be postponed because of non-availability of X-rays. Patients will also have access to their own records, which gives them the opportunity to become more involved in their own care, for example by confirming details of their appointments and prescriptions.

Our strategy will be to adopt solutions from the National Programme when they become available and can offer greater benefit than the systems we use already. Where there is a mismatch of timings between need (generated by MLB) and delivery (from the National Programme), we will consider investment in developing or expanding current systems or procuring interim systems. We expect all organisations to be supported by a nationally provided solution within the lifetime of MLB. IM&T costings for MLB have been based on expanding existing systems to support the new care pathways and the proposed community healthcare hubs.

Please see Working Paper: Investing in Information Management & Technology

8. Costing & Affordability

8.1 Transfer of Resources from Hospital to Community Services

The MLB affordability modelling assumes that PCT growth is fully committed in future years and that any developments in primary, community and social care services will need to be funded by resource transfer from hospital care or from internally generated efficiencies.

Both the community and the LTHT affordability models assume a resource transfer of £37m from secondary (hospital) services to community services at the 2006/07 price base. This assumption was originally made in the Strategic Outline Case (SOC), based on the accrued savings expected from reduction in non-elective hospital spells.

Based on the information within the 2005/06 accounts, the total commissioning spend across primary and secondary care (excluding PCT managed services) was £832m, with £439m spend on hospital services. The cost shift of £37m from hospital to community services represents an 8.4% reduction in secondary care spend; and a 10% reduction in the LTHT contract, if Market Forces Factor is included.

To validate the £37m figure we have identified the shift in activity between 2006/07 and forecast 2012/13, and linked the impact on commissioning spend to the main cost drivers in the hospital costing model. For inpatient activity, one of the main cost drivers for a tariff spell is length of stay. If the trend of reducing length of stay continues, then we would expect the average costs of spells to also reduce – therefore we can use bed day reductions rather than spells to estimate the commissioning spend impact. For outpatients and A&E, the main cost driver is patient attendances.

The assumptions summarised in the table below show that the major contributor to the £37m is the expected reduction in bed days. Transferring this funding to the Leeds PCT would require local agreement. This is because some of the reduction in bed days is generated by efficiency measures taken by LTHT, which under the current rules of PbR would not reduce commissioning spend or be eligible for tariff splitting.

Transfer of Commissioning Spend £37m

Transfer	Activity	Value £	Assumptions
Reduction in bed days	126,027	25,205,440	83% occupancy, £200 per day
Reduction in outpatient follow-ups	56,359	4,508,720	£80 per attendance
Relocation of outpatients into community settings	113,964	1,215,446	10% tariff for outpatients
Reduction in A&E attendances	54,503	4,360,240	£80 per attendance
Outpatient demand management	9,772	1,710,154	£175 per attendance
Total Resource Shift		**37,000,000**	

The table confirms that £37m could be released from LTHT to fund the MLB developments in the community. The £37m includes additional actions to reduce outpatients through demand management schemes included in the PCT commissioning plan for 2006/07. A reduction of 10,000 new attendances would be required to generate the £1.7m needed to ensure a release of £37m.

8.2 Community Costing & Affordability

The approach to costing community services has been to work up the additional cost of delivering community services in the future, taking into account the proposed shifts in services from LTHT and care pathways. Affordability is then determined by comparing PCT resources available through disinvestment in LTHT, against the additional expenditure required to deliver new services in the community.

Incremental Costs above Baseline Budget for PCT Provided Services Calculated for Community Costing

- Costs of implementing care pathways.
- Costs of impact on existing community services, arising from general strategic approach to reduce hospital admissions and facilitate early discharge.
- Transfers of outpatient and diagnostic activity from hospital to community settings.
- Impact on PCT estates requirements.
- Impact on IM&T costs across the health economy.
- Impact of reducing admissions and lengths of stay on the need for home care support.

The results of the costing exercise indicate that the total additional resource requirements are in the order of £42m (based on 2006/07 levels), which includes an assumption of around 900 extra whole time equivalent community-based staff. These results are based on an input-driven assessment, rather than any articulation of required future outputs. They are therefore indicative only and subject to arrangements for how services are commissioned in the future.

Based on the expectation that LTHT's income will reduce by £37m (at 2006/07 levels) as a result of activity being shifted to community-based settings, we would need efficiency savings in community provider services of around £5 million between 2006/07 and 2012/13 for the MLB proposals to be affordable. This represents a 3.3% cost reduction from the future estimated community services cost of £152 million. This level of saving should be achievable over the medium term, and actions are already being taken to begin an external review of community provider services, which should generate efficiency savings through a range of productivity measures.

8.3 LTHT Costing & Affordability

The SOC identified savings from efficiencies and centralisation to fund the revenue consequences of building a Children's and Maternity hospital. LTHT is now in the same position as many other acute trusts, where it has to generate sufficient savings each year to meet the national efficiency requirements, cover any fixed costs losses resulting from the transfer of services and compensate for the loss of income resulting from the roll out of national tariffs. LTHT must also generate further savings to bridge any funding gap that may accrue from the opening of the New Oncology Wing.

LTHT has estimated the combined effect of these factors to be a savings requirement of £182m over the next seven years. This includes the fixed costs loss associated with the £37m decommissioning identified in the SOC and included in the community costing and affordability assumptions. Trans4orm is the LTHT vehicle for delivering the necessary savings.

The MLB care pathways and service efficiency modelling will contribute to meeting the LTHT savings target. The projected reduction in the number of wards and theatres and overall floor area is estimated to generate workforce savings of around £21m per year once fully implemented.

To assess the affordability of MLB from a Trust point of view, its share of activity in 2012/13 has been modelled, adjusted to reflect population changes, known or estimated PCT commissioning shifts, the implications of Choice and predicted changes in care pathways.

LTHT has costed the SOC variant option described in section 7.2 of this executive summary, which would deliver a single acute site at St James's, with new build for children's & maternity, cardiac & neuro and A&E, with the Jubilee Wing used for diagnostics, outpatients and day case surgery. This option maximises efficiency and minimises new build to keep a cap on costs. Nevertheless, this is a major service reconfiguration which requires a significant capital investment in new and refurbished estate, and the associated increase in estate running costs will increase revenue expenditure by an estimated £44m per annum.

This additional £44m cost can only be offset by those savings that could only be achieved as a result of the MLB service reconfiguration – particularly the creation of a single site for acute and complex care at St James's. The detailed analysis of medical costs suggests that £18m could be saved through this centralisation of services and that there would be a consequential saving of £1m from associated administrative staff. Early modelling also suggests a saving of around £10m from clinical support services. The remaining gap of around £15m would be achieved through similar savings through centralisation in other staff groups. As indicated in section 6 of this document, we expect any reductions in workforce at LTHT to be managed by natural means.

The SOC variant option is therefore assumed to be broadly affordable. This is subject to further review at OBC stage.

Please see Working Paper: Costing & Affordability

9. Engaging & Consulting with the Public, Patients, Clinicians & Staff

One of the key aims of MLB is to involve the public, patients & staff in making the vision for health and social care in Leeds a reality. Involving the public and patients for whom the health and social care services are provided in Leeds, and working with them as we plan and make proposals about the future, is fundamental to the way we work. This stems from a core belief that working in this way produces results that work better and fit more closely with what is needed.

We have focused from the outset on wide engagement with the public, patients, staff, partner organisations and stakeholders across Leeds and surrounding health communities. We have identified over 70 separate stakeholder groups and categories of people with an interest in the future of health and social care services in Leeds. Our engagement process is designed to elicit views and ideas from these stakeholders, and to provide further opportunities for feedback to, and engagement with, stakeholders on those views. This work will then inform the final proposals and options to be presented at formal consultation in 2007.

To facilitate engagement, MLB stakeholders have been organised into four stakeholder groups. These groups are shown in the table below, along with an explanation about how MLB has engaged with them. Stakeholder engagement is underpinned by a communications strategy which provides the main messages, mechanisms and media for engagement and consultation with the four stakeholder groups.

Group	Consists of	Engaged through
Public & Patients	▪ Patients. ▪ General public. ▪ Voluntary, community and faith sector organisations. ▪ 10 identified communities of interest; women; children; older people; carers; black & minority ethnic communities; people with disabilities; users of mental health services; lesbian, gay, bisexual, transgendered people; gypsies and travellers; homeless people ▪ The media.	▪ Involvement of specific patient groups and members of relevant Expert Patient Programmes in development of care pathways. ▪ Events and activities targeted at other patients, service users and voluntary sector organisations. ▪ Work via lead organisations to reach and involve the communities of interest. ▪ Communications strategy, including a media campaign and use of the Making Leeds Better website to reach and involve members of the general public.
Staff, including Clinicians	▪ Staff, including clinicians, of the seven Leeds health trusts. ▪ Local Authority social care staff. ▪ General Practitioners (GPs). ▪ Other independent contractors: pharmacists, optometrists, dentists. ▪ Relevant academic staff of the two Leeds universities.	▪ Involvement in driving development and implementation of care pathways. ▪ Clinical Leadership & Engagement Group for Clinical Champions ▪ Staff newsletters. ▪ Open meetings, roadshows and events. ▪ Health Impact Assessments.
Democratic	▪ Health & Adult Social Care Overview & Scrutiny Committee (OSC). ▪ Leeds City Council (LCC) leadership. ▪ Leeds City Councillors (through Area Committees). ▪ Members of Parliament (MPs). ▪ Members of Leeds Initiative Executive Boards. ▪ District Partnerships. ▪ Community Forums.	▪ Visits, presentations and progress reports to meetings of the Area Committees, Leeds Initiative Boards, District Partnerships etc. ▪ Personal briefings to MPs and LCC leadership. ▪ Formal scrutiny by Health & Adult Social Care OSC. ▪ Involvement of West Yorkshire Scrutiny Chairs in scrutiny process.
Outside Leeds	▪ Cardiac Services Network, Cancer Services Network & Specialist Obstetrics and Paediatric Services. ▪ West Yorkshire PCT Chairs, Chief Executives Forum & Commissioning Group. ▪ PCTs in North East Yorkshire & Northern Lincolnshire that border Leeds metropolitan district. ▪ Members of Parliament for constituencies that border Leeds.	▪ Regular presentations and progress reports to meetings of key groups such as West Yorkshire PCT Chairs. ▪ Briefing for West Yorkshire Chief Executives on the emerging Strategic Services Plan for Leeds. ▪ Involvement of West Yorkshire Scrutiny Chairs in scrutiny process.

As the MLB proposals clearly involve a substantial variation and development of health services in Leeds, local NHS organisations have a statutory duty to consult patients and the public on its proposals. The MLB approach is to develop options for change with people and not for them, starting from the patient experience and working with staff to develop new ways of working. In taking a whole system view we have explored the contribution of all health and social care

providers and are working together to build a sustainable solution for the whole community. It is this solution that will be the subject of public consultation in 2007.

Expected Scope of Consultation

- We will use the consultation to build on the changes in primary, community and social care services necessary to deliver the care pathways, as the pathways themselves have been developed with public and patient involvement; are consistent with the Government's White Paper *Our Health, Our Care, Our Say*; and build on existing service improvements.
- The consultation will include those changes needed for more efficient delivery of hospital services, for example treating and discharging more surgical cases within the day and avoiding the need for an overnight stay, but only where these changes involve the relocation of services. Enhancements in clinical practice are a part of everyday service delivery and thus need not be subject to a formal consultation process.
- The consultation will focus on changes to the location of hospital and community services and the Private Finance Initiative proposal for the new children's and maternity hospital and related capital development.

The lead organisation for the public consultation will be the new Leeds PCT. The PCT will form a body responsible for both leading and taking the final decision at the conclusion of the public consultation. It will receive and consider responses, including those from NHS bodies, and ultimately take a decision in light of them.

The table below sets out the key stages in reaching the point at which the final decision is taken. We currently expect that to be in the autumn of 2007. The detailed approach to this work will be further developed and then shared with the Overview and Scrutiny Committee in autumn 2006.

When	What
Autumn 2006	▪ Conclude the awareness or 'deliberative' phase of the communication and engagement programme ▪ Finalise proposals for the establishment of the Consultation Decision Making Board ▪ Agree the options to progress to targeted or "collaborative" engagement ▪ Finalise and endorse the next stage engagement approach and its materials
Winter 2006	▪ Progress the 'collaborative' engagement work ▪ Summarise and analyse the results ▪ Agree the model which should be the subject of the formal public consultation ▪ Prepare and endorse the public consultation resources
Spring to Autumn 2007	▪ Run the formal public consultation process ▪ Summarise and analyse the results ▪ Take the final decision in public

MLB expects to adopt the Cabinet Office *Code of Good Practice on Consultation (2004)* which sets out the code and criteria which all UK public bodies are encouraged to follow in developing their approach to public consultation. The Overview & Scrutiny Committee for Health & Wellbeing and the PPI Forums have also reviewed our plans for engagement and consultation.

Please see Working Papers: ***Engaging & Consulting with the Public, Patients, Clinicians & Staff***
Clinical Leadership & Engagement

10. NHS Board Resolutions and Next Steps

NHS Statutory Boards are meeting on 19 September 2006 to consider the progress made to date by the MLB programme and to agree next steps. The resolutions before this 'Board of Boards', including suggested next steps for MLB, are shown in the table below. A similar process is in place for Leeds City Council endorsement of these resolutions during September and October.

NHS Boards are asked to consider and pass a resolution on each of the following statements:		
1	The Board resolves that the vision set out in Making Leeds Better concurs with and builds upon the Government's new direction for the health and social care system in *Our Health, Our Care, Our Say* and the *National Service Framework for children, young people and maternity services*.	
2	The Board resolves that the delivery of the Making Leeds Better vision will offer significant additional benefits to patients, service users and local communities. The Board is committed to achieving that vision.	
3	The Board is assured of the scope, quality and outputs of the work undertaken to date by the Leeds health and social care economy as part of the Making Leeds Better programme. This is a robust base from which to develop more detailed proposals for public consultation and an outline business case for a new Children's & Maternity Hospital.	
4	The [PCT] Board recommends that the new Leeds PCT quickly establishes the consulting and decision taking infrastructure necessary to progress to public consultation on agreed options at the earliest stage possible.	For PCT Boards only
5	The Board recommends the following key priorities for further action: 5.1. ensure MLB is resourced with adequate capacity (substantially from full-time individuals) to progress all essential work as rapidly as practical 5.2. develop fuller options and costs, including the use of community estate, and taking account of access and transport implications 5.3. develop citywide arrangements for the delivery of key areas of the programme, for example workforce, organisational development, and training and development planning 5.4. establish local arrangements for tariff sharing and releasing the agreed level of commissioning spend 5.5. agree a structure through which the potential integration of health and local authority commissioning and provision should be explored and progressed 5.6. develop a transition plan to mitigate the service and financial risks of delivery between now and 2012/13	Please select from, or add to the range of options shown
6	The Board resolves to mandate its Chair, Chief Executive and Medical Director/PEC Chair to agree a joint way forward and corresponding public statement in the final session of the Making Leeds Better meeting.	

The proposals for the new Children's & Maternity Hospital and other new buildings on the St James's Hospital site will require formal approval by statutory organisations as part of the outline business case (OBC) approvals process in 2008.