NHS LONDON
CAPITAL INVESTMENT BID PROFORMA

NHS ORGANISATION	Whittington Health (Whittington Hospital NHS Trust)
TITLE OF SCHEME	Integrated medical and surgical care assessment unit
CAPITAL VALUE (£'000)	2011/12: £100k, 2012/13: £6.9m, Total: £7m
LEVEL OF PRIORITY (OPTIONAL) If more than one proposal is submitted by the Cluster/NHST/FT, indicate whether this is 1st / 2nd / 3rd priority etc.	2nd priority
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SCHEME SUMMARY	[*Summarise the key dimensions of the scheme]* This bid is for the creation of an integrated medical and surgical assessment unit by the addition of 15 new acute beds. The new 15 bed area will be an extension to the existing 34 bed acute medicine unit, and will include a new integrated care admission avoidance clinic, adjacent to the emergency department. This will deliver the following benefits for the adult emergency patient cohort: • A 33% reduction in long length of stay, reducing excess bed days. • An increase in the proportion of patients on a short stay tariff (<48hours). • A 5% reduction in ED activity for this cohort as all GP expected patients will go straight to the new acute unit. • Enablement of Trust CIP, both through net bed closures and through increased productivity (for each new bed on the assessment unit, two acute inpatient beds can be closed elsewhere in the hospital). • Enablement of the Trust to meet both the ED targets and the Acute Medicine & Emergency General Surgery Operating Framework standards, including 18 week RTT, by separating elective and emergency patient flows, thereby reducing the potential for cancelled surgery.

	• Facilitation of the Trust to most effectively implement the Adult Emergency Services commissioning standards (London Health Programmes, 2011). • Improvement of patient safety through reduction in surgical and medical complications. The unit will allow the Trust to realign existing consultants' job plans. The unit will be consultant led and patients will be managed under evidenced based protocols optimising care and reducing variation of care, in an optimal clinical environment (Blay, Duffield, & Gallagher, 2011). • Improvement of patient experience through the development of a new gender segregated unit with en-suite facilities. • In-reach by community services early in the care pathway will be made more efficient and effective by the development of the unit and the corresponding redesign of the care pathway. Concentrating acute functions to one area in the hospital will allow efficiencies. • Supported early facilitated step down from hospital to community care (including care delivered in the patient's home) will enhance the patient experience through greatly improved integration of hospital and community care. • Avoidance of unnecessary admissions and reduction in duration of necessary admissions will promote care closer to the patient's home. • The new Ambulatory Emergency Care Service will promote early safe continuation of care in the community after discharge through a seamless integrated approach, working closely with GPs and community staff.

STRATEGIC CASE	*[Summarise the key strategic drivers and confirm support of stakeholders.]* *[Confirm the extent to which the scheme delivers on high priority NHS capital investment requirements, e.g. improving patient safety and the patient environment, reducing backlog maintenance (% of total); enabling QIPP delivery, etc.]* *[Confirm the support of key clinicians and the way in which the scheme supports delivery of local commissioning priorities and the requirements of emergent CCGs.]* *[Confirm that premises subject to the investment won't be disposed of within 5 years.]* Whittington Health is a groundbreaking Integrated Care Organisation in which community and hospital services have been fully structurally unified in a single organisation since April 2011. We have the lowest Standardised Hospital Mortality Index in the country, and award-winning community services. The Trust aims to be an international exemplar demonstrating that integrated care increases value by improving outcomes per pound spent by commissioners and providers. Whittington Health is therefore uniquely placed to demonstrate the benefits of a transformational model of streamlined acute care, tightly integrated with community and GP care.

1. Key Strategic Drivers

Trust Strategy

Whittington Health's strategy is to provide first class integrated health care across primary, community, hospital and social care, eliminating the traditional boundaries between service providers. Its aim is to reduce the total cost of healthcare both for the Sector and the Trust and to improve patient experience and safety by providing the best care in the best place.

The Trust currently has a purpose-built acute medical assessment unit of 34 beds co-located with the Emergency Department (ED), theatres and the HDU/ITU. The development of this unit has enabled a reduction in length of stay, a reduction in readmissions and the consequent closure of 61 acute beds elsewhere in the hospital. However, the current acute medical assessment unit has capacity for emergency medical patients only.

This bid is for the creation of an additional 15 acute beds, leading to an integrated acute medical and surgical assessment unit. This will enable a new integration of acute medical and surgical care models, and will also permit a substantial cohort of adult emergency patients to complete their entire hospital stay without transfer into in-patient wards, which typically increases length of stay (Schultz, van Servellen, Chang, McNeese-Smith, & Waxenberg, 1998).

The new unit will also incorporate a new Ambulatory Emergency Care Service incorporating integrated community services, which will minimise unnecessary hospital admissions and facilitate integrated and seamless transfer of care from hospital into the community to support care closer to home.

As more care is delivered in the form of ambulatory care, or is transferred to more appropriate locations within the community, the successful hospital of the future will have a substantially reduced bed base. However, those patients who do require hospital admission, particularly for a prolonged period, will be increasingly elderly with complex co-morbidities. This proposal will therefore alter the Whittington's bed profile in a way that will meet the future changing health requirements of our population.

Sector Strategy

This bid fits with the NCL Commissioning Strategy and QIPP Plan. Key NCL strategic and QIPP goals that this development will enable include:

- Meeting the three key goals of the Acute Productivity Work stream : Streamlining of care delivery, reduction in admissions and reduction in length of stay .
- Reduction in costs for the Sector.
- Reduction in the overuse of A&E.

- Improved outcomes & productivity.

- Refocusing care into the community through integrated community and acute support for discharge from hospital.

2. Deliverables

If this bid is successful:

- Unplanned emergency care will be delivered in a purpose-built acute environment, in which sick acute medical and surgical patients are co-located.

- A new consultant-led Ambulatory Emergency Care Service based on this unit will avert avoidable admissions and oversee appropriate integrated step down care in the community, liaising closely with GPs.

- Care will be provided with intensive acute consultant input and leadership, with intensive in-reach by specialty consultants, an appropriate nursing staff skill mix, and intensive support by community-facing consultants, specialist nurses and allied health professionals, who will transfer ongoing care seamlessly back into the community.

- Emergency medical and surgical patients referred in by their GPs will go straight to this combined unit, not attending ED (cost benefit to commissioners).

- 29 beds will be closed elsewhere in the hospital, giving a net reduction of 14 beds.

- Length of stay will be greatly reduced, and unnecessary ward transfers will be avoided, so the proportion of patients on a short stay tariff will increase (cost benefit to commissioners).

- Existing staff will be redeployed and will be more productive (no additional staff are required).

- Patient experience will improve through the seamless integration of hospital with community-based care, leading to care being delivered closer to home wherever possible.

- An increase in single rooms within the unit will improve infection control

- Rationalisation of the acute front end of the hospital will then facilitate redevelopment of the deeper hospital along leaner functional lines. This will permit implementation of a joint care 'hospitalist' model - surgeons will consult on operative matters and related complications. Physicians will work alongside surgeons and consult in a parallel way on medical co-morbidities. In the United States, this model has driven the growth of

hospitalist consultants from almost nothing to now being the largest hospital based medical speciality. This model has significantly reduced length of stay and improved patient safety (Wachter, 2011).

3. Capital expenditure

There exists a vacant space ideally located for this capital build next to the ED, the existing acute wards and the HDU/ITU.

Importantly, there are already completed architects' plans for this capital build.

Backlog maintenance will be reduced through permanent closure of significant parts of the Trust estate and this will also reduce fixed costs through impairment. Other revenue costs (and carbon reduction) will be reduced through the consolidation of space utilisation.

The additional capital charges of £450k per annum, arising from the £7m investment, will be covered by the savings associated with the greater number of beds that are being permanently closed.

Confirmation of non disposal

We confirm that the premises subject to the investment will not be disposed of within the next five years.

4. Stakeholder Support

This proposal has the support of:

- General Practitioners:

Peter Christian, Whittington Health GP Lead for West Haringey
Lead GP(West Haringey)
Haringey Shadow Commissioning Board

Greg Battle, Medical Director of Integrated Care at Whittington Health, GP

- Commissioners:

Steve Davis, Turnaround Director, NCL

- NCL:

Liz Wise, Director of NCL Strategy and QIPP Programme

- Patient & public representatives:

Helena Kania, Chair of Haringey link
Ron Jacob, Lead of Whittington Council of Governors

- Local Authority:

Carol Gillen, Director of Integrated & Acute Care, London Borough of Islington, & Director of Operations, Integrated & Acute Care, Whittington Health

	• Trust staff Celia Ingham-Clark, Medical Director Bronagh Scott, Director of Nursing Martin Kuper, Medical Director, Division of Surgery, Diagnostics & Cancer Richard Jennings, Medical Director, Division of Integrated Care & Acute Medicine **5. Clinician & Commissioning Support** Both the model of bed reduction through the creation of an Acute Unit, and this current bid, have been clinically led. Whittington clinicians have demonstrated their commitment to the model through their proactive support for the development of Integrated Care and the current Acute Admissions Unit over the past four years. Integrated Care is a key commissioning priority. The CCGs support the move towards care closer to home, with rationalised cost-effective hospital care for those who need it. Commissioners are interested in the development of a more US-type model of acute inpatient care delivered by hospitalist-type acute physicians working alongside surgeons. The proposal also meets the recommendations of the recent independent commission for the Royal College of General Practitioners and the Health Foundation that there is a need for more generalist medical care (Independent commission, 2011).

ECONOMIC CASE	*[Confirm the scheme benefits – including financial (cash releasing and non cash releasing) and non financial (quantifiable and non quantifiable) and how the scheme delivers value for money.]* *[Confirm other options considered to achieve the scheme's objectives.]* **1. Financial** <u>Benefits to commissioners</u> £210k reduced payment to Trust plus £460k reduced payment to NHS London (emergency tariff 70% component) • Reduction in longer length of stay Emergency Admissions • Reduction in Excess Bed Days • Increase in short stay admissions • Reduction in Emergency Attendances to A&E <u>Benefit to provider</u> • Reduction in Length of Stay leading to reduction in Acute Bed Base and other efficiencies less additional capital charges • Reduction in costs associated with A&E attendance reduction CIP of £800k from ward closure less capital charges of £450K and less reduced income £210k = £140k net benefit Overall this will effect a saving to the health economy and provide better value to the taxpayer.

1.1 Value for money

Financial (cash releasing) benefits
As discussed, this scheme delivers value for money through the net closure of beds of 14 beds. The beds that will be closed are currently occupied by patients with greater than average length of stay, and the savings generated by their closure will cover and exceed the additional capital charges. This will allow for an income adjustment to the Trust commensurate both with the reduction in excess bed days and with the corresponding increase in the proportion of patients attracting the short stay tariff.

The scheme will also strengthen the Trust's ability to meet its CIP target

The evidence that the Trust will reduce its bed base is:

- Trust audit data from 2008 indicated a reduction of length of stay by 1.9 days associated with implementation of the Acute Unit model in medicine.

- Since 2007 the Trust has been able to permanently close 61 beds as a result of creating 34 Acute Unit beds, and has for the past two years avoided the practice of seasonally opening a "winter pressures" ward

- The increased acute bed capacity will prevent clinically unnecessary ward transfers. There is good international evidence that ward transfers increase length of stay by approximately one day per transfer (Blay, Donoghue, & Mitten-Lewis, 2002; Parker et al., 1998)

- The Ambulatory Emergency Care service approach has been shown to prevent unnecessary admissions – for example, Whittington audit data indicates that the Trust's Ambulatory Intravenous Antibiotic Service has saved 247 bed days in 12 months in 2009/10

- In elective surgery, implementation of an enhanced recovery model has greatly reduced length of stay (Dr Foster intelligence, 2011; Kuper et al., 2011). Enhanced recovery pathways improve patient experience and quality, enabling patients to recover quicker from surgery and return home earlier but fitter, with no increase in readmissions or burden on primary care. Analogous approaches in emergency surgery and acute medicine are already being piloted (in Torbay and also in Denmark) and are anticipated to also yield significant bed day savings. The new model at Whittington Health will enable the broader application of the enhanced recovery model to acute surgery and acute medicine.

- Experience in other countries indicates that rationalisation and integration of acute and community services can lead to very radical reductions in the bed base required (the Kings Fund, 2010).

Financial (non cash releasing) benefits

The transfer of acute care from existing in-patient wards to the proposed expanded Acute Unit will produce additional time capacity for staff that will no longer be focused on acute care. This can be used to add value through refocusing on meeting commissioning standards and targets (London Health Programmes, 2011), and through refocusing on integrating hospital care with community and GP care.

2. Quality

A reduction in avoidable admissions and length of stay enhances patient experience and safety.

The more intensive and consultant-led model improves patient safety – there is a robust national evidence base for this.

Furthermore, the space proposed is on the hot floor, co-located with A&E, ITU/HDU and the existing acute wards. It is appropriate that this uniquely located space should be utilised to add value to the care of acute sick inpatients.

Non-financial (quantifiable) benefits

- Improved patient safety – quantifiable through standardised hospital mortality index, serious and high risk incident numbers and infection control data.

- Improved patient satisfaction – quantifiable through patient-reported outcome measures, patient surveys, single sex accommodation patient surveys and numbers of complaints.

- Improved and innovative undergraduate and postgraduate education, arising through opportunities to embed integrated care in training – quantifiable through PMETB and other postgraduate and undergraduate surveys.

Non-financial (non-quantifiable) benefits

- This transformation of acute care will provide a flagship example to the broader national health economy of the way in which Integrated Care can add value, improving outcomes and yet reducing the total cost envelope of healthcare provision.

3. Other options considered to achieve the scheme's objectives

- An alternative to this scheme would be to create an Acute Surgery Unit (SAU) on one of the existing surgical wards. This alternative is not favoured because it does not bring the major benefits of physical co-location with the A&E, acute medical wards and HDU/ITU, it does not realise the major benefits of clinically integrating acute medical and surgical care, it does not

	minimise inefficient ward transfers and it does not co-locate acute surgery with the Ambulatory Emergency Care Service that will integrate acute surgery with general practice and community care. **4. Contribution to carbon reduction plan** • The reduction in overall bed base resulting from this proposal will contribute a significant carbon reduction corresponding to that of a hospital ward.

FINANCIAL CASE	*[Confirm the capital costs of the scheme and anticipated dates of capital deployment (and any associated disposals) split between 2011/12 and 2012/13]* *[Confirm the recurrent revenue costs of the scheme. Where these are anything other than revenue neutral or revenue saving confirm the source of additional revenue.]* *[Confirm that the recurrent revenue cost of the scheme is affordable]* **Capital costs** 2011/12: £100k – appoint project manager and project enablement including preparation for procurement. 2012/13: £6.9m, Total: £7m **Recurrent Revenue Costs and Affordability** Full year effect of capital charges 2013/14 £450k per annum with partial impact in 2011/12 and 2012/13. The additional capital charges and income reduction is fully funded by the additional number of bed closures.

COMMERCIAL CASE	*[Confirm the commercial arrangements for delivery of the proposed capital investment, e.g. procurement approach and proposed contract type (If not using Procure21+ for new build or refurbishment or projects explain why not).]* *[Confirm when any necessary full planning consent will be achieved.]* *[Confirm status of legal documentation and what (if anything) remains to be agreed.]* *[For new build and refurbishment projects confirm: i) compliant with DH guidance (HBN & HTM); ii) compliant with eliminating mixed sex accommodation; iii) intention to undertake BREEAM assessment and target outcome.]* Commercial arrangements Procure 21+ Planning consent Full planning consent not required. Legal documentation No other approvals are required other than those associated with building control, and these will be obtained as part of the specification and tender process. Compliance This refurbishment of an existing space will be compliant with HTMs, HBNs and BREEAM requirements. The new unit will provide gender segregated bays and single rooms with en-suite facilities.

MANAGEMENT CASE	*[Confirm the key risks to delivery and measures to mitigate and manage these risks.]* *[Provide a simple timeline with key milestones for the procurement and delivery of the scheme.]* **<u>Key risks to delivery</u>** • Delays in appointing a preferred partner for Procure 21+. This will be mitigated through the engagement with the DH procurement advisory unit to help develop a procurement plan and act as advisors throughout the process. • Delivery within the required timeframe. Mitigation against this is already available through the completed scoping and design of the space, curtailing the initial design and planning phase. **<u>Timeline</u>** Scoping, the agreement regarding outline plans and the drawing up of finalised architects' plans has already been completed. Months 1-3 • Commencement of Procure 21+ • Design team produce packages of work for design and build contractor to cost Month 3 – 12 • After procurement appointment of design and build contractor • Contract agreement, pricing and designing packages • Pre order long deliver items • Site mobilisation circa 8 weeks • Works underway Month 12 • Work completed.

LOCAL APPROVAL PROCESS	*[Confirm whether the scheme has yet received full Board approval, and if so the date on which this was confirmed. If not, confirm the anticipated date of approval and the extent to which the scheme has already received Board support, e.g. Outline Business Case approval.]* The Trust has identified this scheme as desirable, both in terms of best clinical practice and in order to transform the emergency care pathway to release efficiencies. The scheme has been approved by the Executive Committee and given Chairman's approval pending full Trust Board approval of the outline business case on 25th January 2012.

CONFIRMED AS SUPPORTED BY:

CLUSTER/NHS TRUST/ FT CHIEF EXECUTIVE OR DIRECTOR OF FINANCE:	
NAME:	**Caroline Taylor**
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LEAD COMMISSIONER (NHS TRUST / FT BIDS ONLY):	
NAME:	**Liz Wise**
TITLE:	**Director of Strategy and QIPP**
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