University Hospitals of Leicester NHS
NHS Trust

Our Clinical Services & Reconfiguration Strategy - DRAFT

2018-2023

Chapter 1: Our strategy

UHL provides health and care services for over a million people in Leicester, Leicestershire and Rutland, specialised clinical services for the population of the East Midlands and some highly complex services nationally. Locally, we provide these services as part of a networked health and social care system across the LLR sub-region forming the basis of our Sustainability and Transformation Partnership. This wider local system provides services to support people to stay healthy and lead independent lives, and when people are ill our services are there for them, their carers and families. Regionally, we provide services working in partnership with other specialist trusts and district general hospitals (DGH) to support the continuation and development of local care and secure referrals of specialised patients into UHL. Our Specialised Services Strategy, which will be published later in 2018, will describe our approach and plans for regional services in more detail.
Over the next five years, the services we deliver as part of these networks and partnerships will need to adapt and transform in order to ensure that they of high quality and remain clinically and financially sustainable.

Our clinical services and reconfiguration strategy is set in the context of the evolving, overarching Leicester, Leicestershire & Rutland (LLR) 5-year Sustainability and Transformation Partnership (STP). As such it is designed to represent an appropriate secondary and tertiary care response that is consistent with the principles identified and the drive to optimise outcomes and enhance quality of life. Our plans will also enable elimination of the structural element of the Trust's financial deficit, putting the Trust in a stronger position as we continue on our journey of financial transformation over the next 10 years.

Complementing the plans of our partners, UHL's clinical services and reconfiguration strategy will address the unique healthcare demands from the socio-economic and ethnically diverse populations across our local and wider catchment areas. A particular emphasis is placed on addressing the known high morbidity and mortality from cardiovascular and associated diseases.

Chapter 2: Our Vision

By 2023 University Hospitals of Leicester NHS Trust will have a well-deserved reputation as one of the best health and care providers in the country, functioning as part of a truly integrated health and care system. This will attract high performing and compassionate staff who embrace innovation to deliver the best possible outcomes for our patients.

As our role in this integrated health and care system becomes increasing clear, we expect our specialist teams, including hospital consultants to increasingly work in, and with, the community, sharing their expertise with our GPs and community teams. These health and care professionals will work in a partnership of trust with patients as equal partners to keep people fit and well and reduce reliance upon our acute services wherever appropriate.

We will be recognised as the leaders of the regional healthcare agenda with respect to setting the strategy and describing how services will be delivered across the East Midlands. We will support NHS District General Hospitals (DGHs) to continue to provide and develop services for their local populations so that patients only have to travel for treatment when it is absolutely necessary. We will present NHS England, in their role as commissioners of specialised services, with the regional solution to deliver the requirements of the national service specifications.

When people are ill we will help provide high quality care and support to help them to manage their own condition - mainly within their own homes or local community where possible. If people do need to come into our hospitals to receive care they will have confidence that they will be treated with dignity and respect.

Our patients should expect to recuperate at or near home, freeing up our hospital beds for those who really need them. We expect our ED department to be seen as the last rather than the first port of call for the majority of our patients and when these services are required, they will be provided in the most effective and efficient manner possible.

The funding we receive will fairly reflect the needs of our local populations enabling us to make the best use of every NHS and Social Care pound, meaning that as well as maintaining existing services we can take advantage of new technology and advances in medicine at an early stage to provide the best possible outcomes for our patients.

We expect people will live longer and in terms of their health and well-being will have a better quality of life wherever they live, whatever their socio-economic circumstance or whether their needs are of a physical and/or a mental nature. When people reach the end of their lives, wherever possible this will be in their place of choice; either in our hospitals, at home or in a specialist place of care such as a nursing home or hospice.

This strategy outlines our thinking about the future shape of our clinical services to best meet both need and expectation outlined in this vision.

Chapter 3: Our strategic goals

The vision outlined in this strategy will be achieved through delivery of our 5 strategic goals over the next 5 years:

1. **To deliver safe, high quality, patient-centred, efficient healthcare**

Our quality commitment is at the heart of our strategic goals and centres around three key themes; patient safety, clinical effectiveness and patient experience. These themes run through every intervention we make, either clinically or otherwise, and are fully embedded within the Trust culture.

2. **To ensure that we have the right people with the right skills in the right numbers in order to deliver the most effective care**

Our people are the key to delivery of our quality commitment and every service across the Trust. If we don't have the right people, in the right numbers we cannot deliver safe, effective or efficient care. We recognise that we have much work to do to deliver this objective; improvements will be delivered through our Workforce Plan, which includes how we will increase the diversity of our workforce at all levels, and our People Capability Plan, which will outline a plan to address issues in culture, performance and development.

3. **To deliver high quality, relevant, education and research**

UHL has a long and successful history in delivering innovative research in partnership with the University of Leicester. We will strengthen this collaboration over the life of this strategy, ensuring our priorities are aligned through implementation of a joint research strategy.

We are well placed to train undergraduate and postgraduate medical, nursing and allied health professionals of the future but recognise that we need to retain a higher level of medical staff and increase the satisfaction scores of our trainees. We have joint plans with our university partners to address these issues.

4. **To develop more integrated care in partnership with others**

Our intention is to continue to develop our offer as part of a wider health and social care system. We have already seen early improvements in the care we are able to provide through collaboration with our voluntary, primary, community & ambulance partners and our intention is to increase seamless models of care, particularly for our frail population and for those in care homes. A holistic model of care will enable better outcomes for our patients and the creation of a sustainable system.

Regionally, we will develop our partnership working with other specialist trusts and district general hospitals (DGH) to support the continuation and development of local care and secure referrals of specialised patients into UHL. Our Specialised Services Strategy, which will be published later in 2018, will describe our approach and plans for regional services in more detail.

5. **To progress our key strategic enablers**

Delivery of our strategic enablers will allow us to deliver the first four strategic priorities above. This includes progressing our reconfiguration plans in support of this strategy, continuing on our journey

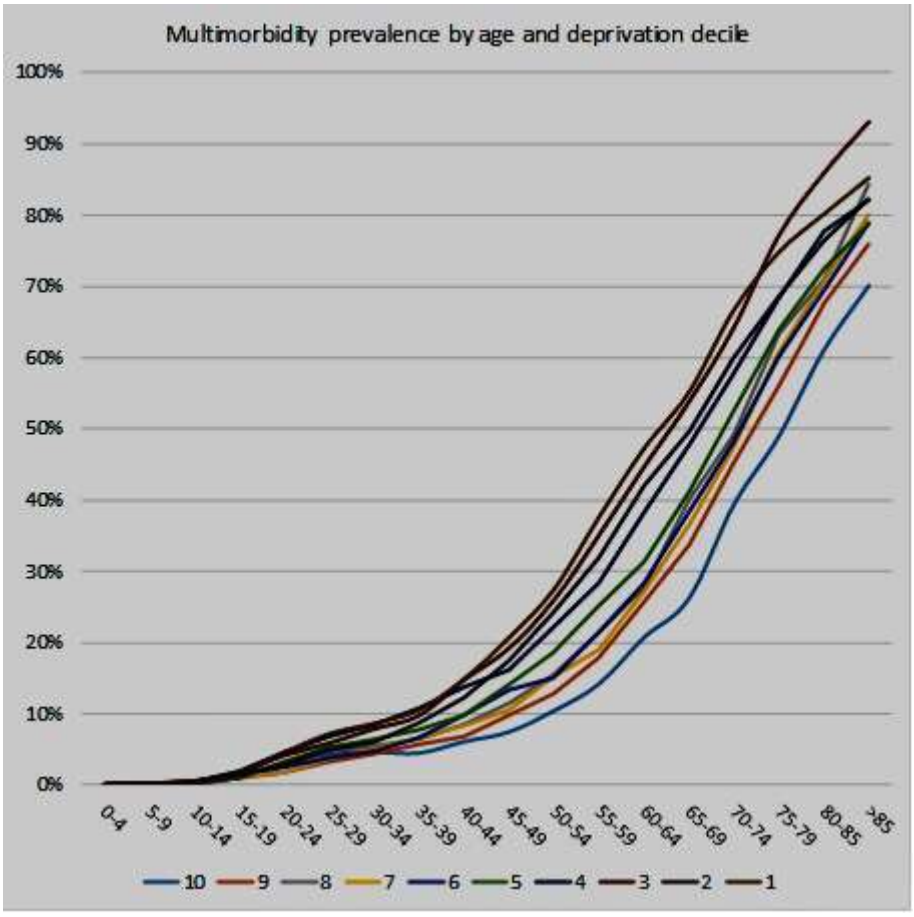
towards becoming a paperless hospital, implementing a system-wide corporate services review, and delivering financial stability.

Chapter 4: A population focus on delivering new models of care

If we are to truly transform the care we provide, we recognise that we must fundamentally change the way we deliver services. For nearly two decades the need to consolidate our acute services has been widely recognised. The current, three acute site configuration is an accident of history, not design, and is suboptimal in clinical, performance and financial terms, with a significant impact on patient outcomes and staff morale. Staff resources are spread too thinly making services operationally unstable, and duplication and triplication of services is inefficient.

Many planned, elective and outpatient services currently run alongside emergency services and as a result when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations. We recognise that over the last two decades there has been significant and sustained under-investment in UHL's acute estate relative to other acute hospitals across the UK. We also have a significant backlog maintenance requirement which will be reduced substantially through the consolidation of services onto two sites.

Concurrently, the positive trend in life expectancy in our local populations has added additional complexities to both service design and delivery - despite now living longer than 5 years ago, our populations are living with multiple long term conditions, with recorded prevalence trends increasing year on year. Coupled with the deprivation noted in the local areas across Leicester and some areas of Leicestershire in particular, it is recognised that the changing the demand curve for our multi-morbid and often frail patients will not be a simple task:



We know the bulk of our demand locally comes from an increasing level of need from people with multi-morbid conditions; frail patients; high levels of admissions for ambulatory case sensitive conditions; over-reliance on emergency and urgent care. We also recognise that there is inconsistent delivery due to the lack of skills and confidence to maintain the target patient cohorts in the community.

We see this manifest in the rising numbers of patients who are acutely frail or multi-morbid who access our hospitals largely through our emergency pathways and receive a sub-optimal service as our current configuration does not lend itself to multi-specialty, more generalist model of care.

The Better Care Together Programme (our local STP brand) is in the process of redesigning services to support a population health model where ill health can be prevented, unnecessary demand on the health and social care system avoided and hospital stays reduced. Our system has identified that to make a real shift in the demand curve on the acute site in particular, the LLR health and care system needs to move to integrated placed based care, focussing on bettering population health at all levels.

This means that the configuration of our clinical services also needs to take into account the needs of our multi-morbid population, which we know need a broader approach. Our current configuration means multiple referrals across many services to manage individual patients. This is duplicative and inefficient, and is burdensome and unsafe for patients because of poor coordination and integration.

Delivering new models of care across the LLR health and care system

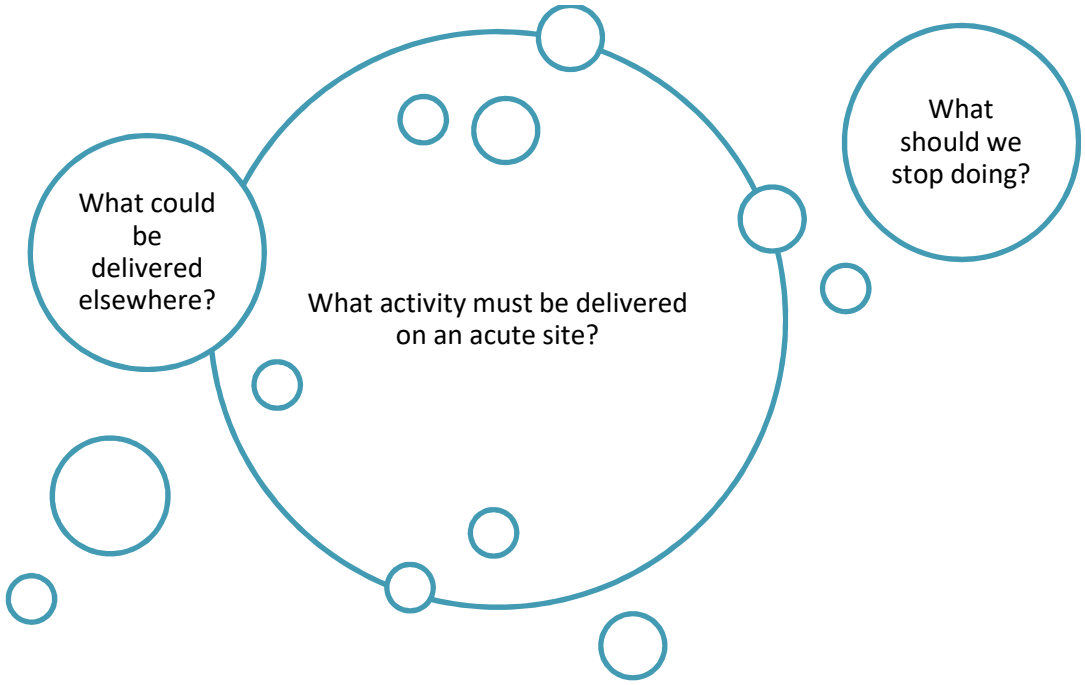
We will continue to work with our STP partners to deliver a programme of transformation which ensures patients are treated in the most appropriate settings by the most appropriate person. In May 2018, UHL and partners launched the Frailty Task Force, with the objective of designing and delivering an integrated model of care across LLR for functionally frail patients.

This adopts the principles outlined in the Kings Fund model of integrated care and covers three areas of care:

The focus of this model of care will be on people living with frailty and multi-morbidity. We believe this will ensure that people can remain in their own homes; and that when a hospital admission is unavoidable, it will ensure that their discharge is appropriately planned to get patients back into their usual place of residence where possible and as soon as appropriate, with minimal risk of re-admission.

Delivering new models of care within UHL

As part of our strategic planning, UHL has been working on revised models of care across specific specialties for some time now. These models largely assess all activity that historically has come onto a UHL acute site and asks 3 questions:



Through a series of 'Listening into Action' events and/or clinical engagement events, our clinical and managerial teams along with patients and partners, have answered these questions, pragmatically redesigning pathways and services into optimal models of care.

The outputs of these redesigned models of care have influenced this strategy and our wider transformation plans.

Impact of these system-wide changes to models of care

The re-designed models of care both within UHL and across the health and care economy are expected to reduce the growth in demand on acute services over the life of this strategy; and these shifts will enable the consolidation of acute services and resources onto the LRI and GH. We expect that reconfiguration of services will improve outcomes for patients through increased consultant presence and earlier, more regular senior clinical decision-making; and the opportunity to grow specialised, teaching and research portfolios. Our hospitals will therefore concentrate on providing acute care in hospital that cannot be provided in the community.

The next sections describes the key changes we will make to our services to enable these redesigned models of care.

People with planned care needs

UHL currently delivers a full range of elective services from day case procedures through to complex tertiary & quaternary surgical work across its three sites but we recognise that the way in which we

will need to provide these services in the future will fundamentally change in order to deliver our vision.

As a member of the LLR NHS Alliance Partnership, UHL will work in partnership with other NHS providers and our local commissioners to develop and provide truly pioneering, integrated services for elective care across the LLR sub-region, ensuring that where possible, care pathways are seamless across health and social care agencies, reflect best practice, deliver care closer to home in the most appropriate setting and improve patient experience and access.

We will work collaboratively and in partnership with the health community and patient groups to agree how and where elective care services are best delivered. Our strategy recognises that how and where these services are delivered must change from the traditional hospital site based system to a more distributed and integrated model of care delivering care closer to the patient's home whenever possible. Planned care services will be delivered in the lowest safe acuity setting possible for the clinical condition such as in clean rooms in GP Practices or in our community hospitals.

As well as being good for patient care, this change in model of delivery of care is essential to allow UHL to realise its ambition of ensuring high quality emergency care and tertiary complex services continue to be delivered efficiently from our hospital sites.

Specific plans over the next 5 years are outlined below.

1. **We will design and implement a Planned Care Treatment Centre at the Glenfield Hospital**

Our plans to improve our planned care services are centred on the development and implementation of our Planned Care Treatment centre at the Glenfield hospital. This centre will enable us to provide safe high quality outpatient and day surgery, with extended recovery (up to 23 hour care), reflecting best practice and improving outcomes and experience. We anticipate that the majority of adult outpatient services, and day case and extended recovery procedures and endoscopy will be provided at this hub, separating the services entirely from emergency care at the Leicester Royal Infirmary.

The Treatment Centre will include:

Outpatient services - for those adult OPD services which cannot be provided in the community, we will centralise a significant proportion in the treatment centre. This will release space elsewhere across the Trust to facilitate reconfiguration and the move of services across sites.

Day surgery and day surgery with extended recovery – a purpose designed facility bringing together day surgery and provision for extended recovery for a range of services, from across the Trust, would again release valuable estate while generating efficiencies by providing these procedures in one location as opposed to multiple locations across the three hospitals, and by improving models of care.

We will implement new approaches to the assessment and management of patients undergoing more complex surgery to improve the quality of recovery, reduce the incidence of postoperative complications and reduce lengths of stay. Many of these techniques are based on the wider application of well-established day surgery principles and are aimed at improving the quality of recovery so that the patient is well enough to go home sooner.

The treatment centre will also provide a single contact centre for outpatients, able to deal with 80% of queries from our patients, first time.

2. **We will work with our partners to develop new community-based service models for relevant services**

We will move significant amounts of planned activity into more appropriate settings through the LLR Elective Care Alliance. This will include development of new service models for the provision of Dermatology, Rheumatology, Diabetes & Ophthalmology (amongst others) in the Community.

3. **We will ensure our planned outpatient imaging services and therapeutic procedures support timely decision making and patient access 7 days a week.**

We propose to leave a GP access imaging hub at the LGH which will consolidate direct access imaging, to ensure that the imaging units at the LRI and GH focus on acute work. The treatment centre will house plain imaging and ultrasound to support the outpatient process.

4. **Planned care services will be delivered using 'one-stop' arrangements where possible**

We will ensure that our patients receive diagnosis and treatment in one visit where possible and we will implement one-stop nurse led pre-admission clinics in the community to reduce the need for patients to travel to hospital for pre-assessment.

5. **We will improve the IMT infrastructure to enable an efficient service**

We will complete implementation of our IMT programme, including rolling out of digitised notes, a new modern PAS system, a functional dictation function, a voice recognition transcription service, electronic communications to GP colleagues and an e-ordering system for diagnostics.

6. **We will grow our specialised planned care services on the Glenfield site**

We will lead the development of a regional tertiary services strategy, ensuring that UHL is at the heart of a network of specialised services, growing our tertiary services provided on the Glenfield site and supporting our smaller DGH partners.

7. **We will improve access to endoscopy services**

We will work with our partners to increase access to community based endoscopy services through the development of a network of fully accredited community screening sites which will prevent the need for patients to travel further than need be.

What will this mean for people with planned care needs?

Patients will have access to safe, high quality planned care services largely on one hospital site
Patients will experience efficient and effective planned care, fully coordinated across health and social care
Patients will be supported to have care as day case or ambulatory care where possible
Where a hospital stay is required, patients will only stay for the appropriate duration
Patients will have access to one stop planned care services, minimising multiple trips to multiple sites
Patients will leave our care with appropriate care in place to support them at home

People with unplanned needs

We know that some of our patients continue to have a poor experience when needing unplanned care, with many patients waiting for excessive periods and performance against the 4 hour standard being well below the national standard of 95% at the LRI. This reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

Working with our partners across the health and social care community, we have implemented an integrated Clinical Model for Unscheduled and Emergency Care that extends beyond the physical walls or buildings of our hospitals but rather as part of a networked model of care. This includes the design and delivery of a clinical navigation hub to direct patients to the right service for their need, enhanced primary care services to reduce the pressure on our ED and an enhanced social care offer to ensure only those with a medical need are transported to our hospitals.

Concurrently, we have started a programme of reconfiguration work to move our unplanned care services largely to the Leicester Royal Infirmary site. This had included the development a modern Emergency Floor, which was clinically designed to address the demand and flow challenges faced by both ED and medical assessment services, with the intention of developing a future proofed solution that would flexibly meet future demand over the next 10 years.

We completed phase 1 of this programme in 2017, with a brand new £30m emergency department opening to the public in April 2017. This included:

- The UK's first 'frailty friendly' emergency department
- Dedicated rapid ambulance access
- More space, more treatment rooms, more technology
- State of the art imaging embedded: CT and X-ray
- Integrated mental health unit
- Fully electronic ED, saving space and speeding up flow/waiting time

The new ED incorporates a dedicated Children's Emergency Department. It treats children under the age of 16 in a specially designed unit that has its own separate entrance on the same side of the site to the adult Emergency Department. The department includes three high dependency beds for critically ill children who need close observation, and a children's short stay unit (CSSU) with beds which can keep children for up to 18 hours whilst tests and observations are carried out.

Phase 2 of this programme completes in May 2018, with the entire emergency floor integrated to provide an effective and efficient patient flow. This included the redesign and development of the following services:

- GP Assessment Unit (GPAU)
- Elderly Frailty Unit (EFU)
- Acute Frailty Unit (AFU)
- Acute Medical Unit (AMU)
- Acute Care Bay (ACB)
- Emergency Decisions Unit (EDU)

The resulting emergency floor at the LRI is a modern, fit for service building which brings together services for unplanned care together on one floor. Our plans over the next 5 years now include the following:

1. **We will optimise our pathways and our model of care to provide the best outcomes**

We will continue to design and implement an effective and efficient ED patient journey, reducing delays in the patient journey through early senior medical assessment of patients, fast tracking and early initiation of clinical care.

2. **We will integrate our community and acute 'bed' stock, both virtual and physical, with a single coordination structure coordinating flow across the system**

This will involve a fundamental shift in the way we manage patient flow across the system, breaking down current organisational barriers, and giving the single flow team command over the use of resources across the system. At times of peak demand, this will help us regulate patient flow, reduce delays and ensure that our patients are in the right place at the right time.

3. **We will continue to work with our partners across health and social care to ensure patients are seen at the right place, at the right time and by the right professional**

This will include full integration of the LLR Out of hours pathway within our blue zone, strengthened booking facilities into primary care from the blue zone and further refinement of the pathway for GP-referred patients.

4. **We will ensure our staffing model is innovative and spans primary and community pathways were relevant, attracting & retaining the best talent to our system**

The new models of care described through this document will only become a reality if we have enough staff with the right skills, values and behaviours to deliver them across our health and care system. We will work with our partners to develop a workforce able to work across settings and traditional professional demarcations, with flexible skills.

5. **We will implement an end to end frailty pathway across the hospital, starting with all appropriate patients being assessed using the 'Clinical Frailty Scale' in ED, and then creating an end to end pathway for frail patients across the wider health and social care system**

We will lead the design and delivery of an LLR Frailty pathway, ensuring that frail, multi-morbid patients access a seamless model of care across primary, community, social and secondary care. This will include ensuring a place based integrated model of care is available in the community, effective acute care is accessible in a crisis and discharge planning is robust and holistic.

6. **We will fundamentally change the model of ophthalmology, delivering a triage based model of care, ensuring that our patients are treated in the right place**

A fundamental redesign of ophthalmology services will take place, with patients better differentiated into those with emergency problems who need to be seen immediately at an acute site and those who can be seen in the ophthalmology services across the wider non-emergency

acute and community system dependant on the acuity of their need. To enable this, all ophthalmology services (including activity going into the current eye casualty) will be moved to the Glenfield site with the exception of children's eye services. These will remain at the LRI alongside the Children's hospital at the LRI.

7. **We will relocate the general surgical emergency take from the Leicester General Hospital to the LRI.**

This will improve the emergency pathway, patient experience for general surgical patients and allow development of 7-day week consultant delivered surgical triage meaning that general surgical patients will be seen and assessed more quickly by senior decision makers. Additional theatre sessions will be provided at the LRI to accommodate the increase in demand from emergency surgical services on a single site.

8. **We will implement a Cardiorespiratory acute floor at the Glenfield site & provide specialty cardiology input at the LRI**

This will include development of our speciality take in the Clinical Decisions Unit (CDU) and Coronary Care Unit (CCU) at Glenfield as the "Cardiorespiratory Acute Floor" to ensure streamed patients receive timely care in the most appropriate setting. We will also ensure cardiology input into the LRI emergency floor.

9. **We will ensure that we retain our status as a lead provider nationally and internationally recognised for its ECMO services**

We will develop ECMO as a key part of an integrated advanced respiratory support service for adults with serious respiratory failure at the Glenfield site and a children's and neonates service at the LRI site.

10. **We will create 2 super Intensive Care Units, one at the LRI and one at the Glenfield, ensuring that UHL has the right number of Augmented and Critical Care beds (level 2-3) in the right locations**

We will implement an integrated Critical Care service across two acute sites. This will enable UHL to retain Intensive Care training accreditation, recruit and retain staff, improve efficiency & sustainability of the services as well as respond to changing demands for the service.

The Trust currently falls short of the number of ICU beds required for level 2 and 3 care. Patients visiting our hospitals are getting sicker and the ability to offer acute care is growing. This situation results in patient flow issues which includes cancelled elective surgery. The extension to the existing ICU will provide 43 additional beds.

What will be different for people with unplanned care needs?

Patients will have access to a high quality and safe system of care 24/7

Patients will be seen in the right place, at the right time, by the right professional across health and social care

Patients will not need to understand how our services work - we will make care seamless, efficient through one integrated access point

Patients will have access to primary, community and hospital care when they need it

People with functional frailty

Management of the rising prevalence of long-term disorders is the main challenge facing health-care systems across the UK. Although individual diseases dominate health-care delivery, medical research, and medical education, people with multimorbidity— those with two or more chronic morbidities—need a broader approach.

Use of many services to manage individual diseases can become duplicative and inefficient, and is burdensome and unsafe for patients because of poor coordination and integration. Multimorbidity becomes progressively more common with age and is associated with high mortality, reduced functional status, and increased use of both inpatient and ambulatory health care.

Specific plans over the next 5 years to improve pathways for this cohort of patients are outlined below.

1. **We will lead the Frailty Task Force to foster greater multidisciplinary working around the needs of our functionally frail patients, both whilst they are in our care and following discharge**

We are working with our health and social care partners to improve the care of our patients with multiple long term conditions – we will support GP-led multidisciplinary teams to identify and manage frail, multi-morbid patients in community settings minimising the need for hospital care. This will include detailed care planning, with coordination across our whole pathway of care for frail people.

2. **We will further refine patient pathways to minimise duplication and fragmentation across our services and those across the wider health and social care system**

We recognise that our IMT infrastructure and administration systems across the wider health and social care system are not designed or configured in the most efficient manner possible. We

currently have multiple systems in use, with limited interoperability. Over the life of this strategy, we will ensure that these systems are networked so that frail patients are 'flagged' at each significant touch point across health and social care.

3. **We will use technologies to support the development of new model of care for frail patients, particularly focussing on our care home population**

Our care home residents often receive a poor patient experience due to fragmented pathways across primary, community, ambulance and acute services. As a health and social care economy, we will apply learning from national vanguard programmes to improve the quality of life, healthcare and care planning for people living in care homes using evidence-based and innovative technological solutions where appropriate.

4. **We will increase the support, education and specialist advice we offer to our patients and our partners to help them receive/deliver care in the community in order to reduce demand on our hospitals**

There are currently multiple 'single points of access' available to our patients and our partner agencies across health and social care. We plan to consolidate these points of access virtually, enabling faster and more targeted access to services and advice for our frail patients and partners.

5. **We will strengthen our discharge planning processes both within the Trust and as part of a wider health and social care system**

An increasingly complex population, particularly multi-morbid patients, require a highly coordinated discharge planning process which begins at the moment of an acute episode. We will continue our work internally to increase the rates of coordinated discharge before noon to ensure our frail patients are home in time for tea with the right support to prevent readmission and further acute episodes where possible.

What will be different for our frail patients?

Complex patients will have access to a seamless pathway across primary, community and secondary care
Complex patients will receive care from multiple partners in a coordinated manner
Complex patients will be referred to a range of preventative services where relevant whilst in our care

Women, children and families

Our vision for women, children and family services is to provide high quality health care services that compare favourably with the best in the world; bringing together patients, their families, professionals and our partners to achieve responsive high quality services, enhancing patient experience.

The Women's and Children's services clinical model is to consolidate services for those patients who require hospital care in a single Maternity and a single Children's hospital entity at the Leicester Royal Infirmary – all services together under one roof. This would be complemented by optimising out of hospital services for those patients where it is safe and appropriate.

The Children's Hospital services are an essential and extremely important part of health provision for any community. The Trust has therefore established a UHL Children's Hospital Board with the express objective of developing further the clinical services and reconfiguration strategy for children's services, overseeing the optimisation of the clinical model of care for Children within Leicester including transition to both adult services and to community and primary care providers. The Children's Hospital Board has a membership which includes community partners and will include parents and young people's representatives.

Specific plans over the next 5 years are outlined below.

1. **We will centralise all Childrens services into a consolidated Children's hospital on the Leicester Royal Infirmary site**

Children's services are currently spread predominantly across Balmoral and Windsor Buildings at the LRI; however there are pockets of paediatric space all over the LRI, many within adult areas. The scope of the Children's Hospital Project is to bring together all children's services into one area of the LRI site creating a consolidated Children's Hospital. This will improve adjacencies, split paediatric and adult flows, ease our ability to provide age appropriate facilities and create a defined identity for the Children's Hospital. Through the Children's Hospital Project, we will also increase the upper age limit of Leicester Children's Hospital, from a patient's 16th birthday to a patient's 19th birthday.

As part of Reconfiguration, Children's Services will be moved into the Kensington Building, to sit alongside the paediatric EMCHC.

2. **We will implement the redesign of our maternity and birthing services**

The Trust currently supports the majority of births and maternity care across Leicester, Leicestershire and Rutland with an annual birth rate of circa 10,000. A new build Maternity Unit is proposed to be developed on the Knighton Street campus area of the LRI, encapsulating the services currently provided both at the LRI and the General sites.

3. **We will move the paediatric EMCHC service from the Glenfield site to the LRI site, growing the service into a system leader**

In 2015, NHS England published a new set of standards for Congenital Heart Disease, outlining a minimum level of activity for each centre, and requiring paediatric congenital heart services to be co-located with other paediatric services. Through the EMCHC Co-Location Project, we will move all paediatric cardiac services from the GH to the LRI, and ensure sufficient capacity is available in order to achieve the required level of surgical activity.

One of the key aims of our clinical services and reconfiguration strategy for children's services is to strengthen our specialised services, especially those provided by the Paediatric EMCHC, through meaningful partnership and networking whilst at the same time developing a vertically integrated

model of local service provision with our community providers to realise more effective care clinical pathways ensuring care is delivered in the right setting.

The Trust is also working in partnership with Nottingham University Hospitals (NUH) to establish a Paediatric Intensive Care Transport service alongside the well establish CenTre Newborn Transport service to ensure children are in the right hospital, at the right time, for the right care.

4. **We will refine the clinical model of care for children's ED for those children who require further care**

As part of the redevelopment of our emergency floor at the LRI, we plan to implement a single front door for paediatric emergencies to reduce duplication and improve patient experience.

5. **We will improve services for Children, Teenagers and Young Adults building on the clinical models of care in our Teenage and Young Adults (TYA) Cancer Unit.**

The needs of older children and young adults will be the focus of work to develop better services and facilities for this age group and support their transition to adult services.

6. **We will develop an ambulatory gynaecology service**

Ambulatory gynaecology services will be developed, expanding the number of procedures performed in a day case and outpatient setting. This will create additional capacity in the inpatient setting to accommodate the more complex gynaecology care.

What will be different for women, children and young people?

All children using our services will have access to a state of the art Children's hospital
Children with unplanned needs will access services through an integrated emergency pathway
Expectant mothers will be able to access safer, higher quality birthing services at our hospitals
Patients will have local access to a nationally recognised paediatric congential heart centre

Chapter 5: A new configuration of services

If we want to deliver safe and effective care as described in earlier chapters of this document, we recognise that our clinical services and the configuration of our sites will need to change over the next 5 years. To enable this, we have thoroughly assessed and re-assessed our assumptions with regards to clinical pathways, area, scope, opportunities and constraints. This has led us to the following site reconfiguration plans:

Leicester Royal Infirmary

LRI will continue to be the primary site for emergency care. LRI will accommodate a consolidated maternity service and all gynaecology services, as well as the creation of a 'super ICU'. The paediatric element of the East Midlands Congenital Heart Centre (currently at GH) will move to LRI as the first stage in delivering the vision to create a fully integrated children's hospital and in order to meet national standards.

Glenfield Hospital

GH will grow as services move from both LGH and LRI. The relocation of vascular surgery from LRI was the first of these moves creating a complete cardiovascular centre. ICU, some surgical and transplant services will move from LGH to GH into new build wards with a supporting admissions unit; the inpatient renal service will follow shortly afterwards in capacity vacated by the move of children's EMCHC service. GH will also see the creation of a 'super ICU'. The Trust also intends to build a new Planned Care Treatment Centre at GH which will offer outpatient and day case care with a stay of up to 23 hours with immediate and timely access to the necessary diagnostic and support services.

Leicester General Hospital

Subject to the formal public consultation, the plan remains for emergency and specialist services to be moved off the LGH to the LRI and GH. The Leicester Diabetes Centre of Excellence (as well as some connected services) will remain at LGH. Imaging intends to leave a community hub at this site to serve the East side of the city and county. Administrative accommodation will also remain as part of the decant enabling required from the LRI and GH.

LGH will also continue to be home to other health and social care services. The Evington Centre will continue to provide community beds as well as our integrated stroke & neurology rehabilitation services. Leicester City CCG are also considering using a small portion of the LGH site as a centre for a primary care hub providing extended hours GP services and associated diagnostics.

Proposed site diagrams are available in Appendix 1 of this strategy.

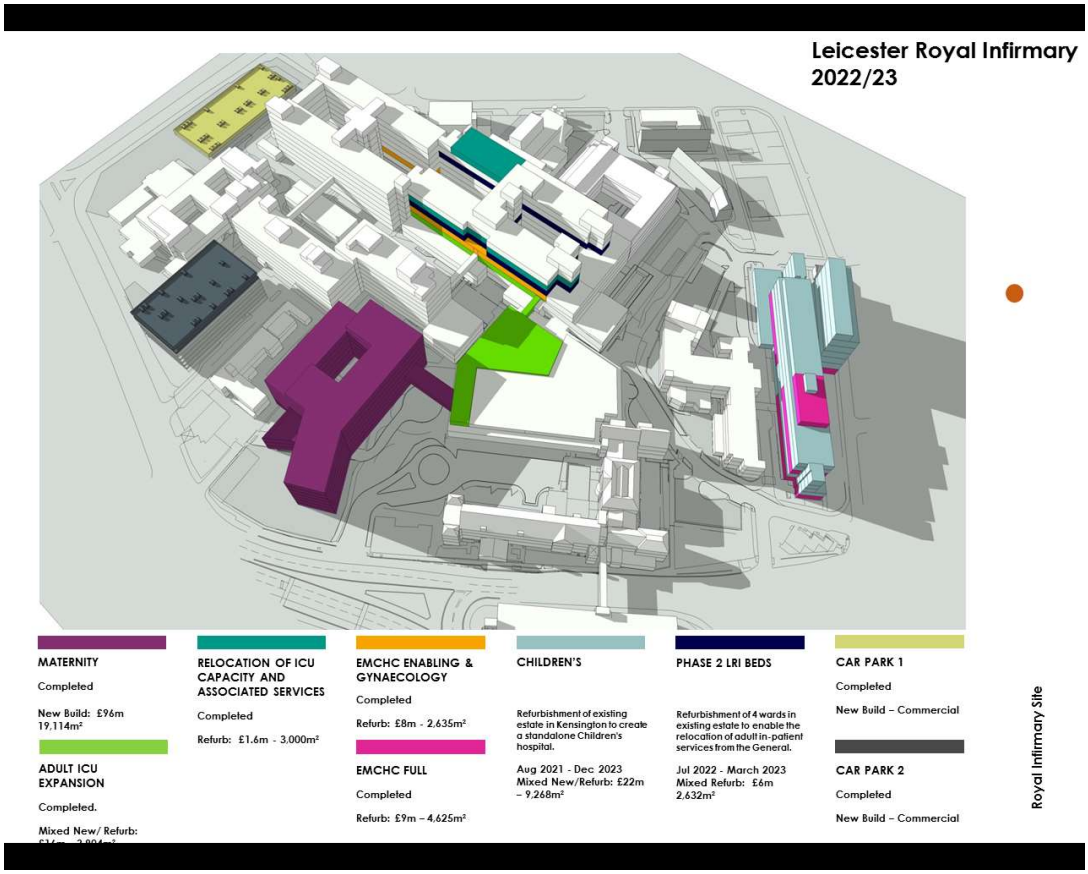
Chapter 6: Conclusion

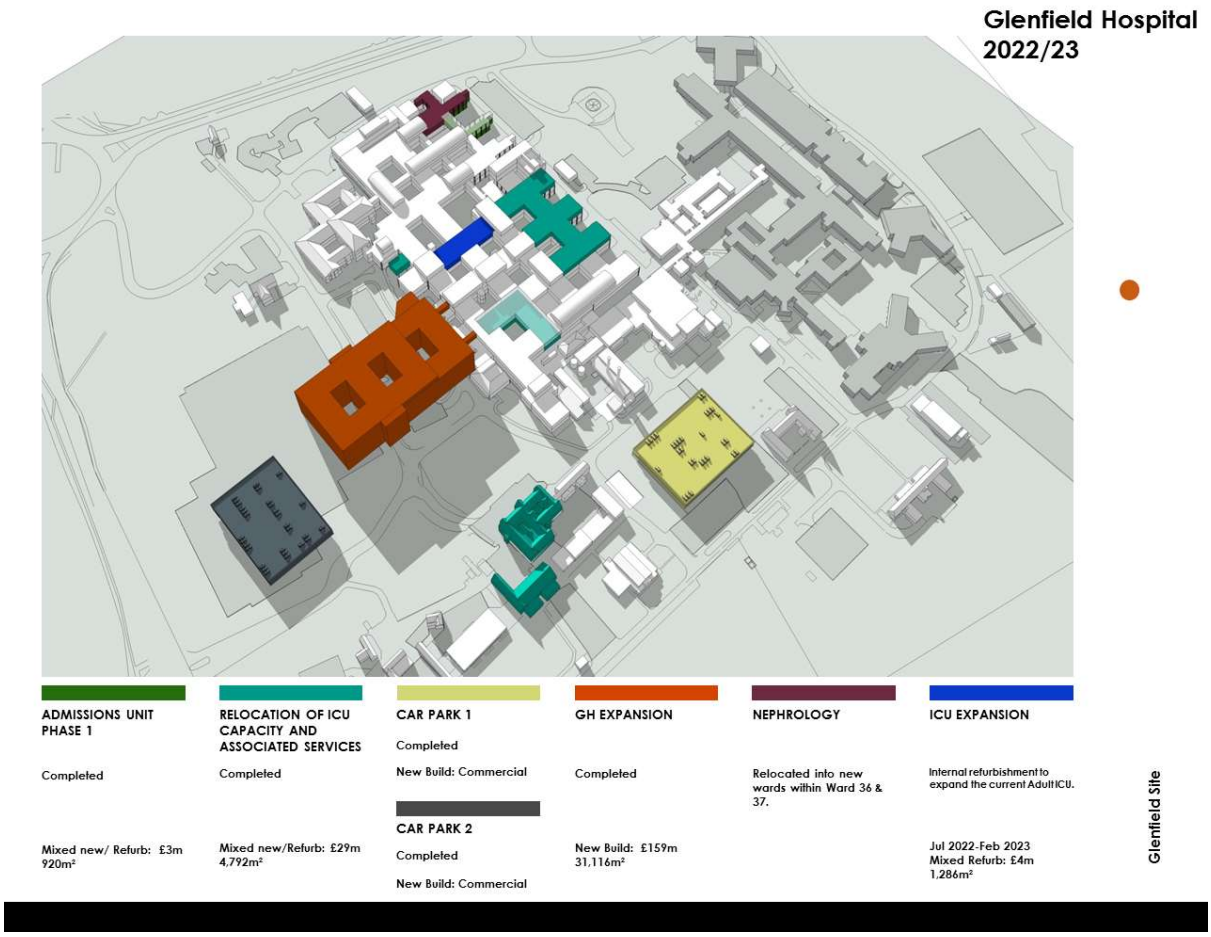
This clinical services and reconfiguration strategy demonstrates the breadth of our ambition to improve the care we provide for our patients and our commitment to providing an improved working environment for our staff, delivering transformed models of care and enabling the reconfiguration of our hospitals.

The reconfiguration of services across our three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care quality and outcomes; while at the same time ensuring that pathways of care are effective, efficient and locally based for our communities.

Delivery of this strategy will be a critical and tangible step towards sustainable health and care for the people of Leicester, Leicestershire & Rutland. While keeping our planned development of primary, community and social care clearly within view, we will deal with the urgent need to redefine the future shape of our acute hospitals to ensure long term clinical and financial sustainability.

Appendix 1 – Site diagrams 2022/23




Glenfield Hospital
2022/23
ADMISSIONS UNIT PHASE 1
Completed
Mixed new/ Refurb: £3m
920m²
RELOCATION OF ICU CAPACITY AND ASSOCIATED SERVICES
Completed
Mixed new/Refurb: £29m
4,792m²
CAR PARK 1
Completed
New Build: Commercial
CAR PARK 2
Completed
New Build: Commercial
GH EXPANSION
Completed
New Build: £159m
31,116m²
NEPHROLOGY
Relocated into new wards within Ward 36 & 37.
ICU EXPANSION
Internal refurbishment to expand the current Adult ICU.
Jul 2022-Feb 2023
Mixed Refurb: £4m
1,286m²
Glenfield Site

[redacted]

Year
5
4
3
2
1
0

YEAR 2 – 2019/2020

Services leaving in year:
- Level 3 Beds – Jul 2019
- HPB – Jul 2019
- Colorectal – Jul 2019
- Nephrology – Dec 2019

YEAR 3 – 2020/2021

Services leaving in year:
- Level 2 beds – Dec 2020

YEAR 4 – 2021/2022

Services leaving in year:
- Maternity services – Aug 2021
- Gynae In-patients, Out-patients and Day Case – Aug 2021

YEAR 4 – 2022/2023

Services leaving in year:
- Theatres – Jul 2022
- Out-patient services – Jul 2022
- Elective Orthopedics – July 2022
- Urology – Jul 2022
- Brain Injury – Mar 2023

All supporting services will vacate sequentially across the programme.

General Site
University Hospitals of Leicester

[redacted]