North West London Collaboration of
Clinical Commissioning Groups

Shaping a healthier future
Strategic Outline Case part 1

Version 0.4

December 2016

Notes

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Executive Summary

This is our business case for the capital investment needed to effectively deliver high quality health services for the residents of NW London across primary care, the community and acute hospitals.

We have a mandate for change

In North West London, our Sustainability and Transformation Plan (STP) builds on a central core that has undergone full public consultation, been agreed by the Secretary of State for Health, and has already successfully delivered many of its planned benefits without requesting additional capital expenditure. This core component is a clinically-led portfolio of programmes called *Shaping a Healthier Future* (SaHF). SaHF is a comprehensive and ambitious strategy, covering physical health services in primary care, the community and hospitals, and it is key to fully meeting the ambitions of the *Five Year Forward View* (FYFV) in NW London.

The SaHF proposals underwent full public consultation in 2012. The preferred option was published in a Decision Making Business Case (DMBC) in February 2013 which was approved by a Joint Committee of PCTs and then subsequently by the Secretary of State for Health in October 2013. The key feature of the DMBC was an interconnected model of care in which:

- most clinical activity takes place in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
- our acute services are reconfigured to ensure better quality care and clinical sustainability, while also achieving financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

This Strategic Outline Case (SOC) sets out how the right investment will be made to close the three gaps defined in the FYFV, namely health and wellbeing, care and quality, and finance and efficiency. This SOC comes with the whole-hearted support of clinicians, hospital trusts, community providers and health commissioners across NW London. The principles of this SOC have been widely discussed with our local authorities, patient and public representatives, Health & Wellbeing Boards, local councillors and MPs. We are now planning a further extensive and detailed period of engagement locally to help shape local investment plans and new service models.

Be well and live well: this is our vision for a better health system in NW London

Our vision for health and care in NW London is that everyone living, working and visiting here has the opportunity to be well and to live well. We know that currently the quality of care and the experience and outcomes for people varies across NW London.

Residents of NW London will have their clinical and social care needs met in the place that is most familiar to them, which will, for the most part, be in their own home. We will implement a model of care to save patients unnecessary visits to acute hospitals by reducing unwarranted variation in the management of long term conditions in the community, improving care planning and case management for people with complex needs, and providing more seven-day access to both hospital and out of hospital care. We will achieve better outcomes through consolidating expert care for particular acute conditions onto fewer sites. We have already made a lot of progress but we know there is sizable opportunity to do much more.

We developed our STP in direct response to NHS England's FYFV, the *General Practice Forward View* (GPFV) and the *Mental Health Forward View* (MHFV), and it describes how we will change the historical approach to managing care. The NW London STP covers eight boroughs and encourages greater coordination and cooperation across the health and care system, reflecting the way patients use it. We will take our out-dated, reactive, increasingly acute-based model of care and turn it on its head, through a new model where patients take more control, supported by an integrated system

which proactively manages care. The default position will be to provide care close to people's homes, and only resort to the acute sector when there is no safe alternative for that person. This will improve health and wellbeing, and care and quality, for all our residents, and help our providers and commissioners achieve financial balance so that we can continue to deliver safe and effective services.

The case for change

Our current system is unsustainable: the health and wellbeing of our residents is not well-managed locally, care and quality suffers as too many services are offered from too many sites, and our health and care system is facing significant financial deficits. It is clear that we have to change our health and care model to close the gaps identified in the FYFV.

There are a number of challenges facing health and care services in NW London:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population
- At any given time, almost one third of inpatient beds in our acute hospitals are occupied by people who could and should be better cared for elsewhere, preferably in their own homes
- Unacceptable variation in the quality and delivery of all services, as well as in health outcomes; for example:
  - there is a difference of 17 years in our best and worst life expectancy, depending on where you live
  - Hospital Standardised Mortality Rates, though generally low, vary from 0.76 to 0.90 between our best and worst performing acute providers (June 2016)
  - average length of stay for patients admitted to hospital for procedures e.g. elective primary knee replacement surgery varies from 4.3 days to 7.5 days
  - in most general practices, there is approximately 40% or lower adherence to the statin prescribing guideline for people with diabetes, despite the strong correlation with good control of serum cholesterol which is protective against cardiovascular disease
- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with
- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to deliver a 7-day service under the current model across multiple sites
- Too many small hospitals resulting in a compromise of clinical productivity for the residents of NW London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals
- A large proportion of GP practices operate out of outdated premises that are often poorly accessible and with limited facilities for additional services.

Although services do provide a good standard of care at the moment, they are not sustainable in their current form. There is a high risk that as services become unsustainable, it will be patients, their carers, and the clinicians who treat them and care for them, who will be the first to feel the consequences.

We need to ensure that people in NW London have access to the right care, in the right place at the right time. High quality, effective treatments for patients need to be provided consistently where they are needed, within places that are appropriate for individual needs. Care needs to be provided in a more integrated way, in partnership with social services and local government. It must be clear to patients how to access their care, and they must be able to move between different care settings with no disruption to the care they receive.

More investment needs to be made in GP services and other local healthcare services, so they are more consistent and of a higher standard, bringing better routine treatments closer to home and

supporting more services outside hospitals. Alongside this, clinical teams need to be established so that patients needing specialist treatment can be certain they will be seen by experienced specialist clinicians, who are familiar with, and who regularly treat, similar patients with their condition.

Our acute provider trusts face enormous financial challenges: currently trusts are running in-year deficits which will require an estimated cash support of £1.1bn over the next ten years, and we simply cannot afford to subsidise this.

Given the population health trends, coupled with our current model of care and health infrastructure, we can only achieve our vision by making major changes to how we deliver care.

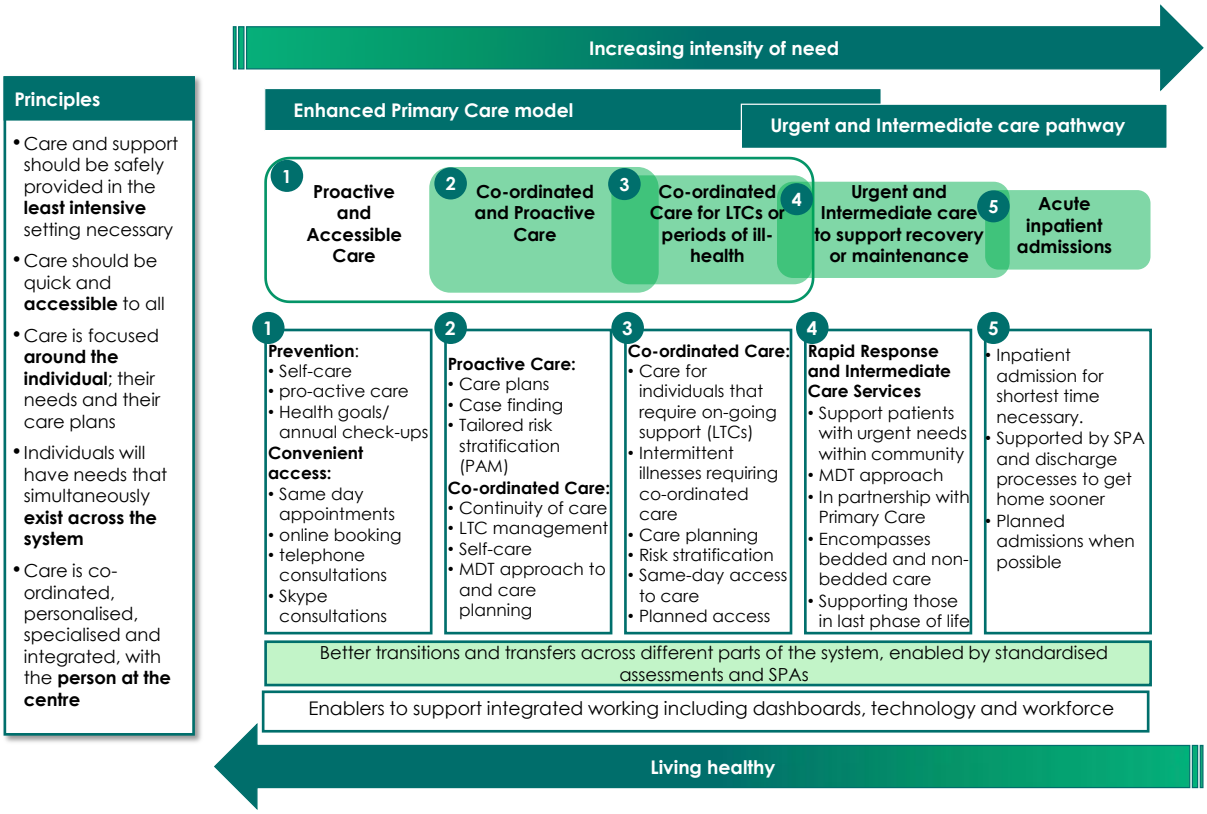
Personalised, localised, coordinated and specialised: this is our proposed solution

We will reconfigure health services so that they are personalised, localised, coordinated and specialised across health and social care providers to improve care for our patients.

PERSONALISED	Personalised, enabling people to manage their own health and wellbeing and to offer the support they need to do this. To provide care based on individual need for people and their carers where it is required.
LOCALISED	Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is convenient.
COORDINATED	Delivering services that consider all the aspects of a person's health and wellbeing and are coordinated across all the services involved. This ensures services are appropriate and efficient.
SPECIALISED	Centralising services where necessary for specific conditions ensuring greater access to specialist treatment to deliver high quality care.

Our proposed model of care consists of two inter-related parts. The first relates to primary care and out of hospital services, which will result in transformation of out of hospital care and a net shift of care from hospitals into community settings, closer to where people live. The second element is a reconfiguration of acute services so they can best serve the local population, providing high quality, sustainable expert clinical care.

We want to provide primary care that is accessible, proactive and coordinated. We will achieve this by giving primary care the opportunity to deliver care in larger premises through a more consistent hub and spoke model. This will provide seven-day extended access and improve the management of long term conditions to give everyone access to the same, high quality services. These are vital for the sustainability of our health and care economy. Our model of care is set out below:



Our proactive model of care for primary care encourages GPs to work together, organised into federations, and care will be increasingly delivered through a hub-and-spoke approach, providing a range of population and system benefits. It will enable us to:

- reduce unwarranted variation and improve patient outcomes for people with long term conditions in primary care
- provide a multidisciplinary team-based model of care delivery
- provide a consistent approach to seven-day extended access to primary care
- deliver better care-planning and case management.

We will also:

- improve co-ordination of care by making sure information relevant to the care of an individual can be shared by everybody involved in their care
- provide a support function for unpaid carers that look after the majority of residents with complex needs
- support people to better manage their long term conditions, increasingly by adopting digital technologies.

We know that better outcomes can be delivered by expanding and improving out of hospital services in all areas and moving more activity, and associated funding, into community-based care. A key feature of our service provision will be out of hospital hubs. Hubs are a facility where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient-centred services that can't be achieved through the current configuration of 450 primary care sites. Some hubs will be used to group together general practices, which will increase access and result in better provision of same-day appointments for patients with more urgent problems. The hubs will offer modern, purpose-built or adapted facilities and will offer those GPs working there the opportunity to share overhead costs. This will also make extended opening hours and a broader range of services more viable.

We will reduce unwarranted variation through implementation of more consistent care processes across all general practice. We will continue to support the development of federations and enable the delivery of primary care at scale. We will support the development of GP leadership in networks to share best practice ideas and unblock front-line problems. Our improved primary and community care, centred around the hubs, will lead to a reduction in A&E attendance and non-elective admissions for those people whose conditions can be better managed outside of hospitals, and to shorter lengths of stay for those people for whom hospital admission is appropriate.

The preferred reconfiguration option in the DMBC also included the development of 29 out of hospital hubs across inner and outer NW London. The preferred option for the number of hubs has subsequently been reduced to 27 because, in the intervening period, each CCG has developed further work on the proposed services and activity at each site, the estimated capital cost and funding source. Further engagement on these changes, and their associated impact on equalities, will take place during the options appraisal and OBC development stages of the hubs business case process.

The capital investment requested in this SOC for the out of hospital estate will address the problem of our outdated and poor quality primary care estate and enable us to ensure that there is sufficient capacity in modern, purpose-built facilities to meet the current and growing demands for primary care. The hubs are crucial to delivering our new model of care.

All hospitals with an A&E will continue to provide a 24/7 Urgent Care Centre (UCC), working to the same clinical standards across NW London. UCCs will treat around 60% of people who would otherwise have attended A&E. Acute hospitals will be designed to support the implementation of the new model of care and using scarce resources to best effect, including centralising services where necessary and concentrating a full range of specialist services on fewer sites to be able to most effectively treat acutely ill patients. We have developed plans for which services will be offered from each hospital site. The preferred option for the acute reconfiguration, agreed through the DMBC, has five major hospitals, two local hospitals, one elective hospital and one specialist hospital.

Hospital site	Proposed status following reconfiguration
Chelsea and Westminster Hospital	Major Hospital
Hillingdon Hospital	Major Hospital
Northwick Park Hospital	Major Hospital
St Mary's Hospital	Major Hospital
West Middlesex University Hospital	Major Hospital
Hammersmith Hospital	Specialist Hospital with obstetric-led maternity unit and a Local Hospital
Charing Cross Hospital	Local Hospital
Ealing Hospital	Local Hospital
Central Middlesex Hospital	Local Hospital and Elective Hospital

The intention is that the local hospitals will become an integral part of the local community, with involvement of local patients, patient groups, the voluntary sector, the local council through the Health and Wellbeing Board, and local clinicians in developing the range of services which will deliver the majority of care that communities need, such as diagnostic tests and treatments. The Ealing Local Hospital service model, as set out in the DMBC, consisted of an Urgent Care Centre, an outpatients department, outpatient paediatrics, ante and postnatal care and a limited range of diagnostics (X-ray and ultrasound). In keeping with the Secretary of State's explicit request, Ealing and Charing Cross Hospitals will continue to offer an A&E service although it may be in a different shape or size from that currently offered, and will be developed using guidelines from the Keogh review. We have built on this core set of services to develop more comprehensive proposals for the clinical model for the site, which have been informed by clinical design and feedback from stakeholder engagement. These

proposals, and their associated equalities impacts, are part of an ongoing process of design that will continue with local clinicians and residents as we develop the OBC.

We have evidence that our model can work and is already working

Our model of care is closely aligned to that promoted in the FYFV and the GPFV, and is very similar in concept to the models proposed by many of the Vanguard sites for multidisciplinary community providers. We have undertaken analysis of our current utilisation patterns and health outcomes and, from this, have identified four discrete opportunities in NW London to deliver more care to people at or close to home, and to only deliver care in acute settings when it is really needed.

We know that it is generally underestimated that many people who are admitted as non-elective acute cases are actually in their last phase of life and could be more compassionately care for elsewhere, according to their stated wishes. We also know from analysis commissioned in 2015 from GE Healthcare Finnamore on admissions avoidance and length of stay reduction, that by focussing on alternative out of hospital provision for people with certain known long term conditions and admission patterns, we can achieve a considerable net reduction in acute activity. Using this analysis as the basis of our activity modelling, and offsetting it against projected demographic growth, we have forecast that better investment in long term condition management and community alternatives will reduce demand for acute beds by 364 by 2025/26, within the scope of this capital investment.

Further opportunities for reducing activity in the acute sector are found in elective outpatients. We have identified a cumulative reduction of more than 300,000 consultations by 2025/26, made up of a combination of activity re-provided in hubs and consultations avoided altogether through better co-ordination of primary and secondary care, and by delivering consultations using alternative channels, such as digital.

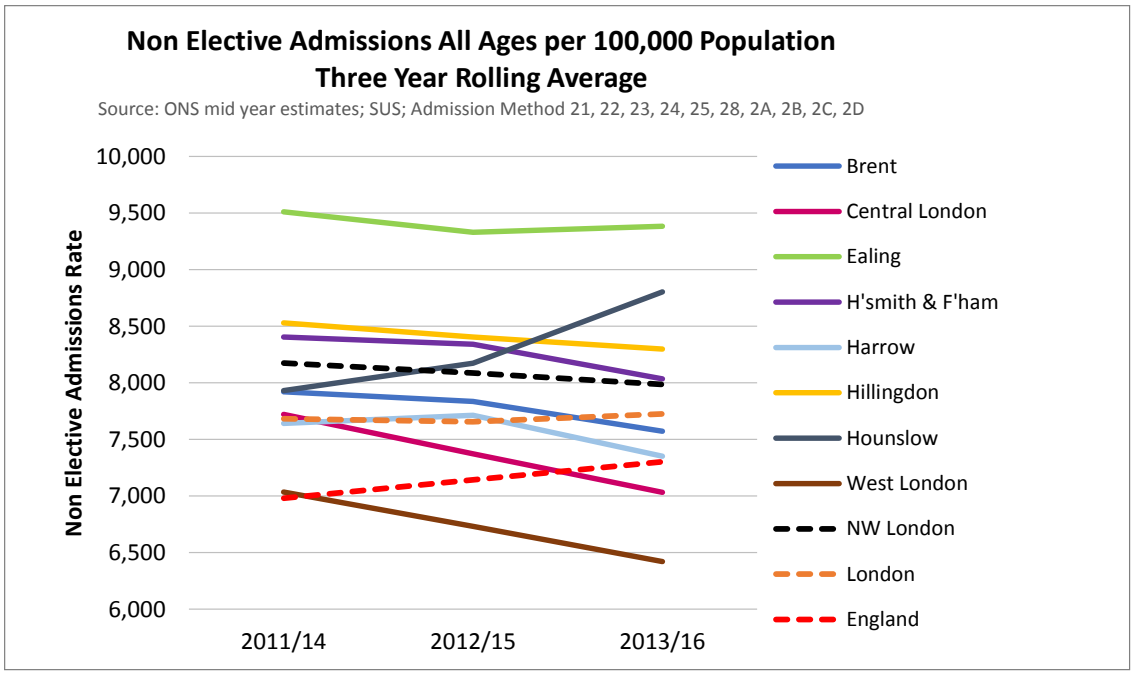
We also know that we currently have an unacceptable level of variation in care processes, especially for people with long term conditions who often experience fragmented, poorly-co-ordinated care. This may in part explain our observed variation in non-elective bed days per person over 65years per general practice of around 400%.

Beyond the sizing of the opportunity, we also have evidence of many areas where we have already been able to effect change. Since receiving approval for our DMBC in 2013, we have:

- transformed maternity services and closed the Ealing inpatient maternity unit. In 2015, the programme delivered significant clinical improvements for women and newborn services via consistent and networked model of care for maternity services, including 100 more midwives in post, and an average of 122 hours of consultant presence a week in maternity units
- transformed paediatric services and closed the Ealing paediatrics inpatient ward. In 2016, the programme, working with our providers, has delivered a major change to services for children and young people in need of acute care including consultant-staffed paediatric assessment units, a new children's A&E at Hillingdon, 60 more children's nurses and nine more consultant paediatricians in post
- closed two A&Es at Hammersmith Hospital and Central Middlesex Hospital that cannot meet NW London standards of care to concentrate expertise and resources at nearby A&Es
- started piloting improved services for hospital patients seven days a week with increases in consultant involvement in care and decision-making, improvement in therapy and pharmacy services and faster access to diagnostics
- invested in new technology at 80 GP practices meaning that half a million patients can use online, email, video or telephone consultations; and invested in a single information system for primary care across our CCGs
- established the St Charles Hub in West London which is successfully integrating care in collaboration with GP surgeries, local NHS hospitals and community and social care services
- instituted a diabetes performance dashboard by CCG and by GP federation and network which has had a major impact on improving diabetes care across NW London

- commenced collaborative development of a NW London older people's frailty pathway, involving providers, commissioners, service users, carers, representative groups, and local authority colleagues, to be applied across all care settings

We know that these and other service improvements are already making a difference. The three-year rolling average non-elective admission rates per 100,000 show an overall reduction in NW London, with five of our CCGs showing an obvious downward trend, two holding steady and only one with an upward trend. In contrast, the non-elective admission rate in London as a whole has increased slightly, and nationally it shows a clear upward trend. There is a correlation between those CCGs that are furthest ahead in the delivery of the new model of care and where reductions in non-elective activity have been greatest. We are confident that further implementing changes and operating at scale can reduce non-elective admissions and occupied bed days.



The data on non-elective admissions and bed days for all our commissioned care with all acute providers shows there is clear evidence that in NW London, we can and are delivering our strategy and realising benefits. However, to maintain this progress, make it universal for all our population in all our CCGs, and fully realise the benefits, we need to be working at greater scale.

We've already achieved a lot, but now need to invest to deliver our plans in full

Our achievements to date have not necessitated any additional requests for capital funding. We have now gone as far as we can with limited capital. We require investment to deliver the planned changes in the model of care. We are requesting capital because the forecast changes in activity cannot be accommodated in existing estate facilities. The size of the capital request is reflective of the overall poor quality of estates in NW London which are increasingly costly to maintain, do not meet modern standards and are not fit for purpose.

We have presented our Strategic Outline Case (SOC) setting out the strategic, economic and financial, commercial and management rationale for capital investment over a ten-year period. Our SOC is presented in two parts, of which this document is part 1. The SOC is in two parts because capital funding is being produced to different timelines. SOC part 2 is predicated on some complex commercial negotiations; the timescale for its development and submission is still to be determined with NHS England. For the purposes of SOC part 1, all the acute sector changes proposed are those associated with the transition of Ealing to becoming a local hospital, while the out of hospital changes

described cover the whole of NW London with the exception of the hubs proposed for St Mary's and Charing Cross sites. SOC part 2 will present the case for a further estimated £314m net capital to enact the SaHF plans for acute reconfiguration in inner NW London.

SOC part 1: overarching case plus the detail for outer NW London

- SaHF related changes at Ealing, Northwick Park, Hillingdon, West Middlesex and Central Middlesex hospitals
- SaHF's out of hospital hub developments across all boroughs, but *excluding* the hubs intended for development on the St. Mary's and Charing Cross hospital sites
- Additional primary care estate (non-hub)
- Overall maximum NWL capital envelope based on a 'placeholder' for SOC part 2, and rationale for splitting the SOC

SOC part 2: detail on inner NW London

- SaHF related changes at Charing Cross, St Mary's, Hammersmith and Chelsea & Westminster hospitals
- SaHF's out of hospital hub developments on the St Mary's and Charing Cross hospital sites
- Re-development of St Mary's Hospital
- Agreement of services between Hammersmith, Charing Cross and St Mary's

Following approval of SOC part 1, each hospital reconfiguration project and out of hospital scheme that requires capital investment will be required to complete an Outline Business Case (OBC) and a Full Business Case (FBC) before implementation can begin. The detailed implementation plans for the hospital reconfiguration and out of hospital capital programmes will be outlined in the relevant business cases.

This case sets out the requirement for £513m of capital investment to deliver these changes in an accelerated timeline of which £377m is within this Comprehensive Spending Review (CSR) period for SOC part 1. This is essential to enable delivery of our STP. SOC part 1 sets out the strategic case for all of NW London but the capital is only for the out of hospital hubs and the outer NW London hospitals.

We have set out an accelerated timeline for the capital requirement. The accelerated timeline reduces the overall capital requirement from £529m to £513m, a reduction of £16m and substantially changes the phasing of the capital requested in each CSR period. This case is requesting funding on the basis of an accelerated timeline given the urgency of the clinical and financial challenges we are facing. The summary of net capital requirement for SOC part 1 traditional timeline is set out as shown:

£m	2016/17	2017/18	2018/19	2019/20	2020/21	Total CSR 1	Total CSR 2	Total 10year
Primary care estate								
Total primary care estate for refurbishment of GP premises		13	56			69		69
Acute services								
Total acute services net capital	0	1	4	18	149	172	131	303
Out of hospital								
Total out of hospital net capital	6	16	38	68	8	136	5	141
Total net SOC part 1 capital	**6**	**30**	**98**	**86**	**157**	**377**	**136**	**513**

The place where the challenge is most acute is Ealing Hospital. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. There is currently a financial deficit of over £30m associated with Ealing Hospital. The costs of staffing it safely are greater than the activity and income for the site, meaning that the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period and apply the accelerated timeline to delivering the changes there. Under a traditional business case approval timeline, we would not be able to address the Ealing site issues, or fully deliver the new model of care, until 2024.

We know that there will be a good return on the capital, and that we can afford to make the investment

The economic appraisal sets out the value for money case for the proposed capital investment, through a structured comparison of costs and benefits, including quantifiable and non-quantifiable financial and health benefits. This assessment demonstrates an overall benefit in Equivalent Annual Cost (EAC) terms of the investment of £181m which includes the following;

- The changes in capital and revenue costs of both hub and hospital schemes equates to a £43m EAC per annum benefit, demonstrating value for money.
- The capital investment is calculated to provide wider economic benefits of £44m (in EAC terms).
- The capital investment is projected to result in health benefits equivalent to 334 lives saved per year, equivalent to £94m (in EAC terms), using the Quality Adjusted Life Year approach used by the NHS to calculate health benefits.

The capital investment brings further benefits, including improvements to the quality of the patient environment and quality of care able to be provided. These are non-quantifiable and so have not been costed in the value for money analysis.

The financial analysis demonstrates that we can afford to make this capital investment, and that it will help us to ensure that the health economy is financially sustainable. We can demonstrate a sustainable financial position for NW London CCGs through the 10-year financial projections to 25/26. Within the CCG projections, the affordability of the hub capital investment to the CCGs is

demonstrated. The NWL CCGs' underlying position by year shown in the table below shows that with the inclusion of the incremental revenue impact of the out of hospital hubs the CCGs are in an overall net underlying surplus in all years.

Total (£m) (Underlying)		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Opening RRL		2,639	2,716	2,763	2,814	2,868	2,971	3,036	3,105	3,178	3,253	3,331
Running cost allocation		47	51	46	46	47	47	46	46	47	47	48
Total RRL		**2,686**	**2,767**	**2,809**	**2,860**	**2,915**	**3,018**	**3,082**	**3,152**	**3,225**	**3,301**	**3,379**
Baseline cost		2,637	2,637	2,700	2,735	2,782	2,830	2,931	3,021	3,091	3,165	3,239
Recurrent	Growth		83	89	87	86	88	106	109	112	114	116
	Tariff Inflation/Deflation		42	11	11	11	11	9	9	10	10	10
	Other		30	52	48	45	73	64	47	50	50	51
QIPP	Saving		(94)	(116)	(98)	(95)	(71)	(92)	(97)	(100)	(102)	(103)
Total costs		**2,637**	**2,699**	**2,735**	**2,782**	**2,830**	**2,931**	**3,018**	**3,088**	**3,163**	**3,237**	**3,314**
Net Surplus		**49**	**69**	**75**	**78**	**85**	**87**	**64**	**63**	**62**	**64**	**65**
		1.8%	2.5%	2.7%	2.7%	2.9%	2.9%	2.1%	2.0%	1.9%	1.9%	1.9%

For trusts under the 'comparator' scenario, where no commissioner QIPP is assumed to be delivered and with business-as-usual CIP delivery, all our provider trusts will be in financial deficit, with a combined deficit of £114m at 2024/25. However, if commissioner QIPP were delivered, trusts' I&E would improve to a combined deficit of £18m as additional CIPs can be achieved (termed the 'SaHF scenario before reconfiguration). The CCG QIPP delivery is dependent in part on the building of the hubs, which is why it is not included in the 'comparator'. If we receive the capital funding we are requesting, the trusts' financial projections demonstrate that all trusts will have a sustainable I&E surplus position of £27.6m at 2024/25, with the reconfiguration contributing a c£50m benefit (termed the 'SaHF scenario after reconfiguration').

Currently the trusts are running in-year deficits which would require an estimated cash support of £1.1bn over the next 10 years (and continue thereafter), which would reduce to £0.5bn under the 'SaHF scenario before reconfiguration' (where additional CIPs are delivered, partly due to hub investment to enable QIPP delivery). Under the SOC part 1 option ('SaHF scenario after reconfiguration'), the cash deficit support in the 10-year period would reduce further to £0.4bn and are eliminated post reconfiguration.

If the capital investment were funded by loans, two of the trusts would have a below target Financial Sustainability Risk Rating (FSRR) and be unable to meet the loan repayments. As the loan funding scenario is unaffordable from a liquidity perspective, we have explored two further scenarios and have concluded that our preferred option is for Public Dividend Capital (PDC) funding, and an accelerated timeline.

We have also demonstrated that the case is affordable under a range of scenarios by conducting sensitivity analyses.

We will deliver the individual schemes locally with central programme support

We will deliver the procurements through existing arrangements. The individual trusts will lead on procurements, supported by a central programme function to realise the benefits of economies of scale.

The procurement implications of the proposals have been identified and worked through, and we have identified commercial arrangements for each of the 27 hubs. The hospital reconfiguration element involves five schemes across three trusts. Assumptions have been drawn up for each scheme, and they will be further developed in Outline Business Cases. Where staff are affected by changes, we will seek to retain them in the NHS in NW London.

We are ready to deliver and have a governance structure to make it happen

Clinicians across NW London have been working together for several years to plan how to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. Our programme has been clinically led, and will continue to be. There are three medical directors, who provide general clinical oversight of the programme and ensure that all decisions are clinically-led and focused. A Clinical Board provides clinical input to the programmes of work.

We regularly engage with our stakeholders, including patient representatives and patients, and this is strengthened for services changes such as the recent reorganisation of paediatric and maternity services at Ealing Hospital. Engagement, especially with hard-to-hear communities remains a key priority, and patients and their representatives continue to have an important role in co-designing services, along with carers, the third sector and our local authority colleagues.

We have a proven record of progress and have had successes in improving patient care and clinical outcomes so far but need to increase the pace and scale of what we do if we are going to achieve the full benefits of SaHF.

For the next phase of our programme, we have prepared clear plans, established programme assurance and identified key risks to support and enable the effective delivery of our proposed changes to the local health economy in NW London. NW London has well established collaborative working arrangements, including a CCG Collaboration Board and an Implementation Programme Board. This governance structure has been effective in helping us to manage input from multiple stakeholders, including providers, clinicians, strategic finance, our operational delivery boards and collaboration with our CCGs. Maintaining strong clinical leadership through a clinically led process, to ensure that clinicians and decision-makers can be confident that changes can be made safely and sustainably is essential.

It is adherence to governance principles, supported by a strong and effective Programme Management Office (PMO) with a Programme Executive that has enabled a range of transformational changes to take place safely and successfully without significant capital investment to date. We have built on our existing arrangements and are updating our governance to ensure it is fit for purpose to deliver the STP and the next phase of SaHF.

We are aware there are interdependencies and are factoring this into our planning. For example, the out of hospital hubs have a dependency on sufficient capacity and the range of services becoming available at the right time within the hubs to enable a shift of activity from acute hospital settings to enable all transitions, while the acute hospital reconfigurations are linked to the requirement for additional capacity at West Middlesex, Northwick Park and Hillingdon Hospitals in order to enable the transition of Ealing Hospital to become a local hospital with out of hospital capacity.

Conclusion

This investment is needed to deliver a major component of our STP. NW London residents will have their clinical and social care needs met in the place that is most familiar to them, which will, for the most part, be in their own home. The investment will allow us to reorganise our of hospital services so that we can better support people to manage their long term conditions, improve care-planning and case management for people with complex needs, and provide more seven-day access to out of hospital care. This investment will help us to achieve better outcomes through consolidating expert care for particular acute conditions, seven days a week, onto fewer sites.

Our Strategic Outline Case part 1

The detailed content of this business case is set out in a five case model according to HM Treasury guidance. The five cases, and their key purposes, are:

- The Strategic Case explains what changes are required within the health economy and why they cannot be delivered without significant capital investment.
- The Economic Case sets out the value for money case of the proposed capital investment, through a structured comparison of the costs and the benefits, including both the quantifiable and non-quantifiable financial and health benefits of the investment.
- The Financial Case assesses the affordability of the proposed capital investment to CCGs and Trusts. It sets out proposed funding routes for the capital investment and for transition costs that are affordable.
- The Commercial Case demonstrates that the “preferred option” will result in a viable procurement and well-structured deal.
- The Management Case demonstrates that the “preferred option” is capable of being delivered successfully, in accordance with recognised best practice.

Chapter 1

Strategic Case

The Strategic Case explains what changes are required within the health economy in NW London and why they cannot be delivered without significant capital investment

1. **Our Sustainability and Transformation Plan sets out our aim to help people to be well and to live well.** We aim to close the three gaps identified in the Forward View: the health and wellbeing gap; the care and quality gap and the finance, efficiency and sustainability gap.

2. **Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care,** given the population health trends, coupled with our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.

3. **We have a strategy to meet our residents clinical and social care needs in the right place at the right time.** We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care.

4. **We are confident that based on our experience of successfully delivering change and identified opportunities, our new model of care will address the key issues.** Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.

5. **Our new model of care requires major changes.** Our Shaping a Healthier Future (SaHF) proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which:

    - Retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
    - Reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

    We have a comprehensive plan for our capital requirements. To complete our implementation and fully realise the benefits for our local population we require a significant capital investment to:

    - Fully implement our out of hospital hubs across the eight CCGs in NW London
    - Make the necessary investment in primary care estate
    - Redevelop our acute sites, including the development of the local hospital at Ealing, an elective hospital at Central Middlesex and investment in the major acute sites at Hillingdon, Northwick Park and West Middlesex hospitals

6. **We now urgently need to complete implementation of our strategy but require capital investment to achieve this.** We have already made significant progress in implementing our SaHF strategy in a capital constrained environment.

    - We have closed two A&Es that cannot meet NW London standards of care and transformed our maternity and paediatric services
    - There is now an urgent need for change at Ealing hospital therefore an accelerated timeline has been developed to address issues as soon as possible

7. **This case sets out the requirement of £513m of capital investment to deliver these changes in an accelerated timeline of which £377m is within this CSR period. This is essential to enable delivery of our STP**.

    - The Strategic Case covers all of NW London and the capital is for GP practices, the out of hospital hubs and only the outer NW London hospitals

1.1 Our Sustainability and Transformation Plan sets out our aim to help people to be well and to live well

1.1.1 Our vision for health and care in North West (NW) London is that everyone living, working and visiting here has the opportunity to be well and to live well. We know that the quality of care varies across NW London and that where people live can influence the outcomes they experience.

1.1.2 Residents of NW London will have their clinical and social care needs met in the place that is most familiar to them, which will, for the most part, be in their own home. We have begun to implement a model of care whereby we will reduce reliance on use of acute hospitals through reducing unwarranted variation in the management of long term conditions, improving the consistency of care planning and case management, and ensuring seven-day access to out of hospital care. We will achieve better outcomes through consolidating expert care for particular acute conditions onto fewer sites. We have already achieved a lot but we know there is sizable opportunity to do much more.

1.1.3 The challenges facing the NHS and the need to radically transform the way we deliver care were set out in the *Five Year Forward View* (FYFV) and the General Practice Forward View (GPFV).

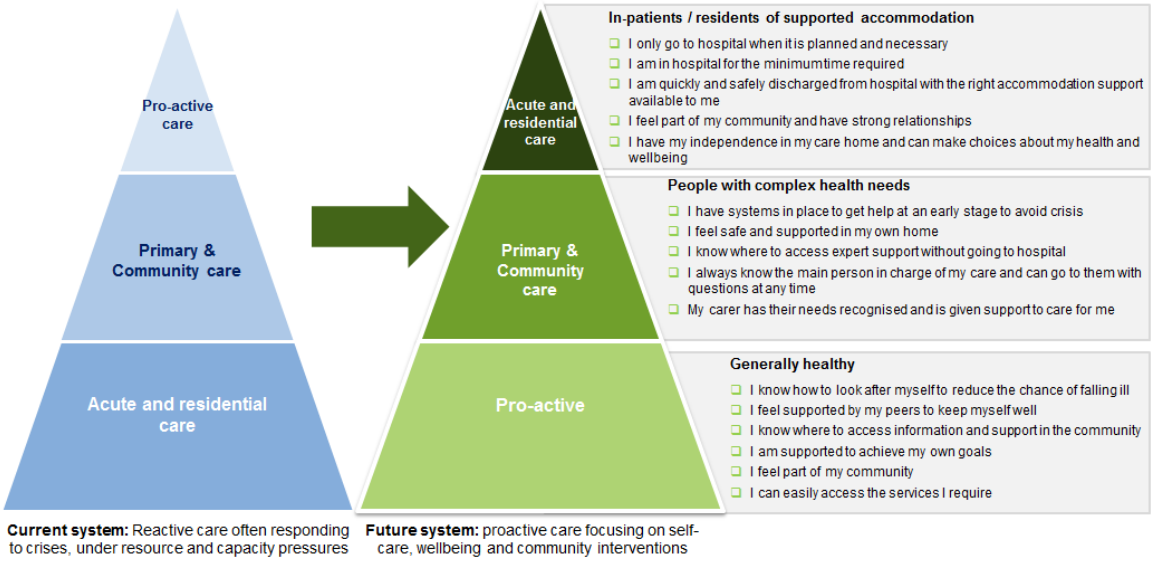
1.1.4 We have published our Sustainability and Transformation Plan (STP) and set out our plan for NW Londoners to be well and live well. This plan is comprehensive and ambitious. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed.

1.1.5 We can only achieve this if we work together in NW London at scale and pace, not just to address health and care challenges, but also the wider determinants of health.

1.1.6 We aim to close the three gaps identified in the FYFV of health and wellbeing, care and quality and finance and efficiency.

1.1.7 Our plan involves changing the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide care close to people's homes. This will improve health and wellbeing, and care and quality, for patients.

Figure 1: Our vision of how the system will change and how patients will experience care by 2020/21



1.1.8 Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with more expensive hospital estate and skills used in a more effective way. This will also allow more investment into the associated elements of social care and the wider determinants of health, such as housing and skills, which will improve the overall health and wellbeing of our residents.

1.1.9 NW London has a mandate to reconfigure acute care in NW London. *Shaping a Healthier Future* (SaHF) published the preferred option in a Decision Making Business Case (DMBC) in February 2013 which was approved by a Joint Committee of PCTs and subsequently approved by the Secretary of State for Health in October 2013.

1.1.10 The Strategic Outline Case (SOC) is for the whole of SaHF and NW London but the capital requirement is only for part of the transformation. The SOC part 1 is the main capital requirement of the STP within the current CSR period. The totality of SaHF includes SOC part 2 but the capital requirement for SOC part 2 will fall outside of the STP period and will be the subject of a separate business case. A summary of the scope of SOC part 1 and SOC part 2 is set out in section 1.5.16.

1.2 Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care

1.2.1 There is currently significant pressure on all parts of the health and care system in NW London. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip planned funding increases.

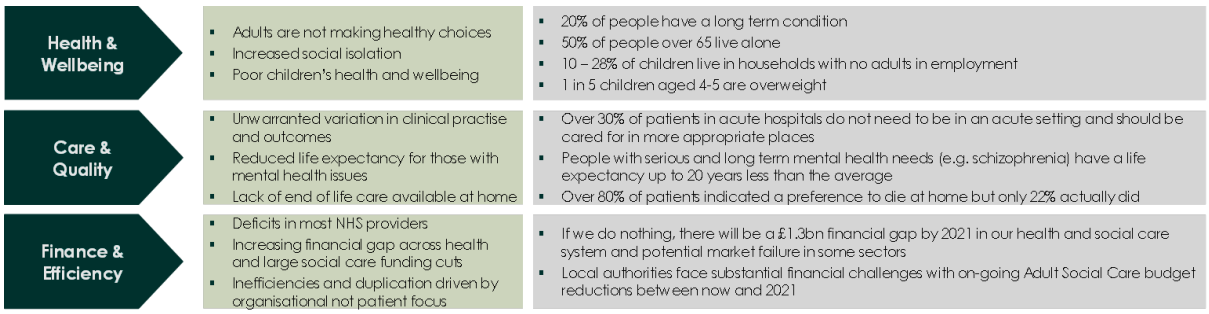
1.2.2 However, we have an opportunity. We know that our services could be better coordinated and that we often don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often experience poor care and that their time is not necessarily valued.

1.2.3 We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill or developing complications of their condition in the first place.

1.2.4 Our budgets are constrained and significantly below both historical funding growth levels and the increase in demand, leading to a £1,113m funding gap by 2020/21. Social care budgets face cuts of around 40% and will have a further £298m gap by 2020/21. If we do nothing, there will be a £1.4bn financial gap in our health and social care system by 2020/21 and potential market failure in some sectors.

1.2.5 The health and social care challenges we face are: building people focused services; doing more and better with less; and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Figure 2: Summary of the STP case for change, aligned to the aims of the *Five Year Forward View*



1.2.6 In particular we face the following major challenges:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population
- Over 30% of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community
- Unacceptable variation in the quality and delivery of all services
- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with.
- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to deliver a 7-day service under the current model across multiple sites
- Too many small hospitals resulting in a compromise of clinical productivity for the residents of NW London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals.
- Poor quality estate in our hospitals and primary care which is increasingly costly to maintain, does not meet modern standards and is not fit for purpose for delivery of care

An ageing population with increasingly complex and costly health needs, with an increase in the overall population

1.2.7 Understanding our population's needs both at a NW London and a borough level is vital to creating effective services.[1] There are increasing demands on the health and care system as more patients are presenting with more complex health and care needs.

- 21% of the population is classed as having complex health needs.
- There is a forecast rise of 13% in the number of people aged over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%.[2]
- Nearly half of our over-65 population are living alone, increasing the potential for social isolation. This can have a major adverse impact on health outcomes and drives activity in many health and social care settings.[3] We have identified that 11,688 of our over-65 population have dementia, and the numbers are increasing.
- The number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26. These people are likely to have increasingly complex, long term conditions. There is an anticipated increase of 6,280 based on the 2014 baseline from 31,400 to 37,680 in 2020 that are currently, and forecast, to be living with a long term condition.
- People with serious and long term mental health needs live 20 years less than the average. The number of people in this group in NW London is double the national average.
- There are currently 338,000 people living with one or more long term condition, and a further 121,680 mostly healthy adults are at risk of developing a long term condition before 2030.[4]
- There is a strong correlation between long term conditions and mental health problems. 317,000 people have a common mental illness, with 46% of these estimated to have a long term condition.[5]
- Some NW London boroughs have the highest life expectancy differences in England. In one borough, men experience a 16.04 year difference in life expectancy between most and least deprived.[6]
- The total population in NW London has increased from 1,953,500 in 2011/12 to 2,086,000 in 2015/16.[7] This figure is forecast to increase by 141,000 (7%) over the period to 2018/19 and will is likely to increase at a similar rate to 2025/26. This is putting extra pressure on our existing health infrastructure and therefore avoidable admissions and occupied bed days. 10-28% of children are currently living in households with no adults in employment and the future trend is rising. NW London's 16-64 employment rate of 71.5% was lower than the London or England average.[8]

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[1] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs.

[2] Office for National Statistics (ONS) population estimates.

[3] http://www.socialfinance.org.uk/investing-to-tackle-loneliness-a-discussion-paper/

[4] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014).

[5] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013.

[6] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea.

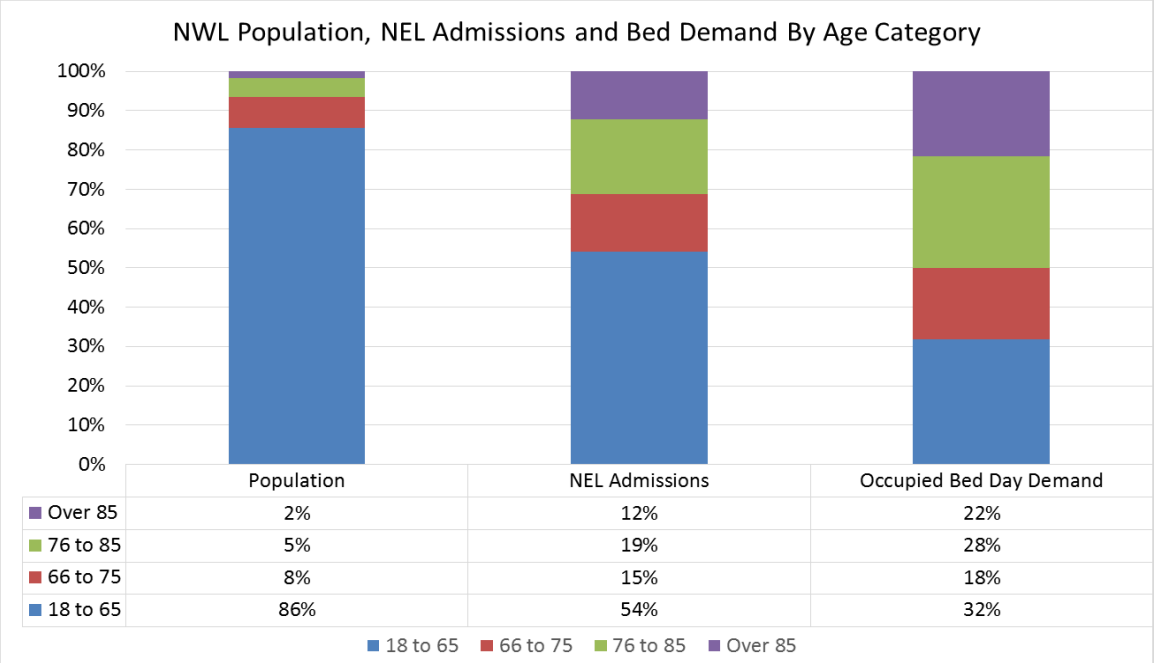
[7] Office for National Statistics (ONS) population estimates.

[8] NOMIS profiles, data from Office for National Statistics.

1.2.8 Over the next five years the scale and nature of the demand will out-strip funding increases and create more pressure on our resources and health infrastructure. This infrastructure is required to serve an ever increasing and ageing population. The projected increases in the number of older people with multiple and complex conditions will significantly increase demand for GP appointments and will require a co-ordinating function within primary care. We anticipate that, under the current clinical model, the increasing population and increased needs will require an increase in acute bedded capacity to be able to meet the demand.

1.2.9 Reviewing non-elective admissions and length of stay data in the context of our population makeup, while people aged over 65 form 15% of the population, between April 2014 and September 2016, 46% of admissions and 68% of hospital bed days were attributed to people over 65. This disproportionate use of hospital capacity is even more marked for over 85s who, despite being only 2% of the population, used almost a quarter of the bed days in NW London in the last two and a half years.

Figure 3: NW London non-elective admissions and demand by age category[9]



	Population	NEL Admissions	Occupied Bed Day Demand
Over 85	2%	12%	22%
76 to 85	5%	19%	28%
66 to 75	8%	15%	18%
18 to 65	86%	54%	32%

Over 30% of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community

1.2.10 Clinical audits regularly show that over 30% of patients in an acute hospital bed do not need acute care.[10] It is best for patients if they are able to return home at the optimal time for them, to be subsequently cared for in the most appropriate setting, preferably their own homes.

- We estimate that 17,000 days are spent in hospital beds that, with appropriate support services in place, could be spent in an individual's usual place of residence. There are many studies going back more than twenty years showing the relationship between prolonged hospitalisation and loss of muscle tone and cognitive function in the over 70s, alongside multiple other forms of functional deconditioning.[11] [12] [13] [14]

[9] ONS mid-year population estimates for 2014, SUS (April 2014 – September 2016)

[10] NW London Sustainability and Transformation Plan v01 21 October 2016.

[11] Creditor MC. Hazards of hospitalization of the elderly. Ann Intern Med 1993;118: 219–23.

[12] McCusker J, Cole M, Abrahamowicz M, Han L, Podoba JE, Ramman-Haddad L. Environmental risk factors for delirium in hospitalized older people. J Am Geriatr Soc 2001; 49:1327–34.

- There is good evidence that this deconditioning worsens with each additional day spent in an inpatient bed, with an adverse impact of the ability to live independently on discharge. NHS Improvement's *Emergency Care Improvement Programme* refers to people over 75 with a 7+ day length of stay as 'stranded', and promotes very proactive case management, early mobilisation and prevention of unnecessary bed rest.[15]
- The higher proportion of non-elective admissions for over 65 age group indicates care is fragmented with 42.1% of non-elective admissions relating to people aged 65 and over.[16] 3% of admissions have a length of stay of more than 30 days but they account for 35% of non-elective bed days.[17]
- People in the last phase of life can be subjected to unnecessary treatments in hospital. Over 80% patients indicated a preference to die at home but only 22% actually did.
- People with mental ill health use more emergency hospital care then those without, with 3.2 times more A&E attendances and 4.9 times emergency admissions.
- Fragmented services to support people in the last phase of life which can be difficult for individuals, their carers' and families. This is the case in the evening and overnight, when the options for support are more limited and anxiety is often more pronounced. Figure 4 describes provision in the tri-borough which is indicative of the range of services available and discrepancies in NW London out of hour's provision.

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[13] McMurdo MET, Witham MD. Unnecessary ward moves. Age Ageing*2013*;*42*:*555-6*. *doi:10.1093/ageing/aft079* *pmid:23892919*.

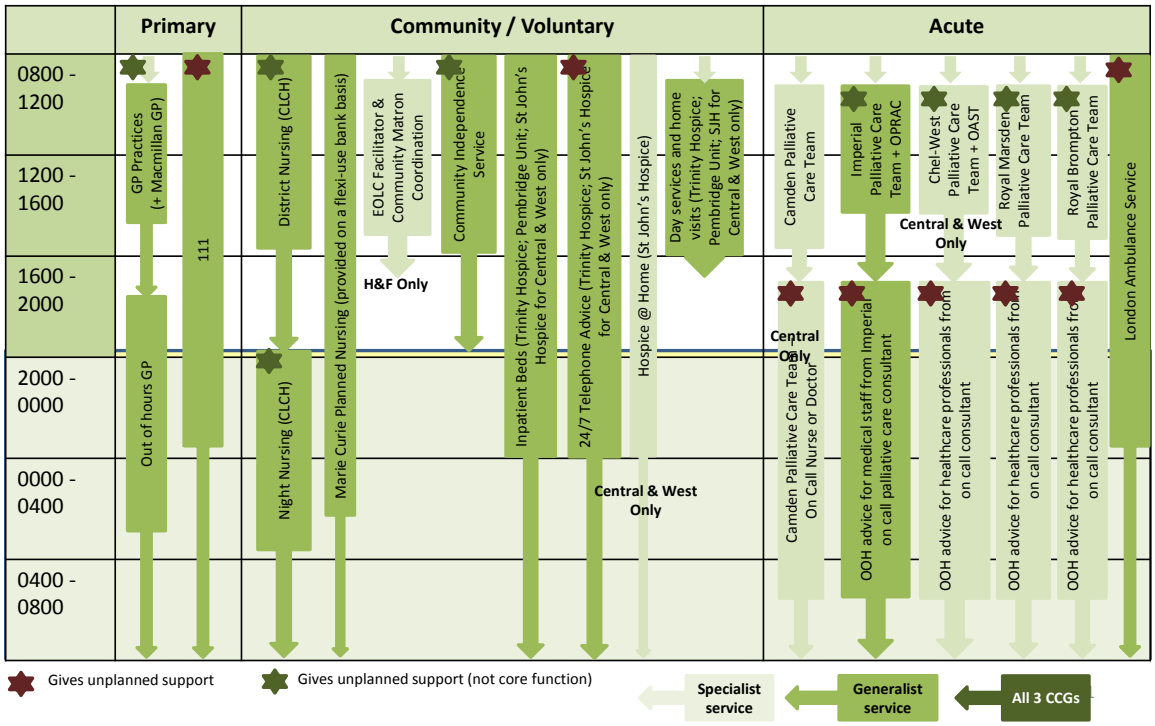
[14] From: Chapter 11, Reducing Functional Decline in Hospitalized Elderly, Patient Safety and Quality: An Evidence-Based Handbook for Nurses.Hughes RG, editor. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr.

[15] Why the stranded patient metric? http://fabnhsstuff.net/2016/02/09/stranded-patient-metric-dr-ian-sturgess-associate-medical-director-monitor/.

[16] SUS data - aggregated as at June 2016.

[17] GE Healthcare Finnamore analysis for NW London, 2016.

Figure 4: Services for people in the last phase of life in the tri-borough



1.2.11 This presents a challenge to the health and care system as we have duplication, gaps, and inefficiencies that mean patients often experience poor care. We have an opportunity to fundamentally improve the way we work with social care and local authorities and therefore the care we offer to people, supporting them to stay independent as long as possible and to ensure people are able to access the right care in the right place at the right time.

Unacceptable variation in the quality and delivery of all services

1.2.12 There is a marked variation in the outcomes for patients across NW London, driven by variation in the quality and delivery of services in both primary and secondary care. Primary care needs strengthening in both capacity and capability to tackle unwarranted variations in care to achieve better management and outcomes of long term conditions.

- 300,000 people, nearly one in six of all ages, have one of the following five long-term conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), and congestive heart failure. [18]
- There are 20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for under-diagnosis.[19]
- 512 strokes per year could be avoided by detecting and diagnosing atrial fibrillation and providing effective anti-coagulation to prevent the formation of clots in the heart.[20]
- 198,691 people have hypertension which is diagnosed and controlled. This is around 40% of the estimated total number of people with hypertension in NW London, but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing the level of controlled hypertension to 66%, as seen in Canada, can prevent 1,308 strokes and 582 heart attacks over five years.

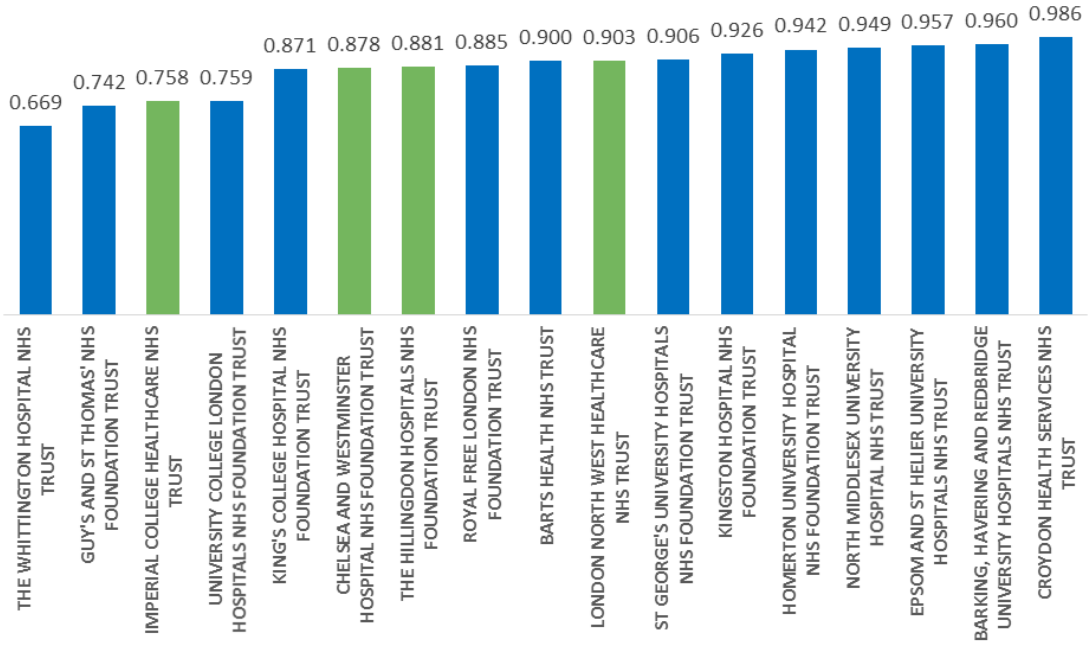
[18] Source: QOF, Proportion of GP registered population in NW London who are on the CHD, COPD, CHF, diabetes and asthma registers.

[19] NHS London Health Programmes, NHS Commission Board, JSNA Ealing.

[20] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015).

- Best practice for areas such as pulmonary rehabilitation, smoking cessation, inhaler technique and flu vaccination is not applied consistently meaning simple techniques for self-care that could be taught to avoid repeat or longer term complications are not being dealt with, placing unnecessary burden on the system.
- There is similar unwarranted variation in secondary care. National evidence indicates that mortality is between 4-14% higher at weekends than weekdays. Figure 5 highlights the variation in mortality rates across London, with those in green being the NW London Trusts. While our outcomes are relatively good, there is still variation across trusts. Our calculations are predicated on achieving the same mortality rates for people admitted at the weekend as during the week.[21]

Figure 5: Variation in mortality rates across London trusts from June 2016



- Recent audits of the percentage of patients admitted as an emergency who receive a thorough clinical assessment by a suitable consultant within 14 hours of arrival at hospital; the percentage of patients in total on the acute medical unit, the acute surgical unit, ITU, HDU and other high dependency areas seen and reviewed by a consultant twice daily; and the percentage of patients who, once transferred from an acute area of the hospital to a general ward, are reviewed as part of a consultant-delivered ward round at least once every 24 hours, seven days a week (unless it has been determined that this would not affect a patient's care pathway) show significant variation in current service provision in trusts across NW London. There is up to 20% difference between hospital sites in percentage of patients who receive consultant clinical assessment within 14 hours of arrival on weekdays; this variation goes up to 70% over weekends[22].
- Data from Professor Tim Briggs's work on *Getting it Right First Time* shows marked variation across NW London in achieving target outcomes for orthopaedics services. There are variations of up to 98% across NW London in the Patient Reported Outcome Measures (PROMs) score which measures the effectiveness of hip and knee surgeries by

[21] *Shaping a Healthier Future* Decision Making Business Case.

[22] Indicative analysis based on recent self-assessment survey conducted with NW London trusts to measure their current position against a number of priority clinical standards for 7 day services, pending publication of full results from the audit.

comparing patients' health and quality of life before and after surgeries. There is also a 5-50% variation for inpatient Average Length of Stay (ALOS) for elective admissions. Figure 6 provides an example of the variation in the majority of prioritised metrics for orthopaedics.

Figure 6: Orthopaedics dashboard that demonstrates the variation for the majority of prioritised metrics

1.2.13 Without consistently applying simple techniques or increasing the visibility of practice performance across specific domains, we will be more limited in our ability to have a significant impact to drive down variation. Without this, we cannot meet minimum acceptable standards and improve clinical outcomes for our patients.

A reactive health service where resources are still focused on getting patients better rather than keeping them well to start with

1.2.14 Many people in NW London are not as healthy as they could be and more needs to be done to promote health and stop people of NW London getting ill.

- There is currently a difference of up to 17 years in life expectancy in different wards in NW London. [23]
- If a basic level of access to GP care is not provided, it can result in more people resorting to using A&E services. These services are more costly to deliver and lack the continuity and historical knowledge that a GP practice can provide.
- The majority (79%) of GP practices in NW London have below national average satisfaction scores. This could, in part, lead to the higher than average use of A&Es, particularly in outer NW London.
- There is a lack of investment in prevention and early detection, we need to engage people in their own health and wellbeing to enable self-care

[23] Greater London Authority (London.gov.uk).

- More support is needed for national campaigns to promote health and work on cancer prevention, mental health stigma and self-care.

1.2.15 Much can be done through successful funding and promotion of public health information and campaigns that assist people to take personal responsibility for their own health.

Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to deliver a 7-day service under the current model across multiple sites

1.2.16 The lack of skilled workforce to deliver a seven-day service under the current model across multiple sites is an issue in NW London.

- Workforce shortages are expected in many professions under current supply assumptions and expected increases in demand making the provision of services more fragile.
- We have more A&E departments per head of population than other parts of the country and insufficient capacity to meet demand as senior staff and resources are spread too thinly across multiple sites.[24] Only one site in NW London is currently providing the level of consultant cover recommended by the Royal College of Emergency Medicine.
- Turnover rates within NW London's trusts have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing and15% medical. [25]
- Vacancy rates in social care organisations are high. The majority of staff in this sector are care workers, with an estimated vacancy rate of 22.4%. Disparity in pay is also an issue e.g. lower in nursing homes. [26]
- NW London has a higher proportion of GPs over 55 years compared to London and the rest of England (28% of GPs and almost 40% of nurses are aged 55+).[27]
- NW London has more than 100,000 unpaid carers and they are a large, hidden but integral part of our workforce that needs support.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery. However, often we do not retain people in NW London for long after they have qualified.

1.2.17 Progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.

1.2.18 However, appropriate workforce planning and active addressing of workforce issues is now needed and will be instrumental in addressing our objectives set out in the STP and in delivering our model of care.

Too many small hospitals resulting in a compromise of clinical productivity for the residents of NW London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals

1.2.19 The total population in NW London is 2,086,000 in 2015/16.[28] With a growing population in NW London it is increasingly hard to provide a broad range of appropriate specialist services at the existing nine acute hospital sites to the standards our patients expect and deserve.

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[24] "Delivering High-quality Surgical Services for the Future", a consultation document from the Royal College of Surgeons reconfiguration working party, March 2006.

[25] Turnover Rates: HSCIC, iView, retrieved 23-05-2016.

[26] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published and Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015.

[27] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016.

- This is because specialist teams gain skills as a result of the numbers of people they diagnose and treat. It is well established that the more specialised doctors and other professional staff become, the better the results for patients.[29] If treated by a specialist physician or surgeon, patients are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital.[30]
- Units therefore need to serve a sufficiently large population so they are busy enough for clinical staff in a variety of specialities and subspecialties to maintain their clinical skills for the best outcomes for patients.
- For example guidance from the Royal College of Surgeons[31] recommends that for emergency surgery to be of high quality, activity from a population of 500,000 needs to be undertaken on one site. This indicates that on pure clinical grounds there should be no more than 4 A&E departments with associated emergency surgery units in the sector. Even with the current configuration of A&E services nationally, the 7 A&E departments in NW London hospitals each have a catchment population smaller than average.
- And clinical evidence has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes.
- It is known that in NW London, our hospitals are only sometimes meeting the seven-day services standards guidelines of emergency general surgery admissions seeing a consultant within 14 hours. Currently three of our four acute trusts with A&Es do not meet the A&E 4-hour target.[32] There are variations in the quality of care and the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another.
- Senior doctors' availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week. National evidence indicates that patients admitted on a Sunday have a 16% greater chance of dying than if admitted on a weekday, with a corresponding figure of 11% on a Saturday.[33]

1.2.20 We have financial challenges across the sector, for example all our outer trusts are currently in deficit. The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. The cost of the site is inefficient because of the scale required to run a 24/7 operation. The need to staff it safely is greater than the activity and income for the site, meaning that the current service profile is not financially sustainable.

Poor quality estate in our hospitals and primary care which is increasingly costly to maintain and does not meet modern standards and is not fit for purpose for delivery of care

1.2.21 NW London has more poor quality estate and a higher level of backlog maintenance across its hospital and primary care sites than any other sector in London.

- The total backlog maintenance cost across all acute sites in NW London (non-risk adjusted) is £614m[34]

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[28] Office for National Statistics (ONS) population estimates.

[29] Hall, Hsiao, Majercik, Hirbe, Hamilton, The impact of Surgeon Specialization on Patient Mortality; Annals of Surgery 2000.

[30] Chowdhury, Dagash, Pierro. A systematic review of the impact of volume of surgery and specialisation on patient outcome; British Journal of Surgery, 2007.

[31] "Delivering High-quality Surgical Services for the Future", Royal College of Surgeons, March 2007.

[32] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard.

[33] Aylin. P. et al (2010). Weekend mortality for emergency admissions. A large multicentre study, Quality and Safety in Health Care, 19: 213-217.

[34] ERIC Returns 2014/15.

- 20% of services are still provided out of 19th century accommodation[35], compromising both the quality and efficiency of care.
- The condition and capacity surveys commissioned by NHS England in spring 2016 revealed that 198 of the 293 buildings in the survey, (68% of the total), were built before 1961. This analysis covers the large majority of premises in the NW London estate but excludes West London CCG: they completed their own survey which confirmed that 58% of the buildings were built before 1961.
- 125 buildings (42% of the total) have fewer than five clinical rooms, 135 buildings (45% of the total) have five to nine clinical rooms and only 40 buildings (13%) have more than nine clinical rooms. Our premises have a small number of clinical rooms which are utilised more than 80% of the time
- 240 (66%) of 370 GP practices operating in NW London are rated category C or worse.[36] The demand for services in primary care has grown by 16% over the seven years from 2007 to 2014[37], but there has been limited investment in the estate.
- There will be implications on the delivery of services as this will restrict access for patients, prevent co-location of health and social care professionals; impact on ability to deliver GPFV and have cost implications that may make services unsustainable.
- The provision of services in multiple locations fragments access and inhibits the provision of integrated, convenient care to patients.

1.2.22 Our outdated and poor quality primary care estate is intensified by high property costs in much of the area. The age of the estate indicates that significant investment is needed in the future to maintain business as usual. This estate is not conducive with the delivery of transformed models of primary care, and offers little flexibility in terms of growth or capacity and does not enable the delivery of primary care at scale.

1.2.23 This means that there is insufficient capacity within our estate that is fit for purpose to meet an increasing demand for primary care, and therefore driving increased pressure on Urgent Care Centres and A&E departments. Significant investment is needed now and in the future to maintain business as usual.

In conclusion, our current system is unsustainable and we need significant capital investment

1.2.24 Given the population health trends we have set out, coupled with the current state of primary care and significant challenges to the health infrastructure it is all too clear that our current system is unsustainable.

- Constraints on estates and workforce in our hospitals already mean that performance is worsening against key national targets and we can't consistently meet clinical quality standards
- Variation in the management of long term conditions means people are suffering avoidable life threatening illnesses such as strokes and heart attacks
- Poor quality, cramped primary care estate is reducing access and increasing pressures on A&E departments

1.2.25 NW London needs to change what services are provided, where they are located and the balance between primary and secondary care providers.

[35] NHSE London Estate Database Version 5.

[36] NW London CCGs condition surveys.

[37] Oxford University's School of Primary Care Research of general practices across England, published in The Lancet in April 2016.

1.2.26 Even if more money were available, the way services are currently arranged does not produce the best quality care for patients. This is a real opportunity that we can seize to improve the quality of care for our patients.

1.2.27 We need to ensure that people in NW London have access to the right care in the right places. Higher quality, more effective treatments for patients need to be provided more consistently where they are needed, within safer places that are more up-to-date. Care needs to be provided in a more integrated way, in partnership with social services and local government, so that it is clear to patients who is managing their care and they can seamlessly transition between care settings.

1.2.28 More investment needs to be made in GP services and other local healthcare, so it is more consistent and of a higher standard, bringing better routine treatments closer to home and supporting more services outside hospitals. Alongside this, clinical teams need to be established so patients needing specialist treatment can be certain they will be seen by experienced specialist clinicians, who are familiar with, and who regularly treat, similar patients with their condition.

1.2.29 We have a solution, but given the scale and nature of transformation and our historical estates problems, we cannot address these issues without significant capital investment.

1.3 We have a strategy to meet our residents' clinical and social care needs in the right place at the right time

1.3.1 This section provides an overview of the strategic solution which has been developed by NW London to deliver a new model of care to improve the experience, quality and outcomes for our population.

1.3.2 Our vision for health and care in NW London is that everyone living, working and visiting here has the opportunity to be well and to live well. We know that the quality of care varies across NW London, and that where people live can influence the care they experience.

1.3.3 Residents of NW London will receive their clinical and social care needs in the place that is most familiar to them, which will, for the most part, be in their own homes. This will mean that more than 50% of the population will receive care in this way. We have begun to implement a model of care whereby we will decrease reliance on use of acute hospitals through reducing unwarranted variation in the management of long term conditions, improving the consistency of care planning and case management, and ensuring seven-day access to out of hospital care. We have begun to achieve better outcomes through consolidating expert care for particular acute conditions onto fewer sites. We have already achieved a lot but we know there is sizable opportunity to do much more.

1.3.4 We want to provide primary care which is accessible, proactive and coordinated. We will achieve this by reducing the number of sites from which primary care is delivered through a more consistent hub and spoke model. This will reduce unwarranted variation, provide seven-day extended access and improve the management of long term conditions to give everyone access to the same, high quality services. These are vital for the sustainability of our health and care economy.

1.3.5 Our proposed model of care consists of two inter-related parts. The first relates to primary care and out of hospital services, which will result in transformation of out of hospital care and a shift of care from hospitals into community settings, closer to where people live. The second element is a reconfiguration of acute services so they can best serve the local population, providing high quality, sustainable expert clinical care. In practice, this approach will provide a continuum of care to people whether they are in their usual place of residence or whether they require a hospital admission.

1.3.6 We are clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care both in and out of hospitals; we must reconfigure our acute services to enable us to staff our hospitals safely in the medium term.

1.3.7 The current contractual landscape in NW London of multiple contracts all with their own key performance indicators contributes further to fragmentation of the care system. It is our intention to use the proposals outlined in this SOC to add momentum to adopting an accountable care approach in NW London.

Local clinicians have led the development of our new model of care

1.3.8 In the development of our DMBC, local clinicians, supported by patients and their representatives, the public, commissioners and providers, created visions for emergency and urgent care, maternity and paediatrics. These included patients having quick access to high quality care, regardless of the time or day of the week.

1.3.9 To drive the improvements in clinical quality, clinicians developed a set of clinical quality standards. The work by London Health Programmes to determine the London Quality Standards was a key driver in developing the standards and the latest evidence from Royal Colleges and NICE guidelines were also taken into account. During formal public consultation, the programme received feedback about the proposed standards for care and responded by updating the acute standards to ensure that 24/7 consultant presence was available in all maternity units and further developing the specification for Urgent Care Centres (UCCs).

The principles for our new model of care

1.3.10 We set out a new model of care where a greater proportion of our resources are focussed on keeping people well and where we can meet their care needs largely in the community. For those people genuinely in need of acute care, this will be concentrated into fewer sites from which higher quality care can be provided every day of the week, no matter what time of day. Care will be integrated, recognising the psychological and social dimensions to the management of people with long term conditions, with the focus always being on supporting people to stay healthy and maintain their independence.

1.3.11 Clinical leadership is core to our model of care and the way that we operate. Three medical directors provide general clinical oversight of the programme working with a wider multi professional Clinical Board of CCG Chairs, Medical and Nursing Directors, lay partners and academics to ensure that all decisions are clinically-led and focused.

1.3.12 Our clinically-led process developed into a major programme of service redesign. We will reconfigure health services according to four overarching principles so that they are:

PERSONALISED	Personalised, enabling people to manage their own health and wellbeing and to offer the support they need to do this. To provide care based on individual need for people and their carers where it is required.
LOCALISED	Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is convenient.
COORDINATED	Delivering services that consider all the aspects of a person's health and wellbeing and are coordinated across all the services involved. This ensures services are appropriate and efficient.
SPECIALISED	Centralising services where necessary for specific conditions ensuring greater access to specialist treatment to deliver high quality care.

1.3.13 Though this work preceded the *Five Year Forward View* and the *GP Forward View*, it is fully aligned with both of these national imperatives and policies, and formed a central part of the thinking in our STP. Our four principles were used to develop a model for out of hospital care.

Our strategy for transforming primary care and out of hospital services

1.3.14 Our plans for the development of integrated out of hospital care will deliver more personalised, localised and integrated care to the whole population. Patients will be supported to take more control in an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. We will reduce variation in care process and outcomes through multi-disciplinary and team working and use of existing and emerging technologies such as home monitoring.

1.3.15 Our aim is to accelerate investment in infrastructure for a network of out of hospital hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of primary care services in NW London.

1.3.16 The focus of the STP for the first two years is to develop the new proactive model of care across NW London and address the immediate demand and financial challenges.

Reconfiguration of health services to provide the preferred model of care

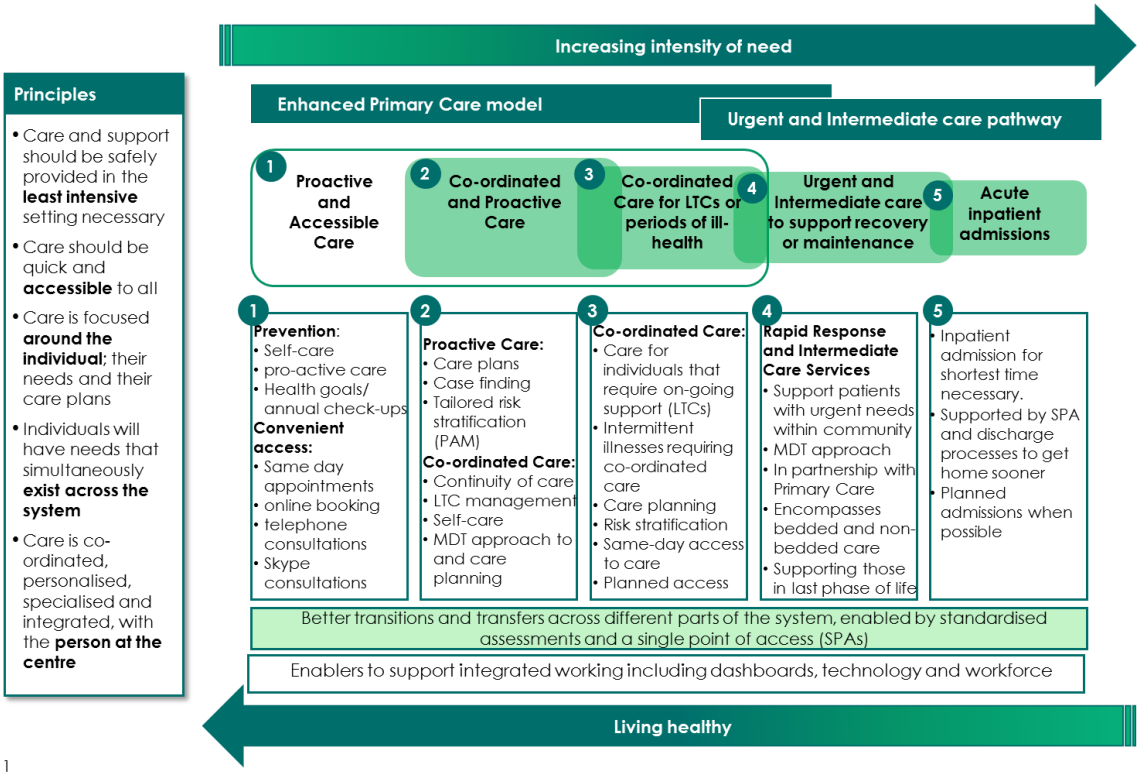
1.3.17 The DMBC documented the decision-making process to identify how the current healthcare services of NW London would be reconfigured to provide the preferred option for the model of care. It was underpinned by four intentions:

1.3.18 Our SOC is presented in two parts, which are further described in paragraph 1.5.16. For the purposes of SOC part 1, all the acute sector changes proposed are those associated with the transition of Ealing to becoming a Local Hospital. The out of hospital changes described cover the whole of North West London.

Description of model of care for integrated primary and out of hospital care

1.3.19 We have developed a model of care for integrated and out of hospital care that will change the way we work and best serve the needs for our whole population in NW London.

Figure 7: Our model of care



1.3.20 We need a combination of a proactive and reactive approach to reduce preventable admissions and to enable discharge when patients are medically fit. These include:

- Proactive: multi-disciplinary teams, care co-ordination and care plans
- Reactive: rapid response, diagnosis and assess and appropriate discharge

1.3.21 The Strategic Commissioning Framework (SCF) is London's agreed approach to supporting the focus on accessible, proactive and co-ordinated care within primary care. Self-care is an integral part of proactive care contributing towards enhanced primary care offer.

1.3.22 Our proactive model of care for primary care will be accessible and coordinated. It will be provided from a reduced number of sites compared to currently, and delivered as a consistent hub-and-spoke model, providing a range of population and system benefits. It will enable us to:

- Reduce unwarranted variation and improve patient outcomes for people with long term conditions in primary care
- Provide a multidisciplinary team-based model of care delivery

- Provide a consistent approach to seven-day extended access to primary care
- Deliver care planning and case management.

Furthermore it will enable us to:

- Improve co-ordination of care and make it less fragmented
- Provide a support function for unpaid carers that look after the majority of residents with complex needs
- Support people to better manage their long term conditions, increasingly by adopting digital technologies.

1.3.23 This will be implemented by:

- Organising primary care at scale through the hub-and-spoke model
- Co-location of the primary care teams alongside community social and mental health services
- Consistent patient access and contribution to care records and care plans
- Video-linked tele-health and tele-coaching
- Meeting a patients need in their known and familiar place of care
- Common and interoperable digital platforms
- An achievable and sustainable workforce model.

1.3.24 Our reactive model of care for intermediate and acute care will focus on decreasing inappropriate time spent in bedded care away from home or the usual place of residence. This will be provided by planning the reactive services around a patient's need focusing on developing a consistent model that appropriately treats patients at varying levels of acuity.

1.3.25 We will decrease attendances at A&E and inappropriate admissions to hospital by:

- Creating a single point of referral to rapid access services and having a rapid assessment process
- Providing rapid response care in a person's home or usual place of residence
- Providing a consistent approach to reduce the number of unnecessary conveyances and admissions
- Improving step-up bedded care and making more effective use of community beds and social care funded bedded care.

1.3.26 We will reduce length of stay (LOS) by:

- Creating a single point of referral to rapid access services and efficient transfer of care of patients with appropriate support
- Providing hospital in-reach teams
- Creating effective reablement and rehabilitation services to meet the demand projections for these services
- Improving step-down bedded provision and making more effective use of community beds and social care funded bedded care
- Improving seven-day access to pioneer new models of care and improve weekend acute care in hospitals
- Improving processes for diagnosis and management of patients through use of common and interoperable digital platforms across care settings to enable more consistent patient access and contribution to care records and care plans.

1.3.27 Our primary care prevention will involve taking action to reduce the incidence of disease and health problems through measures that will address lifestyle risks associated with heart disease, stroke, type 2 diabetes and cancer. Systematic prevention will be critical to reduce

the overall burden of disease and is an excellent use of our resources compared with many treatments.

1.3.28 We will access secondary care expertise using digital technology where appropriate for the benefit of patients being looked after in a primary care setting to put in place the management plan and avoid the onset of complications.

1.3.29 These secondary care interventions are often highly cost-effective and, if implemented at scale, would rapidly improve patient experience and life expectancy. This would involve the systematic application of standard, low-technology interventions.

1.3.30 We are already implementing our intended model of care and improving care processes and patient pathways. We have made the best use of the existing public sector estate with 15 out of hospital hubs already operational from pre-existing sites.

Delivery of primary care at scale

1.3.31 The delivery of primary care at scale is crucial for more localised, integrated and specialised care to meet the needs of our population. To deliver accountable care for patients across NW London, the CCGs will continue to develop their federations. This support will help deliver better care that is more convenient and efficient for patients and focus on three key areas:

- Developing leaders across primary care and strengthening care teams to support GPs
- Encouraging clinical effectiveness and developing specialist expertise by operating multi-disciplinary teams and sharing resources
- Implementing consistent organisational standards across general practice.

1.3.32 We are well on the way to federating all our general practices; Figure 8 shows that practices are now, or soon will be, organised into formal federations which are legal entities. Some CCGs have organised clinical networks as well or instead, and the practices in Harrow CCG have formed a Community Interest Company. These equivalent arrangements of practices will enable the sharing of best practice, provide peer support for process improvement and monitoring, provide support for other practical operational improvements, and support GPs to engage in development programmes and to develop clinical change champions to help clinicians. From a commissioning perspective, it becomes easier to embed quality standards and clinical outcomes into contracts. We have single IT systems across each CCG that enable the sharing of care records with patient consent.

1.3.33 We will reduce unwarranted variation through implementation of more consistent care processes across all general practice. We will continue to support the development of federations and enable the delivery of primary care at scale. We will establish formal GP federation leadership networks to share best practice ideas and unblock front-line problems.

Out of hospital hubs are key to the delivery of our model of care

1.3.34 We know that better outcomes can be delivered by expanding and improving out of hospital services in all areas and shifting more activity and income into community-based care. A key feature of our service provision will be out of hospital hubs.

1.3.35 Hubs are a facility where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient-centred services that can't be achieved through the current configuration of 450 primary care sites. Some hubs will be used to group together general practices, which will increase access and result in better provision of same-day appointments for patients with more urgent problems. The hubs will offer modern, purpose-built or adapted facilities and will offer those GPs working there the opportunity to share overhead costs. This will also make extended opening hours and a broader range of services more viable.

1.3.36 The hubs enable the proactive model of care, will offer a wide range of intervention on a face to face basis, but will also organise, as safe receiver, care for individuals at home, and in care and nursing homes, through coordination of intermediate and community services over 24/7.

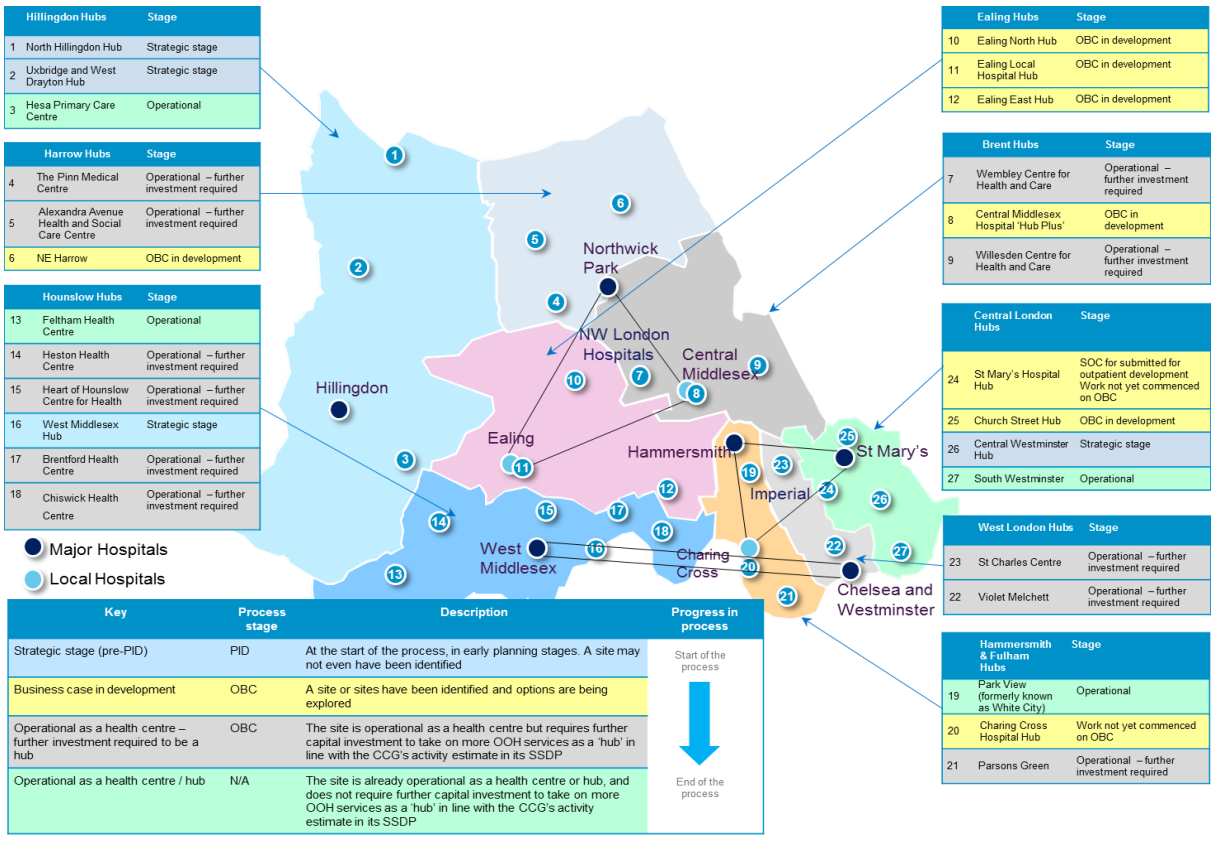
1.3.37 The local teams, based in out of hospital hubs throughout NW London, will function as trusted and safe receivers enabling a timely return home for NW London residents who currently occupy beds in acute hospitals without having acute need. This will reduce acute bed days through reduced length of stay and increase the number of people looked after in a place of care most appropriate to their needs. As a result we will achieve material benefits for our population and for system sustainability.

1.3.38 The preferred reconfiguration option in the DMBC also included the development of 29 out of hospital hubs across inner and outer NW London, as shown in Figure 8. Primary, community, mental health, social and acute care providers will come together to deliver integrated, patient-centred services in the hubs. This will also allow more services to be delivered outside of hospital settings. The preferred option for the number of hubs has subsequently been reduced to 27 because, in the intervening period, each CCG has developed further work on the proposed services and activity at each site, the estimated capital cost and funding source. It was proposed that two sites were not viable, and services could be effectively offered from hubs on other sites. Further engagement on these changes, and their associated impact on equalities, will take place at the options appraisal and OBC stages of the hubs business case process.

1.3.39 We will concentrate delivery into fewer sites and reduce the number from which primary care is currently delivered. Hubs will allow us to both address our poor quality primary care estates challenges by co-locating several practices into one hub, and enabling new ways of working and the new model of out of hospital care.

1.3.40 The capital investment will address the problem of our outdated and poor quality primary care estate and enable us to ensure that there is sufficient capacity in modern, purpose-built facilities to meet the current and growing demands for primary care. The hubs are crucial to delivering our new model of care.

Figure 8: Out of hospital hubs proposed for NW London



1.3.41 While there is a standard vision for how the hubs will operate, there is no single stipulated set-up. The hubs will develop in response to local geographic and demographic need. For example, a service will not be replicated in a hub if it is already being delivered successfully

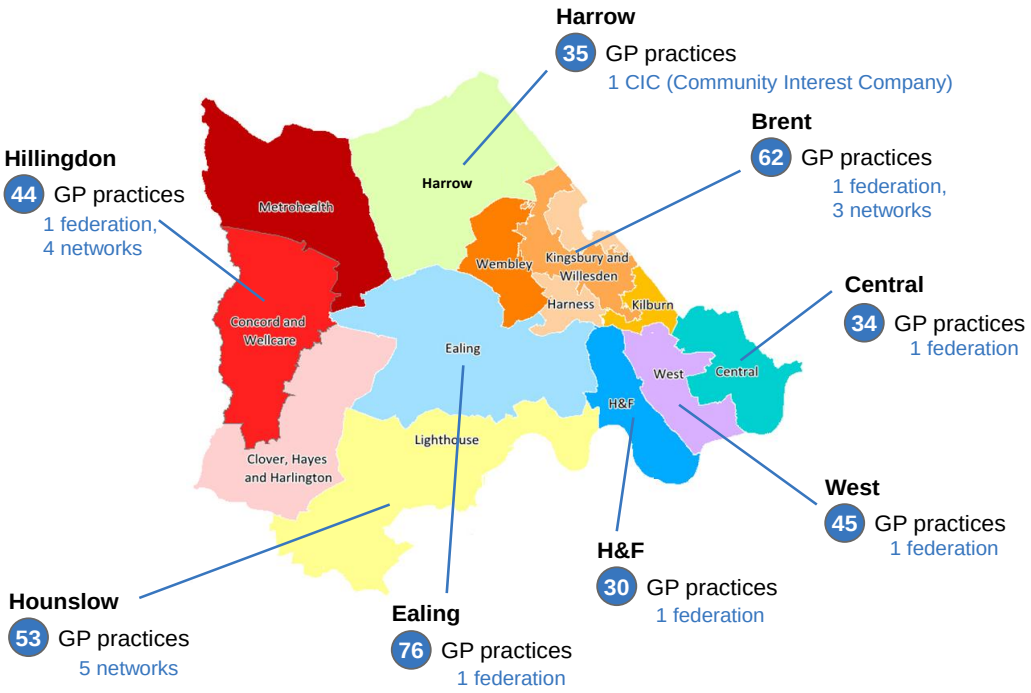
very nearby; and a service that may be culturally appropriate in one area, may not be required in another where the local population has different needs.

1.3.42 The hubs will directly address the problem of outdated and poor quality primary care estate in NW London, an issue that is intensified by high property costs in much of the area. There are plans to initially relocate at least 20 practices into new out of hospital hubs.

The transformation of general practice will provide more consistency in the delivery of our services

1.3.43 In NW London we currently have 1,093 GPs, 473 practice nurses and 273 clinical support staff, with an average list size 5,560. Our GP and nurse workforce supply is the lowest in London. We have 379 GP practices with 31 sites open at weekends delivering services in a networked way to the mapping of patients in NW London - enabling 1.9m NW London residents to access GP services at weekends.

Figure 9: Map of GP practices across NW London including summer 2016 position on federations and networks



1.3.44 We will continue to engage our federations, and work with General Practice to improve consistency and accountability at a practice and individual level to reduce unwarranted variation in processes and outcomes for managing long term conditions. It is an ambition for our federations to participate in our emerging accountable care partnerships.

1.3.45 Greater use of multidisciplinary teams in primary care will enable us to provide a higher ratio of allied health professionals such as nursing staff, physicians associates, health care assistants, pharmacists, primary care mental health workers, third sector workers including care navigators and social prescribers, all working alongside general practitioners.

1.3.46 We plan to improve access to general practice, resulting in better provision of same-day appointments for patients with more urgent problems and in better out of hours cover. We want to deliver a more consistent service that is available to all.

The reconfiguration of our acute sites is key to the delivery of our model of care

1.3.47 Acute hospitals will be designed to support the implementation of the new model of care and enable scarce resources to be used to best effect, including centralising services where necessary and concentrating a full range of specialist services on fewer sites to be able to most effectively treat acutely ill patients.

1.3.48 We have developed plans for which services will be offered from each hospital site. The preferred option for the acute reconfiguration, agreed through the DMBC, has five major hospitals, two local hospitals, one elective hospital and one specialist hospital.

1.3.49 Through this process, we committed to deliver a local and major hospital on the Chelsea and Westminster, Hillingdon, Northwick Park, St Mary's and West Middlesex sites, a local and elective hospital at Central Middlesex, local hospitals at Charing Cross and Ealing and a local and specialist hospital with an obstetric-led specialist maternity and neonatal unit at Hammersmith.

1.3.50 The preferred option for acute sector reconfiguration will result in changes at the majority of hospital sites across NW London, as shown in Table 1.

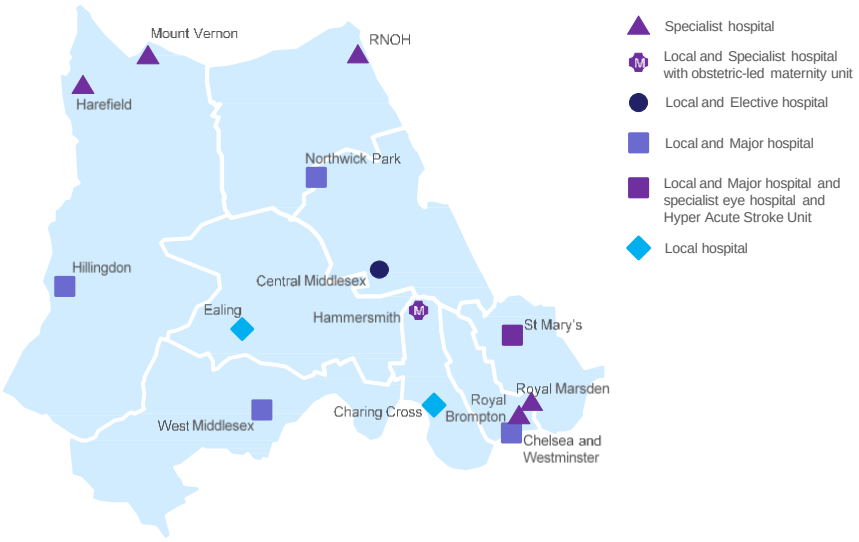
1.3.51 The recommended configuration proposed the following service models at each site, with the consolidation of A&E departments from nine to five sites with units at four hospitals Charing Cross, Central Middlesex, Hammersmith and Ealing hospitals being changed.

Table 1: Changes at hospital sites to deliver the preferred reconfiguration option, as per our DMBC

Hospital site	Proposed status following reconfiguration
Chelsea and Westminster Hospital	Major Hospital
Hillingdon Hospital	Major Hospital
Northwick Park Hospital	Major Hospital
St Mary's Hospital	Major Hospital
West Middlesex University Hospital	Major Hospital
Hammersmith Hospital	Specialist Hospital with obstetric-led maternity unit and a Local Hospital
Charing Cross Hospital	Local Hospital
Ealing Hospital	Local Hospital
Central Middlesex Hospital	Local Hospital and Elective Hospital

1.3.52 Five specialist hospitals in NW London were not affected by these proposals. These are Harefield, Mount Vernon, Royal Brompton, Royal Marsden and RNOH.

Figure 10: Map illustrating the recommended acute reconfiguration



1.3.53 The intention is that the local hospitals will become an integral part of the local community. In practice, this means local patients, patient groups, the voluntary sector, the local council through the Health and Wellbeing Board, and local clinicians will be involved in developing the range of services which will deliver the majority of care that communities need, such as diagnostic tests and treatments.

1.3.54 We will reduce A&E attendance, non-elective admissions, length of stay, and re-admissions so that while there will be increased activity and capacity at receiving hospital sites, it will not be like-for-like provision. We will improve patient satisfaction by focusing resources on the management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most.

1.3.55 The Ealing Local Hospital service model, as set out in the DMBC, consisted of an Urgent Care Centre, an outpatients department, outpatient paediatrics, ante and post-natal care and a limited range of diagnostics (x-ray and ultrasound). We have built on this core set of services to develop more comprehensive proposals for the clinical model for the site, which have been informed by clinical design and feedback from stakeholder engagement. These proposals, and their associated equalities impacts, are part of an ongoing process of design that will continue with local clinicians and residents as we develop the OBC.

1.4 We are confident that based on our experience of successfully delivering change and identified opportunities, our new model of care will address the key issues

1.4.1 Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness..

1.4.2 It is our stated intention that residents of NW London will have their clinical and social care needs met in the place that is most familiar to them, which will, for the most part, be in their own homes. We will implement a model of care whereby we will reduce reliance on use of acute hospitals through reducing unwarranted variation in the management of long term conditions, improving the consistency of care planning and case management, and ensuring seven-day access to out of hospital care. We will achieve better outcomes through consolidating expert care for particular acute conditions onto fewer sites. We have already achieved a lot but we know there is sizable opportunity to do much more.

1.4.3 This section provides evidence of the scale and range of opportunities and of the impact of what we have already implemented in the delivery of our model of care.

1.4.4 In our Case for Change we set out the issues and major challenges facing NW London in the next 10 years. If we are to provide health and social care services that are sustainable, we need to build people centric services; do more and better with less; and meet increased demand from people living longer with more long-term conditions.

1.4.5 We have set out below the evidence to support how our solution will address the challenges set out in the case for change. These include:

The nature and scale of the opportunity to change the way that we deliver care

1.4.6 We have four discrete opportunities to deliver more care to people at or close to home, and only deliver care in acute settings when it is really needed:

- The opportunity to look after patients in a place that is most appropriate to their needs
- The opportunities to provide non-elective care in a setting that is most appropriate with a net reduction in acute activity, quantified through detailed forecasts and modelling
- The opportunities to transfer care from acute setting to the out of hospital hubs
- The opportunity to reduce variation in care processes and to deliver better outcomes for people living with long term conditions

What we have done already to effect change that supports our new model of care

1.4.7 We have evidence of seven areas where we have been able to effect change:

- The impact of the changes made to maternity and paediatric services
- The clinical benefits of centralising specialist services such as hyper acute stroke units and major trauma centres in London
- The impact of work we are already undertaking to improve care processes and patient pathways on non-elective activity in secondary care
- The diabetes performance dashboard by CCG and by GP federation and network
- The impact of work we are already undertaking to improve seven-day acute services
- Integrated care to align clinical care and infrastructure around the needs of the patient
- The case study of the St Charles Hub in West London to demonstrate integrated care in practice and our collaboration with GP surgeries, local NHS hospitals and community and social care services

1.4.8 We have set out the evidence in more detail below.

The nature and scale of the opportunity to change the way that we deliver care

The opportunity to look after patients in a place that is most appropriate to their needs

1.4.9 Using the Royal College of Physicians Day of Care methodology, our audits have repeatedly shown that around 30% of patients in hospital would be more appropriately cared for elsewhere.[38] In our new model of care we will offer alternative services to these people provide care in areas close to people's homes, wherever possible to improve their health and wellbeing and address gaps in care and quality.

1.4.10 It is generally under-recognised that a large proportion of people in acute hospital beds are in their last phase of life. A study of 25 acute hospitals in Scotland in 2010 showed that 28.8% of people with an unplanned acute admission die within the subsequent twelve months. For the over 85s, this figure rises to 45.6%.[39] This would suggest that large numbers of hospital inpatients have entered the last year of their lives. Local data in NW London suggests that the incidence death in the twelve months after acute admission is around 25%, and that in 2014/15 there were over 50,000 admissions of people aged 70 and over. This represents a big opportunity to plan and provide better care for many people in this cohort for whom acute unscheduled care should not be considered an appropriate to acceptable alternative to palliative care.

The opportunities to provide non-elective care in a setting that is most appropriate with a net reduction in acute activity, quantified through detailed forecasts and modelling

1.4.11 We have evidence that our proposed solution and new model of care for integrated primary and out of hospital care can deliver further and more significant changes in the way we provide care. Our assumptions around non-elective admissions and bed days are reasonable. We can achieve the activity changes that we have forecast and that this is part of the picture for achieving financial sustainability of our commissioners and providers.

1.4.12 In 2015, NW London commissioned analysis from GE Healthcare Finnamore with the focus on the opportunity for better provision of care to meet the future healthcare demands of patients in the most appropriate setting. The objective was to understand the scale and nature of the opportunity change, how we deliver unscheduled care, and what would be required to look after more people outside of acute hospitals. The GE Healthcare Finnamore analysis considered this in terms of admission avoidance and length of stay reduction.

1.4.13 The improved co-ordination of care for individuals at home, in care and nursing homes will be particularly important to our many frail residents and those in their last phase of life; our more consistent approach will reduce the number of unpleasant and unnecessary conveyances and admissions by better meeting the person's need in their known and familiar place of care and supporting a larger number of people who wish to die at home to do so.

1.4.14 The timely transfer of care from hospital to home enabled by the hubs (as they will function as trusted and safe receivers) will enable a timely return home for people who currently occupy beds in acute hospitals without having acute need. This will have the added benefit of reducing acute bed days by reducing length of stay and increasing the number of people in a place of care appropriate to their needs.

1.4.15 People with certain long term conditions and patterns of admissions who are already well known to care services should benefit from appropriately planned care that would avoid further admissions. The original analysis identified patients with two or more admissions in one year with a long term condition in their diagnostic code. The second line of analysis was on an improved dataset which included criteria used in risk profiling of patients in primary

[38] Most recent data is from Chelsea & Westminster Hospital NHS Foundation Trust (sample size 574 patients: 298 West Middlesex and 276 Chelsea Westminster).

[39] Clark et al. Imminence of death among hospital inpatients: Prevalent cohort study *Palliative Medicine* March 2014 http://pmj.sagepub.com/content/early/2014/03/17/0269216314526443.abstract

care across NW London. These comprise the analyses of avoidable admissions and indication of unnecessary bed days.

1.4.16 The core data set was extracted from full year anonymised SUS data for the period 2012/13 to 2015/16. The data includes out of area providers as well as NHS England commissioned activity. The patient-level dataset across NW London was applied to different treatment levels to estimate the opportunity.

1.4.17 The GE analysis indicated that the total population of patients in NW London that currently receive care planning is 196,000 and this cohort could receive their care in a different way to enable us to avoid admissions in NW London. The number of people that could have their care transferred earlier could be up to 77,000 people which represents 29,000 patients that receive intensive case management through MDT, 48,000 patients managed at a lower intensity through bi-annual GP care plan reviews and including supported self-care plans. These cohorts account for 74% of acute overnight bed use. Our new model of care is focussed on keeping people well and putting the appropriate services in place, largely in the community, to meet their care needs.

1.4.18 The evidence from the Royal College of General Practitioners states that improved access to general practice can significantly reduce the demand for secondary care, specifically reduce A&E attendances by 15%-50% in the short-term. Furthermore, improved access to general practice could support patients to take a more pro-active approach to managing their conditions leading to a potential reduction of 8-11% in avoidable admissions in the medium-term. The table below highlights that we have applied an adjustment to reflect what we can achieve whilst still adhering to the principles of our new model of care. We are not aiming to achieve a complete transfer of activity, as identified from the GE analysis.

Table 2: Identify opportunity to reduce capacity in secondary care

	Admission avoidance	Length of stay reduction	Total
Total opportunity identified in GE analysis (OBDs)	426,337	142,272	568,609
Adjustment applied for NW London model of care (OBDs)	210,373	42,681	253,054
Target opportunity through NW London plans (OBDs)	215,964[40]	99,591[41]	315,555
Impact on beds	592	273	865

1.4.19 The analysis shows that the implementation of the new model of care could reduce the demand for acute hospital beds by 865 due to better meeting patient needs in other settings, although bed numbers will not reduce by this amount as there will be increased demand from demographic changes, offsetting the reduction. Under the new model there will be 99,106 fewer admissions by 2025/26, as identified from the total activity spells in Table 3 below, from the NW London population cohort, as identified in 1.4.17. The net reduction for hospitals in outer NW London (considered in this SOC) is 364 as a result of the new model of care and the increased capacity created out of hospital through services in hubs and services in people's homes. The reduction for inner NW London hospitals will be confirmed in SOC part 2.

The opportunities to transfer care from acute setting to the out of hospital hubs

1.4.20 Our model of care is a key driver to support our intention to reduce avoidable admissions and accelerate the momentum of primary care at scale through a hub and spoke model of

[40] This equates to 592 beds from admission avoidance and 273** beds from LOS reduction, totalling 865 beds.

[41] This equates to 592 beds from admission avoidance and 273** beds from LOS reduction, totalling 865 beds.

delivery. We have completed analysis to indicate non-elective and outpatient savings that are attributable to out of hospital hubs which are essential to deliver our model of care.

Table 3: Non elective admissions avoided that are attributable to the out of hospital hubs

HUB NEL activity saving	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total activity (spells)	**10,441**	**26,565**	**41,279**	**56,140**	**67,465**	**73,738**	**80,038**	**86,366**	**92,721**	**99,106**
Hub enabled	0	631	3,171	6,450	10,948	13,292	15,645	17,804	20,067	22,378
Other drivers	**10,441**	**25,934**	**38,108**	**49,690**	**56,517**	**60,446**	**64,393**	**68,562**	**72,654**	**76,728**
Hub NEL activity (spells)										
-in year	0	631	2,540	3,279	4,498	2,344	2,353	2,159	2,263	2,311
- cumulative	**0**	**631**	**3,171**	**6,450**	**10,948**	**13,292**	**15,645**	**17,804**	**20,067**	**22,378**
Weighted average NEL tariff (£)	**n/a**	**2.3**	**2.1**	**2.1**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Hub enabled NEL admisions avoided saving (£)										
Tariff saving (in year)	0	(1,454)	(5,453)	(6,810)	(9,212)	(4,761)	(4,751)	(4,340)	(4,533)	(4,615)
Cumulative	**0**	**(1,454)**	**(6,808)**	**(13,397)**	**(22,422)**	**(26,996)**	**(31,587)**	**(35,786)**	**(40,194)**	**(44,689)**

1.4.21 For planned care we assume a reduction in the number of outpatient attendances in acute settings. Of the reduction we expect some attendances will not be needed because we have more efficient pathways, some will be replaced by digital solutions and also by other forms of care, e.g. better care planning and co-ordination that reduces the demand for outpatient appointments. The remaining proportion will still involve an outpatient attendance; however the care pathways are expected to involve care provided by healthcare practitioners other than a hospital consultant-led approach as currently practised. A proportion of this activity will be delivered through the out of hospital hubs and the remainder will be procured.

1.4.22 The new pathways are based on the new clinical skills mix and therefore a reduction in tariff of 20% is considered achievable, based on experience elsewhere.

Table 4: Outpatients savings attributable to out of hospital hubs

Hub OP activity saving	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total activity (attendances) - cumulative	**132,774**	**324,127**	**473,306**	**617,751**	**721,154**	**779,837**	**838,928**	**900,015**	**961,581**	**1,022,037**
Ceased / alternative (see note 1) - cumulative	(49,790)	(121,548)	(177,490)	(231,657)	(270,433)	(292,439)	(314,598)	(337,506)	(360,593)	(383,264)
Re-provision (see note 2) - cumulative	**82,984**	**202,579**	**295,816**	**386,095**	**450,722**	**487,398**	**524,330**	**562,509**	**600,988**	**638,773**
Hub capacity (see note 3) - cumulative	0	20,127	68,509	122,291	168,939	191,439	191,439	198,246	198,246	198,246
Other locations	**82,984**	**182,452**	**227,307**	**263,804**	**281,783**	**295,959**	**332,891**	**364,263**	**402,742**	**440,527**
Hub OP activity saving - £000s										
Hub activity										
- in year	0	20,127	48,382	53,782	46,648	22,500	0	6,807	0	0
- cumulative	**0**	**20,127**	**68,509**	**122,291**	**168,939**	**191,439**	**191,439**	**198,246**	**198,246**	**198,246**
Tariff saving per attendance (£)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)
Hub enabled attendences avoided (£'000)										
Tariff saving (in year)	0	(483)	(1,161)	(1,291)	(1,120)	(540)	0	(163)	0	0
Cumulative	**0**	**(483)**	**(1,644)**	**(2,935)**	**(4,055)**	**(4,595)**	**(4,595)**	**(4,758)**	**(4,758)**	**(4,758)**

Notes:

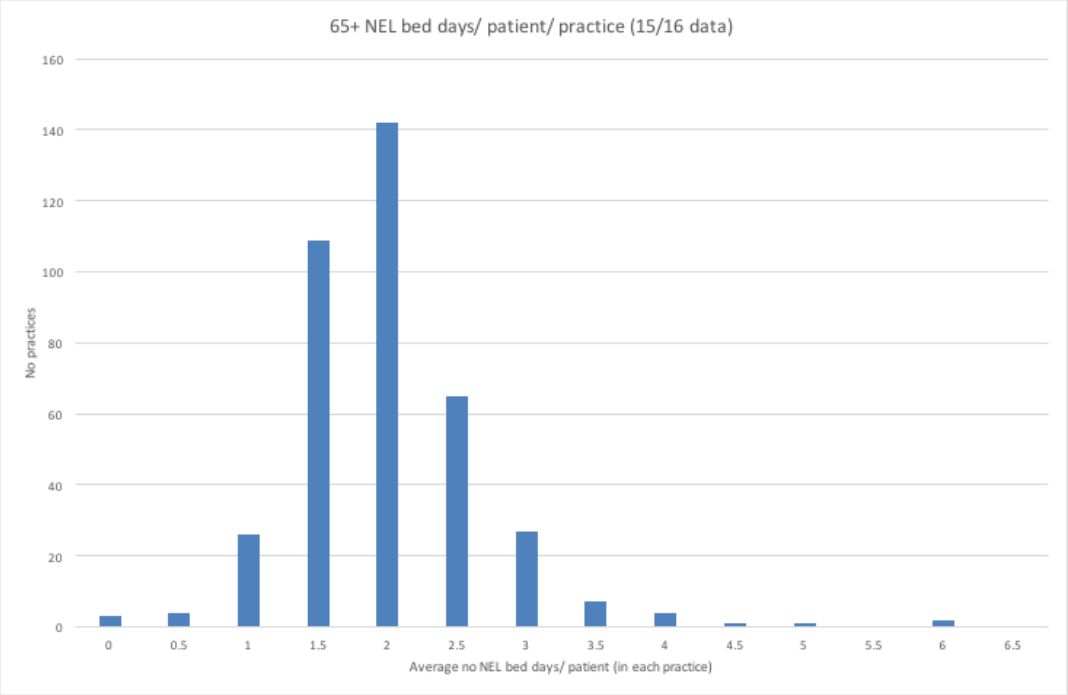
1. *37% of the reduction is outpatient activity that will either be avoided or delivered via alternative clinical pathways. These cost savings are included within CCG plans.*
2. *63% of the reduction in outpatient activity is to be re-provided either in hubs or by alternative locations.*
3. *Activity to be undertaken in hubs as they become operational*

The opportunity to reduce variation in care processes

1.4.23 There are many conditions for which there are well established care processes which are associated with both a positive patient experience and better clinical outcomes. However we see unacceptable levels of variation in the care that we provide across NW London. We can make improvements to the management of our patients with long term conditions through ironing out these kinds of variation. Two examples are shown below.

1.4.24 The graph below, Figure 11, demonstrates significant variation across GP practices in relation to management of patients who are over 65. In some practices, a patient aged over 65 would expect to spend on average 1-2 days per year in hospital as an emergency admission. In some practices, this is over 3 days and can be as high as 6 days. Understanding and acting on the drivers of this variation will be critical to delivering the most appropriate secondary care activity. [42]

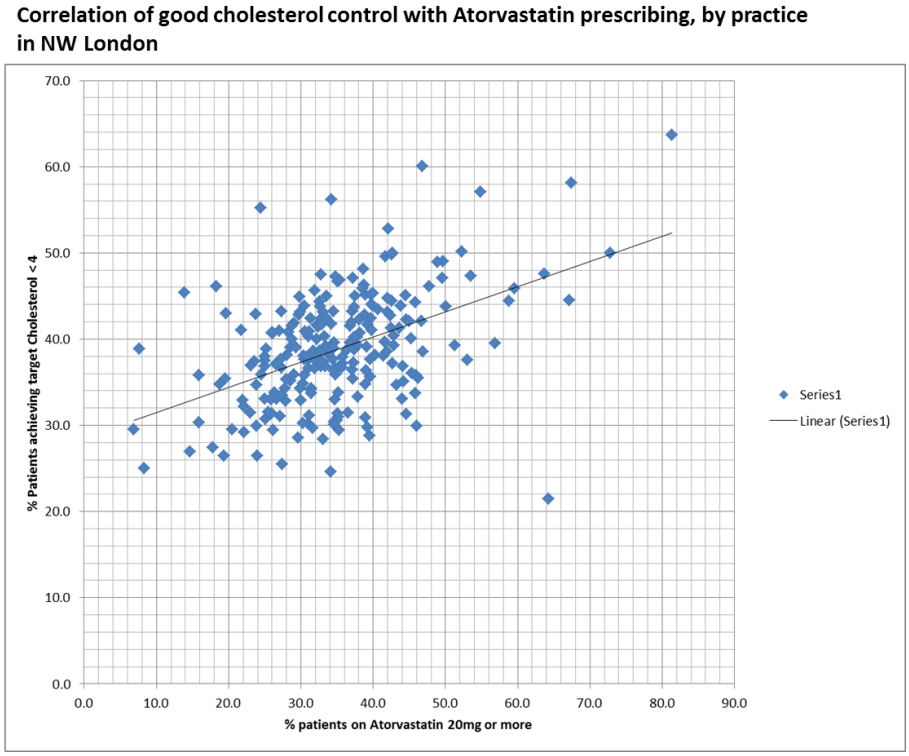
Figure 11: Variation in practice for non-elective admissions and length of stay over 65 per 1,000 practice patients across NW London



1.4.25 An example of unwarranted variation in outcome is that of cholesterol levels in patients with diabetes. Clinical guidelines advise that this cohort of patients should be prescribed the statin Atorvastatin at a dosage of at least 20mg. Figure 12 shows how optimal cholesterol levels are more likely to be achieved in general practices where this guideline is followed.

[42] 2015/16 non-elective SUS data for NWL and practice list sizes, split by age, on 31/03/16.

Figure 12: Correlation of cholesterol control in general practice with adherence to the statin prescribing guideline



What we have done already to effect change that supports our new model of care

The impact of the changes made to maternity and paediatric services

1.4.26 We have transformed maternity services and closed the Ealing inpatient maternity unit. In 2015, the programme delivered significant clinical improvements for women and new-born services via consistent and networked model of care for maternity services. This model has meant:

- Women have increased choices of where they receive their antenatal and postnatal care as well as birth setting
- A range of coordinated community and hospital based services for mothers and babies;
- A consolidation of acute specialist expertise in NW London (from seven inpatient units to six) leading to increased senior consultant cover on the labour wards, from an average of 101 hours before the changes to 122 hours per week after the changes
- Women can receive improved continuity of care under new pan NW London network of maternity services, with an increase from 58% to 79% of women
- Presence of 100 more midwives across NW London.

1.4.27 The changes were endorsed by the Royal College of Midwives and an evaluation after six months showed that all of the short term, and many of the longer term, benefits of the changes had been achieved.

1.4.28 In 2016 NHS England has conferred us with early adopter status for maternity to test new approaches to continuity of care as part of the NHSE National Maternity Transformation Programme.

1.4.29 We have transformed paediatric services and closed the Ealing paediatrics inpatient ward. In 2016, the programme, working with our providers, has delivered a major change to

services for children and young people in need of acute care. Our new model of care has involved:

- Better access to urgent and emergency care
- Provision of Paediatric Assessment Units staffed by consultant paediatricians
- Provision of purpose built units, staffed by consultants, to provide care for children who need observation and clinical intervention
- A large refurbishment and expansion programme has also taken place in our hospitals over the last few months, including the delivery of a new children's A&E at Hillingdon Hospital and the expansion of the children's ward and A&E at West Middlesex Hospital
- Significant changes to the workforce, including 60 additional newly-recruited paediatric nurses across NW London, seven new consultants at Hillingdon providing 24/7 presence, two new consultant posts at St Mary's, and redeployment of consultants from Ealing to Northwick Park to improve the level of consultant cover

1.4.30 The impact of these changes is scrutinised using data submitted for our weekly dashboard.

1.4.31 The main public concern prior to the transition was that many children would need to be transferred out of Ealing Hospital's urgent care centre or adult A&E to receive care. So far the number of children transferred using non-emergency patient transport has been substantially lower than we had planned for, on average just three children a week.

The clinical benefits of centralising specialist services such as hyper acute stroke units and major trauma centres in London

1.4.32 Medical evidence clearly indicates that for life-threatening conditions, for example a heart attack, stroke or major trauma, a good clinical outcome is more strongly associated with accessing the right specialist service even if there is a small increase in travel time.

1.4.33 We know from our London-wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that deliver consistently high quality, well-staffed services by experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills.

1.4.34 Prior to 2010, services for people experiencing acute stroke were delivered from 30 hospitals in London, and outcomes were amongst the worst in the country. Following a period of public consultation, stroke services were reorganised in 2010 into eight hyper acute stroke units (HASUs) from which expert care could be promptly delivered, and stroke rehabilitation provided from 24 units. This was a whole system change, involving earlier recognition of onset of stroke symptoms, a new ambulance protocol, rapid access to imaging, prompt thrombolytic therapy for the correct patients, and timely transfer of care to rehab units. The outcome has been significantly reduced mortality at 3, 30 and 90 days, and shorter length of inpatient stay.[43] This demonstrates that concentrating expert 24/7 care into fewer units gives better outcomes for patients who need a particular kind of acute care for which the appropriate care pathway has been designed and agreed.

1.4.35 Further evidence of the benefits of centralising expert acute care onto a smaller number of sites comes from the London-wide approach to provision of Major Trauma Centres (MTCs), also implemented in 2010 following public consultation. There are now four designated MTCs in London which provide comprehensive care 24/7 to severely injured patients. The outcome has been significantly improved survival of 50% over the last five years, saving an

[43] Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis *BMJ* 2014; 349 doi: http://dx.doi.org/10.1136/bmj.g4757 (Published 05 August 2014)

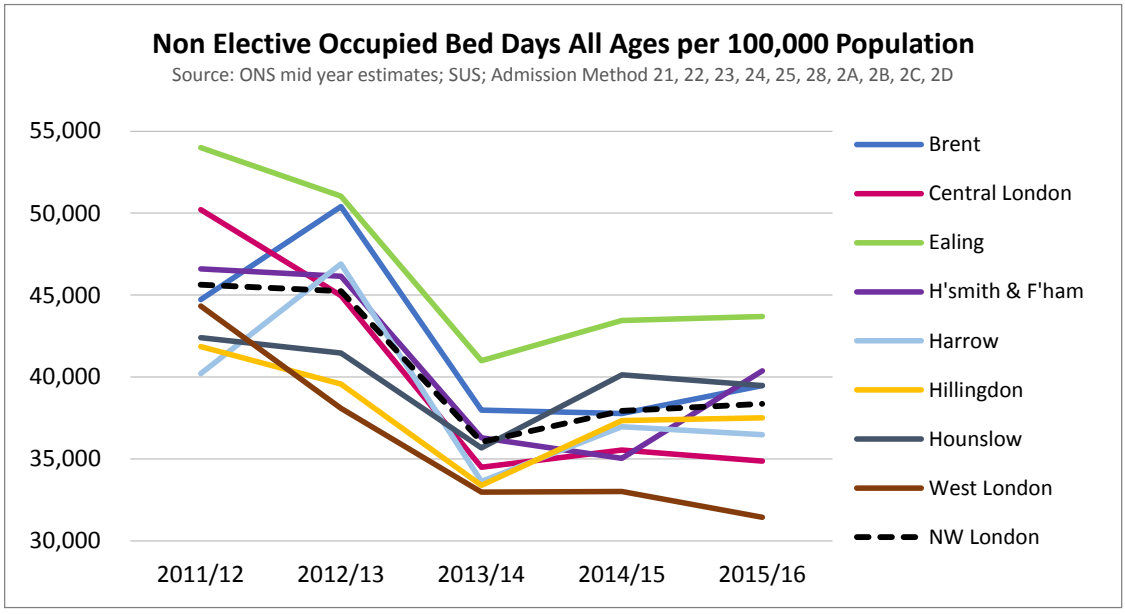
estimated 610 lives.[44] This outcome is attributed largely to improvements in organisational processes.

1.4.36 Heart Attack Centres (HAC) in London are another excellent example of how care and outcomes have improved through concentrating a service into a few expertly staffed 24/7 specialist centres since 2010. There are eight HACs in London, of which two are in NW London; in Hammersmith and Harefield. These provide round the clock access to angiography and angioplasty for anyone with a suspected myocardial infarction (MI). Patients are conveyed according to an agreed protocol with the London Ambulance Service. The time interval between onset of symptoms and intervention is a critical determinant of survival at 30 days.[45] An evaluation of outcomes for patients in cardiac arrest post MI in London in 2011-12 has shown significantly improved survival at 30 days and 12 months.[46]

The impact of work we are already undertaking to improve care processes and patient pathways on non-elective activity in secondary care

1.4.37 All our CCGs have seen a reduction in the occupied bed days per 100,000 over the last five years, from 2011/12 to 2015/16, as per Figure 13. This is the case even for those CCGs that have not seen a fall in admission rates, as shown in Figure 14. It is notable that six of the eight CCGs have seen reductions in non-elective admission rates per 100,000 in 2015/16 as compared to 2011/12. In contrast, the non-elective admission rate in London as a whole has increased slightly, and nationally it shows a clear upward trend. The three-year rolling average shows this more clearly in Figure 15 with five of our CCGs showing an obvious downward trend, two holding steady and only one with an upward trend.

Figure 13: NEL bed days all ages per 100,000 population 2011/12 to 2015/16



[44] The Impact of a Pan-regional Inclusive Trauma System on Quality of Care *Ann Surgery* 2016; 264(1):188-194 doi

[45] Berger et al. Relationship Between Delay in Performing Direct Coronary Angioplasty and Early Clinical Outcome in Patients With Acute Myocardial Infarction. *Circulation* 1999;100:14-20 http://dx.doi.org/10.1161/01.CIR.100.1.14

[46] Fothergill et al. Survival of resuscitated cardiac arrest patients with ST-elevation myocardial infarction (STEMI) conveyed directly to a Heart Attack Centre by ambulance clinicians. *Resuscitation*. 2014 Jan;85(1):96-8. doi: 10.1016/j.resuscitation.2013.09.010. Epub 2013 Sep 19.

Figure 14: Non-elective admissions all ages per 100,000 population 2011/12 to 2015/16

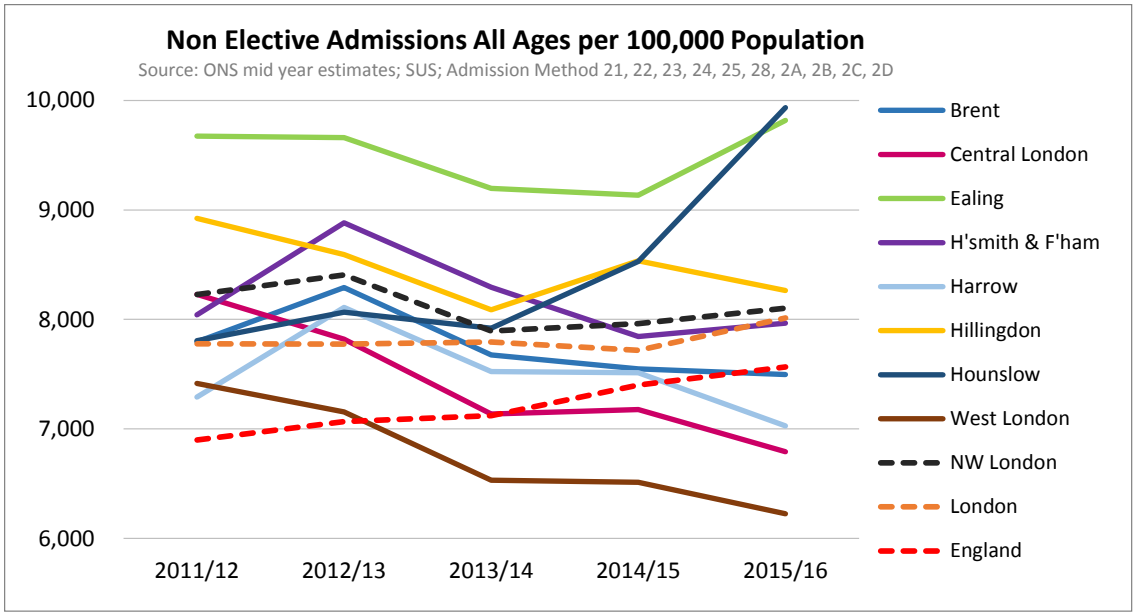
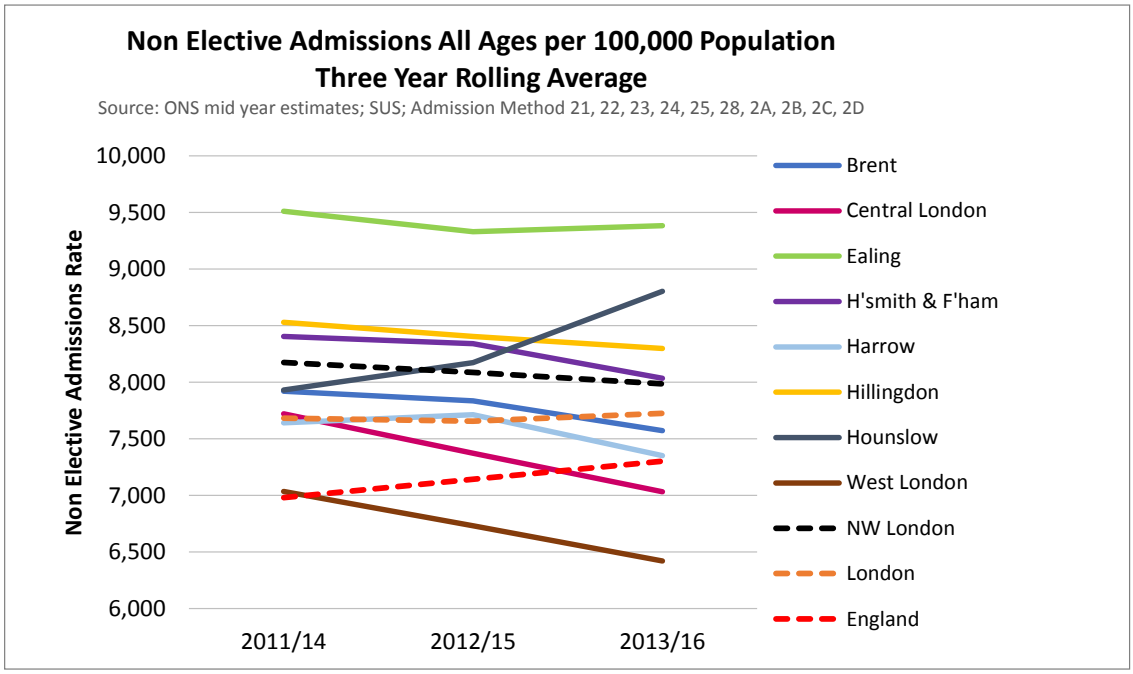


Figure 15: Non-elective admissions all ages per 100,000 population three year rolling average 2011/12 to 2015/16



1.4.38 There is a correlation between those CCGs that are furthest ahead in the delivery of the new model of care and where reductions in non-elective activity have been greatest. We are confident that further implementing changes and operating at scale can reduce non-elective admissions and occupied bed days.

1.4.39 There will be an emphasis on process harmonisation in management of frailty and long term conditions to eradicate unwarranted variation and improve outcomes. Some of the hubs will accommodate an acute frailty service, providing ambulatory i.e. non-bedded, specialist care for people most at risk from being admitted.

1.4.40 The data on non-elective admissions and bed days shows there is clear evidence that in NW London, we can and are delivering our strategy and realising benefits. However, to

maintain this progress, make it universal for all our population in all our CCGs, and fully realise the benefits, we need to be working at greater scale.

The diabetes performance dashboard by CCG and by GP federation and network

1.4.41 Much has already been achieved in the management of nearly 70,000 people with diabetes among the five CCGs in inner NW London. It was recognised that there was considerable variation in clinical practice between, and even within, different GP practices, and that unacceptably poor outcomes needed to be addressed using a proactive population-based approach. The initiative has identified the people at highest risk of complications, such as those with mental health problems, a history of poor compliance, poor motivation or poorly controlled diabetes, and then offers appropriate direct support from a multidisciplinary team (MDT). Currently most care is provided by GPs and practice nurses, but the intention is to change this to community workers, health coaches, physicians' assistants and other 'non-traditional' roles. The infrastructure to support this will be housed in our hubs, from which care can be delivered in person or virtually by members of the MDT.

1.4.42 In inner NW London, a monthly diabetes dashboard is produced and sent to all practices showing compliance with a range of process and outcome-related indicators including blood pressure, HbA1c (a marker of long term sugar levels) and serum cholesterol. The improvement in performance can be clearly seen from August 2015 to June 2016 in Figure 16, noting that the initiative went live later in West London and Central London which accounts for the slower progress in those two CCGs. Any deterioration in monthly performance is quickly spotted, and tailored support can be offered to a practice in difficulty. There has been no correlation between performance and deprivation of the catchment population. Good practice is encouraged through targeted training for GPs and other primary care workers, the appointment of a named diabetes lead at each practice, peer review created by the use of the dashboard, and contractual incentives such as Quality and Outcomes Framework (QOF) and the new out of hospital contract with full population coverage across the five CCGs. Organisation of all practices into federations and networks has made it easier for the CCGs to drive the improvements via contractual mechanisms.

1.4.43 The diabetes dashboards along with other dashboards for asthma, have demonstrated how increasing visibility of practice performance across specific domains will have a significant impact on improving delivery of outcomes.

1.4.44 A three tier approach is proposed to improve performance and drive down variation:

- Set practice-specific relative targets, e.g. any practice within a certain range to improve performance by 5/10/20% over agreed time-period
- Target practices below the CCG or NWL average (mean or median) to bring them up to the current average
- Focus on poor performing practices by setting minimum acceptable standards for NWL

1.4.45 Specific clinically-meaningful outcome measures will be developed to ensure progress with reduction of key events e.g. for diabetes: amputation, blindness, development of chronic renal failure; and improvement in oral anticoagulant prescribing for defined patient-cohorts.

Figure 16: Diabetes performance dashboard by CCG and by GP network/federation in Inner NW London

August 2015

	Diabetes register	% 9 key care processes in 15m	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% Care planning in 15m	% Hypoglycaemia monitoring	High risk of diabetes register	% High risk annual review	% BGTS on formulary
Central	2170	27.6	58.7	59.6	36.5	0.9	4.2	17	0.0	49.3
	3216	31.7	60.9	63.5	37.1	1.0	4.5	3	0.0	64.4
	2093	28.7	65.2	70.4	36.9	0.2	4.5	1	0.0	52.4
Central Total	7479	29.7	61.5	64.3	36.9	0.7	4.4	21	0.0	57.0
Ealing	4059	33.2	42.4	65.5	38.3	0.7	14.0	12	25.0	23.3
	3085	41.5	61.0	65.9	41.0	3.5	17.2	582	6.4	20.5
	2198	32.4	57.9	70.7	42.9	1.2	10.5	211	7.6	25.5
	6620	24.6	46.8	58.3	37.3	0.6	12.0	857	2.2	25.2
	1905	30.7	52.7	65.1	44.8	7.9	5.1	104	3.8	15.7
	3409	18.7	44.1	59.2	37.9	0.5	19.2	602	0.0	17.5
	4108	31.9	53.3	61.7	43.0	2.5	24.1	899	4.0	19.5
Ealing Total	25384	29.5	49.9	62.6	39.9	1.9	15.2	3267	3.5	21.8
H&F	1709	36.1	61.2	65.1	44.1	9.4	21.6	58	20.7	56.8
	1569	32.8	62.7	64.6	38.4	6.6	13.9	315	0.0	32.0
	1004	13.9	61.3	63.9	38.1	2.2	15.0	103	42.7	43.2
	2349	15.2	50.7	63.8	35.8	0.2	2.3	3	0.0	48.0
	1225	26.7	54.8	56.1	34.4	6.6	17.3	174	2.3	35.5
H&F Total	7856	24.9	57.4	63.1	38.2	4.7	12.3	653	9.2	44.6
Hounslow	4750	29.6	52.0	65.8	40.4	2.7	6.5	1637	10.6	64.8
	2852	24.5	47.5	53.0	31.1	1.0	7.8	498	21.3	42.1
	3805	32.1	50.2	71.1	41.7	1.0	6.9	1090	0.6	47.0
	1521	36.4	55.8	65.7	37.5	7.8	13.3	1038	8.8	28.7
	4112	27.0	49.8	56.1	35.7	1.1	1.7	842	0.1	47.8
Hounslow Total	17040	29.3	50.7	62.5	37.7	2.1	6.3	5105	7.4	49.1
West London2	1658	29.9	56.6	61.8	35.3	1.7	5.4	4	0.0	37.7
	2360	33.4	54.2	61.6	37.9	0.8	2.0	5	20.0	47.6
	2255	32.5	59.3	63.9	36.3	1.8	2.3	14	7.1	37.1
	1248	27.3	59.0	61.4	33.9	0.2	5.0	2	0.0	26.0
	1999	18.6	54.2	64.4	34.4	0.2	1.6	0	0.0	41.7
West London2 Total	9520	28.7	56.5	62.7	35.8	1.0	2.9	25	8.0	40.0
Grand Total	67279	28.8	53.2	62.9	38.3	2.0	9.7	9071	6.1	37.4

June 2016

	Diabetes register	% 9 key care processes in 15m	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% Care planning in 15m	% Hypoglycaemia monitoring	High risk of diabetes register	% High risk annual review	% BGTS on formulary
Central	2176	35.2	54.6	61.7	36.7	17.6	19.7	525	5.5	51.6
	3188	32.6	59.2	62.5	37.7	17.4	18.9	1292	6.4	68.4
	2132	44.1	63.6	73.4	37.3	14.3	26.9	476	13.4	55.4
Central Total	7496	36.6	59.1	65.3	37.3	16.6	21.4	2293	7.7	60.3
Ealing	4415	47.3	48.1	65.6	38.9	52.2	35.1	2581	56.8	63.3
	3099	61.1	60.1	65.8	40.8	55.6	55.8	2004	59.7	47.2
	2259	50.4	62.3	69.8	41.5	38.9	40.9	1152	33.9	45.3
	6871	47.0	50.9	58.0	37.2	38.0	41.7	3324	34.3	46.3
	1991	39.8	58.4	65.3	42.2	53.5	26.3	764	38.5	40.9
	3586	39.4	49.1	61.1	38.1	22.8	47.3	2041	21.3	58.1
	4279	46.4	58.6	64.6	43.0	39.7	48.4	2397	38.7	40.1
Ealing Total	26500	47.3	54.0	63.2	39.7	41.9	42.7	14263	41.0	49.7
H&F	1753	44.6	60.0	63.0	45.0	56.2	50.5	585	37.6	63.2
	1545	42.1	60.8	60.8	41.3	59.0	54.1	574	26.5	54.6
	1031	39.0	59.5	64.5	38.6	43.0	46.5	590	34.1	50.5
	2444	33.6	52.7	64.6	38.3	27.3	25.3	298	28.5	55.7
	1285	44.3	51.4	54.9	35.0	56.4	49.0	579	32.5	50.8
H&F Total	8058	40.0	56.5	62.0	39.8	46.3	42.2	2626	32.2	55.7
Hounslow	5010	70.8	59.0	68.9	42.1	59.0	63.8	3735	38.0	68.9
	3052	51.2	59.3	61.0	38.1	44.8	35.7	2347	29.6	49.2
	3912	55.1	56.7	70.2	43.6	60.8	58.8	1601	33.2	53.9
	1553	52.2	61.6	69.9	38.4	41.5	52.5	1312	26.0	34.0
	4399	49.4	55.1	64.7	37.7	44.2	31.1	2513	11.6	56.9
Hounslow Total	17926	57.2	57.8	66.9	40.3	51.8	48.9	11508	28.5	55.8
West London2	3837	48.1	53.4	67.1	39.0	30.2	27.5	1486	43.3	54.8
	2466	36.0	60.3	67.3	37.0	25.2	24.4	939	18.0	48.1
	1290	32.3	56.7	60.9	36.2	11.0	14.7	443	25.3	24.7
	2063	39.9	54.1	67.6	36.6	26.0	40.2	800	29.9	52.1
West London2 Total	9656	41.2	55.8	66.4	37.6	25.5	27.8	3668	31.7	49.2
Grand Total	69636	47.0	56.1	64.7	39.3	40.0	39.6	34358	32.9	52.9

1.4.46 There is potential to apply a similar approach to other long term conditions, such as chronic obstructive lung disease and atrial fibrillation.

The impact of work we are already undertaking to improve seven-day access

1.4.47 In 2015, NHS England appointed NW London as a first wave delivery site for seven-day services, to pioneer new models of care across NW London to improve weekend acute care in hospitals. This is an NHSE priority.

1.4.48 Our achievements to date include:

- Developed and piloted an evidence-based clinical model of care to ensure:
  - All emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital
  - Ongoing review by consultant every 24 hours of patients on general wards
- Implementing a discharge to assess process for patients transferring from acute to community care; assessment for longer-term care and support needs is undertaken in the most appropriate setting and at the right time for the person, as advocated by the DH, NHSE and the Association of Directors of Adult Social Care (ADASS)[47]
- Developing a reporting regime and network to manage demand and capacity for reporting diagnostic tests by radiologists across the whole of NW London
- System criteria for certain diagnostic tests which have to be satisfied, meaning that radiologists spend less time vetting requests and more time reporting on scan findings

[47] Quick Guide Discharge to Assess. NHS England Publications Gateway Reference 05871

- Launched a first of its kind NWL Career Framework for radiographers in order to address current vacancy rates and time lost waiting for access to diagnostics

1.4.49 The table below indicates the current level of inefficiency based on the average number of bed occupied by patients waiting for a diagnostic test to be carried out. It shows that on any given day, almost 300 acute beds in NW London are occupied by someone who has been waiting more than 24hours for a diagnostic test. Applying a 25% sensitivity, it should be realistic and possible to save 74 bed days every day by improving access to testing.

Table 5: Audit findings of acute inpatients awaiting diagnostic testing

Trust/Site	Average number of beds occupied by patients waiting longer than 24hrs for a diagnostic test (request to test)	Potential bed saving (assuming 25% reduction of beds occupied by request to test waits)	Potential bed saving (assuming 50% reduction of beds occupied by request to test waits)
Acute Site 1	54	14	27
Acute Site 2	27	7	14
Acute Site 3	37	9	19
Acute Site 4	21	5	11
Acute Site 5	37	9	18
Acute Site 6	20	5	10
Acute Site 7	13	3	6
Acute Site 8	89	22	45
Total	**298**	**74**	**150**

Integrated care

1.4.50 Integrated care can be defined as the alignment of clinical care, financial incentives and infrastructure around the needs of the patient. Typically, patients have to tell their story multiple times to different clinicians in different organisations, investigations – and sometimes even treatments – are duplicated, it is hard for patients to navigate their way through the system, and patients with long term conditions are poorly incentivised to promote their own health and independence. Integrated care initiatives are designed to overcome these familiar problems.

1.4.51 The NW London Integrated Care Pilot (ICP) was the first iteration of integrated care that was then built on as part of the whole systems integrated care pioneer programme. It was set up to serve patients over 75 or with diabetes and overcome the boundaries between hospitals, community care services, social care and local authorities to allow faster access, streamlined for patients and a stronger focus on their long-term needs. The GP practices involved initially experienced a 6.6% reduction in non-elective admissions for diabetic and elderly patient groups, compared to 0.3% increase for non-involved GP practices.[48]

1.4.52 We found that 20% of patients drive 75% of demand across the health and social care system, and were therefore priorities for an integrated approach. We wanted to encourage a better way of caring for our highest risk patients. This meant the whole system had to work

[48] NW London Integrated Care Pilot preliminary performance assessment 2013/14.

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together differently, so that integration and coordination became the norm for people that require care from more than one organisation or service. At the heart of our approach was a simple, fundamental belief: that health and social care resources should be matched to the need of the individual patient.

The case study of the St Charles Hub in West London

1.4.53 West London CCG has developed two hubs: the St Charles integrated care centre, W10 and the Violet Melchett integrated care centre, SW3.

Figure 17: St Charles Hub in West London

The hubs plays a pivotal role in our ability to implement our challenging Local Services strategy. The Hub is a multi-organisation collaboration with GP surgeries, local NHS hospitals and community and social care services are all working together in partnership with many charities and voluntary organisations to deliver care.

My Care, My Way is an integrated care service for people aged 65 and older. This service is available to all over-65 year old GP registered patients in West London. The Hub at St Charles went live in September 2015. The focus of this exciting service is planned care that anticipates and prepares for any changes in a patient's health and social care needs. It empowers patients to manage every aspect of their care in partnership with their GP.

With longer appointments with their GPs and a wide range of health and social care professionals on hand to provide support, the centres provide patients with a wide range of services conveniently under one roof. Examples services include basic foot care, diabetes clinics and social care. It means patients can access all the service they need in one place at one time.

Since September 2015 over 3,600 patients have been seen by the service and there is a current caseload of over 2,300. Feedback from patients and health and social care professionals has been positive.

Patient feedback following My Care, My Way appointment

"I am grateful to my GP who has assisted me during my many years of working life. Now I am 90 years old and have been in hospital, my GP has introduced me to My Care, My Way*. I did not know that I can get help to make my life better, easier and safer. They are dealing with this now. Many thanks for providing support to improve my health."*

Patient feedback

"It's a wonderful new service, thank you. I felt very well looked after."

Patient feedback

"It was a caring, productive and reassuring experience. I know exactly how to manage my condition should it worsen. I was impressed by all aspects of my appointments. I feel reassured by the care and information on offer."

GPs feedback following *My Care, My Way* appointment

"I have been the patients' GP for the past 15 years but I found out more about them in the session at the St Charles Integrated Care Centre today than I have in the 15 years of looking after them – this is really positive for patients."

Emma, Health and Social Care Assistant, My Care, My Way

"The key benefit of My Care, My Way *is that any problems can be identified and controlled before they become more serious."*

1.5 Our new model of care requires major changes

1.5.1 The *Shaping a Healthier Future* (SaHF) programme was established in November 2011 and builds on significant work previously carried out in NW London by a series of Clinical Working Groups (CWGs) to develop suitable models for clinical services.

1.5.2 The programme is based upon four core principles which are underpinned by the Secretary of State's four tests for reconfigurations. The principles are that the programme should be:

- Clinically led and supported by GP commissioners
- Informed by engagement with the public, patients and local authorities
- Incorporate a robust and transparent process underpinned by a sound clinical evidence base
- Consistent with current and prospective patient choice

1.5.3 We have set out how our proposals deliver much of our STP vision through a new model of care which:

- Retains activity in the community enabled by out of hospital hubs where services are co-located and primary care delivered at scale
- Reconfigures our acute services to ensure better quality care and clinical sustainability, while also achieving financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites.

1.5.4 This section also sets out why we have separated the SOC into two parts and the updated position for Ealing local hospital as a result of the Secretary of State decision. This is distinct from our implementation plan which sits in the Management Case.

Scope of *Shaping a Healthier Future*

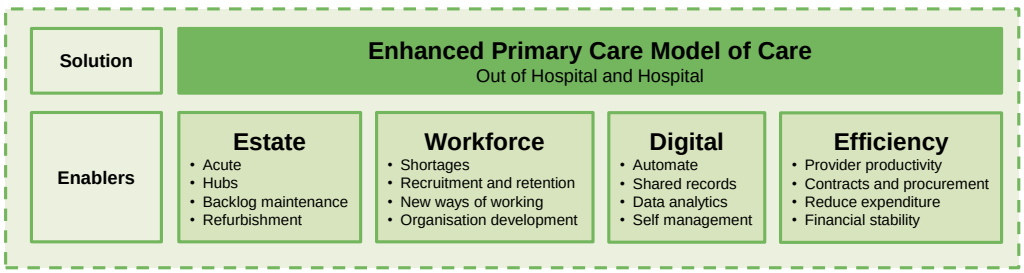
1.5.5 SaHF aims to improve health, care and sustainability in NW London through a new model of care, requiring reconfiguration of hospital and out of hospital services. Whilst SaHF predates the STP, there is congruence between the two and SaHF is a critical part of the NW London STP and is being delivered in this context.

1.5.6 The programme has worked extensively with clinicians, the public, patients and other stakeholders on the proposals to transform out of hospital services. The feedback from the public consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism, which we have taken steps to address.

1.5.7 The impact of the proposals was assessed and we have plans for a sequence of changes required in both the out of hospital and acute environments. We have continued to develop an assurance process to ensure that safe, high quality care continues to be provided during the transition.

1.5.8 We believe they represent the most effective way of providing high quality healthcare for patients in and residents of NW London.

Figure 18: Enhanced model of primary care and associated enablers



1.5.9 The key changes that will need to be made to deliver our integrated primary and out of hospital care will require capital investment to enable:

Estate

- Enhancements at 11 partially or fully operational out of hospital hubs
- Building of seven new out of hospital hubs
- Reconfiguration at two acute sites at Ealing and Central Middlesex Hospital.

Workforce

- Multidisciplinary team approach that includes higher ratio of allied health professionals working alongside general practitioners.
- Sustainable workforce model that will allow a greater percentage of clinician training to take place within the community setting where the workforce, once trained, will be needed.
- GP recruitment and retention, creation of GP and nurse banks, coordinate support to help practices which will address and improve the morale of GPs and their primary care colleagues.
- Development of specialist training in primary care to allow more clinician training to take place within the community setting.
- Development of community education providers' network to enhance workforce skills for future services and consultant outreach into primary care and delivering education and virtual consultations.

Digital

- Improved IT integration through common and interoperable digital platforms across care settings to enable more consistent patient access and contribution to care records and care plans.
- Better sharing of information between health and social care systems due to a lack of open interfaces.
- Automate clinical correspondence and workflows in secondary care settings to improve timeliness and quality of care.
- Support for new models for out of hours care through shared care records and the NWL diagnostic cloud, such as 24/7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks.
- Dynamic analytics to track consistency and outcomes of out-of-hours care.

Efficiency

- Improved provider productivity that will mean more effective, more timely and more tailored care.
- Introduce more contractual measures for improving quality of care.
- Standardisation of processes in primary care.
- Redress balance of expenditure to increase spend on primary and community care over the next five years to 2020/21.
- Maintain financial stability of General Practice through exploring avenues to deliver General Practice at scale.

1.5.10 We are currently exploring the opportunities presented by several technological innovations that will enable us to care better for our residents using digital solutions. As the delivery of our new model of care progresses, application of digital technology will inevitably take a greater role. We have alluded to this in this business case, but are mindful that the case for capital investment in technology will be made separately as required, and according to NHSEs agreed processes.

We have a comprehensive plan which sets out our capital requirements

1.5.11 To complete our implementation and fully realise the benefits for our local population, we require a significant capital investment to:

- Fully implement our out of hospital hubs across the eight CCGs.
- Make the necessary investment in the primary care estate.
- Redevelop our acute sites, including the development of local hospitals at Ealing, an elective hospital at Central Middlesex and investment in the major acute sites at Hillingdon Northwick Park and West Middlesex Hospitals.

1.5.12 This section majors on the estate implications and the costs involved. It explains why each of the elements is necessary and shows the associated costs.

We require a significant capital investment in the estate

1.5.13 We have gone as far as we can with limited capital. We require a capital investment to deliver the planned changes in the model of care. We are requesting capital because the forecast activity shifts cannot be accommodated in existing estate facilities. The capital request is reflective of the overall poor quality of estates in NW London. The poor quality estate in our hospitals is increasingly costly to maintain, does not meet modern standards and is not fit for purpose.

1.5.14 The age of the primary care estate indicates that significant investment is needed in the future to maintain business as usual. This estate is not conducive for the delivery of transformed models of primary care, and offers little flexibility in terms of growth or capacity, and does not enable the delivery of primary care at scale.

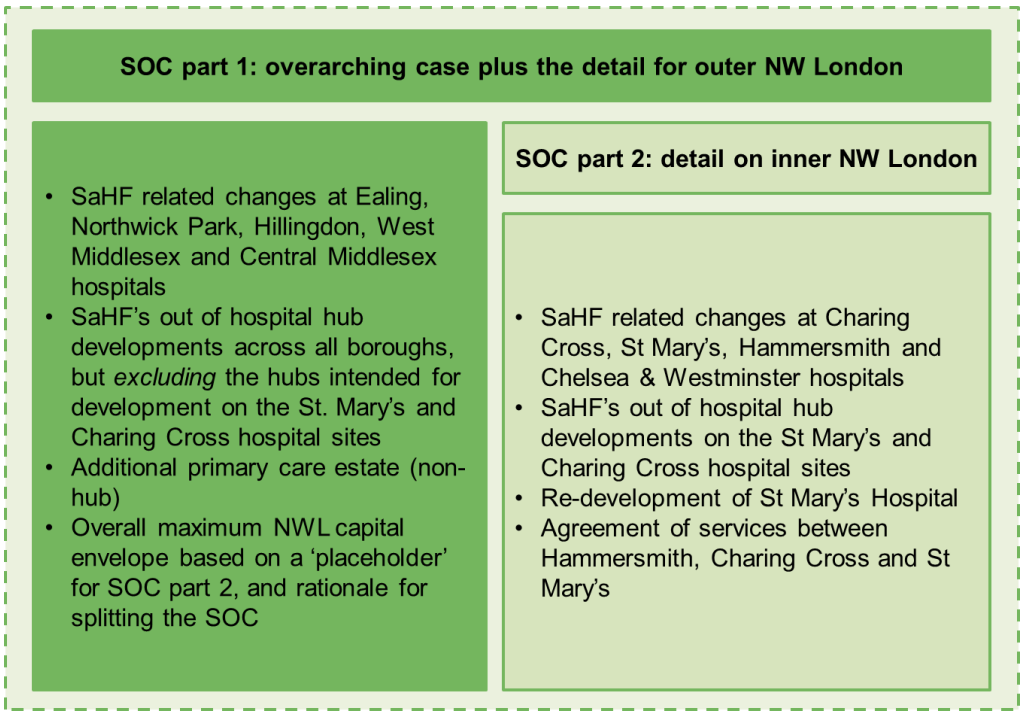
1.5.15 Our primary care estate has insufficient capacity which puts increased demand on Urgent Care Centres and A&E departments.

Strategic Outline Case (SOC) part 1 in context of overall NW London STP capital

1.5.16 The SOC part 1 is the main capital requirement of the STP within the current CSR period. The totality of SaHF includes SOC part 2 but the capital requirement for SOC part 2 will fall outside of the STP period and will be the subject of a separate business case. The scope of the two is set out below:

- SOC part 1 includes acute reconfiguration, out of hospital strategy and primary care
- SOC part 2 outlines a potential need for a further £314m net capital for inner NW London SaHF at Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust. This will be subject to further validation.

Figure 19: Summary of the scope of SOC part 1 and SOC part 2



Change in the capital requirement since the DMBC

1.5.17 There have been a number of changes that have occurred since the DMBC was published. As a result the capital requirement to deliver the proposed service changes under the SaHF programme has increased, for example the Ealing local hospital attributed capital was not part of the original DMBC, but was included in a separate paper considered by the JCPCT in February 2013 and is an integral part of the SOC capital requirement. The purpose of the SOC part 1 as submitted is still to implement the DMBC preferred option, and is not a re-assessment of reconfiguration decision or options.

Investment in the primary care estate

1.5.18 Building on CCG out of hospital strategies, a process was undertaken as part of Strategic Service Delivery Plan (SSDP) analysis to model the type and volume of activity that it is estimated will be brought into an out of hospital setting over the next five years. In the new model of out of hospital care, activity will be delivered in different settings e.g. home, GP practice, care network and health centre or hub.

1.5.19 At the DMBC stage, it was estimated that 29 hubs were required, four of which are no longer proposed as part of out of hospital hub plans. Further detailed analysis completed as part of SSDPs suggests that 27 hubs were required, which includes two hubs not listed in the DMBC. Further engagement on these changes, and their associated impact on equalities, will take place at the options appraisal and OBC stages of the hubs business case process.

1.5.20 We are making the best use of the existing public sector estate and are proposing enhancements at 11 partially or fully operational hubs. We have proposed seven new out of hospital hubs in key localities to enable us to most effectively use the available public estate and acute reconfiguration at two existing hospital sites at Ealing and Central Middlesex Hospital.

1.5.21 The table below includes the proposed 18 hubs for which there is capital investment required. In addition there are four hubs already in existence which do not require capital. There are also two included within the outer NW London hospitals (Ealing and CMH), two within inner NWL hospitals at St Mary's and Charing Cross and there is a further hub under review (West Middlesex) making 27 in total.

1.5.22 Some of these hubs will house both existing and new practices who will then be able to vacate aging, non-compliant estate.

Table 6: Out of hospital hubs where capital investment is required

CCG	Hub	Estimated capital cost incl. VAT and inflation (£'000)
Brent	Wembley Centre for Health and Care	2,449
Brent	Willesden Centre for Health and Care	4,455
Central London	Church Street	14,732
Central London	Central Westminster	4,920
Ealing	Ealing East	21,152
Ealing	Ealing North	14,613
Hammersmith and Fulham	Parsons Green Health Centre	4,814
Harrow	Alexandra Avenue	2,696
Harrow	NE Locality Belmont/Kenmore	15,191
Harrow	The Pinn	675
Hillingdon	North Hillingdon	5,669
Hillingdon	Uxbridge and West Drayton	11,050
Hounslow	Chiswick	1,000

CCG	Hub	Estimated capital cost incl. VAT and inflation (£'000)
Hounslow	Heart of Hounslow	1,720
Hounslow	Heston	15,894
Hounslow	Brentford/West Middlesex	10,210
West London	Violet Melchett	12,712
West London	St Charles	3,952
Total		**147,904**

1.5.23 For acute care, the recommendation is for a local and major hospital on the Chelsea and Westminster, Hillingdon, Northwick Park, St Mary's and West Middlesex sites, a local and elective hospital at Central Middlesex, a local hospital at Charing Cross and Ealing and a local and specialist hospital with an obstetric-led maternity unit at Hammersmith.

1.5.24 We set out further information on the capital investment required to deliver the proposed approach to the reconfiguration of the acute hospitals in NW London. We summarise:

- Total capital requirements for hospital reconfiguration
- Approach to funding capital requirements for hospital reconfiguration
- Profile of capital expenditure.

1.5.25 The table below outlines the potential funding breakdown for capital at acute sites for SOC part 1, which is assumed to be funded by £319m of and £9m of disposal receipts.

Table 7: Acute sites where capital investment is required (traditional timeline)

Gross Capital requirement (£m) - Trust	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	Total
CWFT	-	-	-	0.8	1.2	16.8	24.3	-	**43.1**
LNWH	0.2	2.4	12.4	51.0	64.9	46.6	28.9	-	**206.4**
THH	-	-	-	-	-	39.1	39.1	-	**78.2**
TOTAL	**0.2**	**2.4**	**12.4**	**51.8**	**66.1**	**102.5**	**92.2**	-	**327.7**
Disposals (£m)	-	-	-	-	-	-	(9.0)	-	(9.0)
NET CAPITAL REQUIREMENTS	**0.2**	**2.4**	**12.4**	**51.8**	**66.1**	**102.5**	**83.2**	**0.0**	**318.7**

1.5.26 We have a credible plan for out of hospital and hospital reconfiguration and throughout the SaHF programme there has been ongoing assurance to ensure that proposals are sound, scrutinised and well communicated and considered by all stakeholders.

1.5.27 We have assessed the impact of the proposals and have plans for a sequence of changes required in both the out of hospital and acute environments. We have continued to develop an assurance process to ensure that safe, high quality care continues to be provided during the transition.

1.6 We now urgently need to complete implementation of our strategy but require capital investment to achieve this

1.6.1 We have already made significant progress in implementing our SaHF strategy and delivering the necessary changes which do not require significant capital investment. However, there is now increasing urgency that we complete the implementation to address the issues cited above, in particular at Ealing. This can only be achieved with significant capital investment.

1.6.2 Following approval of the SaHF DMBC and the acceptance by the Secretary of State of the preferred option, work has been ongoing to implement the transformational changes this set out. A significant number of the DMBC proposals have already been delivered, and patient benefits secured, without the need for an externally approved case for capital investment. To date, we have achieved:

- The redesign of the maternity pathway and the closure of the Ealing maternity unit: this has increased the number of women who now have continuity of care between ante natal and post-natal care, and has enabled us to improve the safety of care by recruiting nearly 100 extra midwives and increasing the average level of consultant cover on labour wards from 60 hours in 2013 to 122 hours in summer 2015.

- The redesign of the paediatrics urgent care pathway and the closure of the Ealing paediatrics ward: this has resulted in the opening of paediatric assessment units which reduce the number of children who need to attend A&E or be admitted to inpatient wards, reducing the length of stay for children and taking pressure away from A&E departments. Nursing vacancy rates have reduced, improving safety, and the level of paediatric consultant cover now matches Royal College standards. We are the first whole healthcare sector to achieve this in summer 2016.

- The early closure of the Hammersmith Hospital and Central Middlesex Hospital A&E departments, in response to safety concerns: this was achieved safely and there are now 24/7 urgent care centres on both sites, with increased emergency medicine consultants at St Mary's and Northwick Park hospitals in 2013/14.

- There has been significant investment in primary, community and intermediate care services: this has increased access to primary care at weekends, enabled multidisciplinary team working and the rapid response services to reduce the demand on acute services. Over the three years since the DMBC, non-elective admissions across NW London have reduced by 1.5% from 8,229 to 8,103 (for all ages per 100,000 population), for the period 2011/12 to 2015/16, this is below the rest of London which has increased by 0.5% (for all ages per 100,000 population), for the same period.

1.6.3 These considerable changes have delivered tangible benefits to patients, but despite this, the financial challenge remains considerable and there continues to be unacceptable variation in the quality of services and outcomes. Significant capital investment is now required to fully deliver the new model of health and care in NW London. It is imperative for us to complete the transformation to longer term financial and clinical sustainability.

There is now increasing urgency that we complete the implementation to address the issues cited above, in particular Ealing

1.6.4 The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. Due to the on-going uncertainty of the future of Ealing Hospital the vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. There is currently a financial deficit of over £30m associated with Ealing Hospital. The costs of staffing it safely are greater than the activity and income for the site, meaning that the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

1.6.5 The demographics across NW London are changing, and the current configuration of hospitals does not best meet this demand. The condition of the Ealing Hospital estate is variable. Whilst some areas are pleasant and efficient others are no longer fit for purpose and require a high level of backlog maintenance. The proposed changes at Ealing will help to address both the financial and quality issues associated with the estate.

1.6.6 We agreed the main changes at Ealing Hospital through consultation at DMBC stage, and there has been acceptance of these proposals by both the Independent Review Panel and the Secretary of State for Health. These changes relate to the transfer of acute services from the site, namely the ICU, elective emergency surgery and emergency medicine. This will be enabled by investment in other NW London hospitals to support the increase in their acute activity. The Ealing Local Hospital service model, as set out in the DMBC, consisted of an Urgent Care Centre, an outpatients department, outpatient paediatrics, ante and post-natal care and a limited range of diagnostics (x-ray and ultrasound).

1.6.7 We also described a wider range of services that could be delivered on a local hospital site (such as further therapies and diagnostics) through an 'alternative proposals' paper, submitted to the JCPCT alongside the DMBC. This was in response to feedback during the consultation process.

1.6.8 The JCPCT and IRP noted that Ealing CCG and other relevant commissioners should: *'work with local stakeholders, including Ealing Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Ealing Hospital site consistent with decisions made by this JCPCT.'*[49]

1.6.9 When accepting the IRP recommendations, the Secretary of State for Health also committed us to provide an A&E service on the Ealing site, 'even if it is a different shape or size from that currently offered' to be developed in line with the emerging principles of Sir Bruce Keogh's review of accident and emergency services.

1.6.10 Detailed engagement was undertaken in 2013/14, as set out in the Management Case. The current preferred option was informed by public engagement and clinical co-design, as well as by the principles of the Keogh review. Further engagement work on the preferred option will continue through to OBC stage as the model is refined.

[49] Independent Reconfiguration Panel Advice on Shaping a Healthier Future proposals for changes to NHS Services in North West London, 13 September 2013.

Table 8: Ealing Local Hospital services

			DMBC	Proposed
Core and Enhanced Primary Care	GP and nurse appointments	GP practice(s)	x	✓
		Nurse appointments	x	✓
		Core GP services	x	✓
	High risk patients	Long term care coordinators	x	✓
Rental	Enhanced Primary Care	Enhanced primary care services and community services	x	✓
	Other	Evening and weekend GP services	x	✓
Community and Hospital	Therapies	Physiotherapy	x	✓
		Speech and language therapy	x	✓
		Occupational therapy	x	✓
		Dietetics	x	✓
		Podiatry	x	✓
		Audiology	x	✓
	Diagnostics	X-ray	✓	✓
		Ultra-sound (incl. echo)	✓	✓
		CT scanning	x	✓
		MRI scanning	x	✓
		ECG (incl. stress)	x	✓
	Beds	Elective/non-elective in-patient beds	x	x
		Day care/assessment centre	x	x
		Palliative care beds (Meadow House)	x	✓
		Paediatric inpatient	x	x
		Frailty (incl. assessment/day care)	x	✓
	Ealing Local Hospital	Major A&E	x	x
		Local A&E	x	✓
		Urgent care centre	✓	✓
		Minor illness	✓	✓
		Minor injury	✓	✓
		Mental health liaison	✓	✓
		Endoscopy	x	x
		Near patient testing (i.e. phlebotomy) or Pathology lab (options being evaluated)	x	✓
		Ambulatory care (to include frail elderly and medical day unit)	x	✓
		Paediatric day care/rapid access clinic	x	✓

	Output/ Access to specialist opinion	Cardiology	✓	✓
		Dermatology	✓	✓
		Diabetes centre of excellence	✓	✓
		ENT	✓	✓
		Geriatric Medicine	✓	✓
		Gastroenterology and colorectal	✓	✓
		Gynaecology	✓	✓
		General medicine	✓	✓
		General surgery	✓	✓
		Haematology	✓	✓
		Infectious diseases including tuberculosis and hepatitis	✓	✓
		Clinical oncology	✓	✓
		Anti-coagulant	✓	✓
		Trauma and orthopaedics	✓	✓
		Paediatric outpatients	✓	✓
		Oral surgery	✓	✓
		Neurology	✓	✓
		Respiratory	✓	✓
		Rheumatology	✓	✓
		Sexual health	✓	✓
		Urology	✓	✓
		Vascular	✓	✓
		HIV	✓	✓
	Maternity	Ante and post-natal	✓	✓
	Specialist	Renal	x	✓
		Chemotherapy	x	✓
		Ophthalmology	✓	✓
		Breast screening	✓	✓
Mental Health	Mental Health	MH outpatients	x	✓
Other	Base for field teams and meeting space	Base for mental health and social care field teams to support integrated working and assessment	x	✓

1.6.11 Following transition, we envisage that Ealing will function as a local hospital, which will co-ordinate a range of services in an integrated site. The hospital is expected to host GP practices, a community hub and an extensive range of outpatient and diagnostic services; meeting the vast majority of the local population's routine health needs. Through this, the site would continue to provide care for the local community, through a local A&E, which would be equipped to cater for the majority of unplanned care needs experienced by Ealing residents. A dedicated older people's frailty pathway could be delivered on the site, which will improve people's independence, reduce demands on major acute services and help to co-ordinate older people's care closer to home. In the preferred option this service will include some short stay specialist bedded care on site. Services will be provided by a range of providers in line with the needs of the local population.

1.6.12 To achieve this vision, we plan to work with the local population and clinicians from a range of organisations and specialties to define the detailed clinical model for Ealing, and the configuration of services at the site. We have enhanced the range of services in consideration for the site from those set out in the DMBC in response to feedback from local clinicians and residents, and will continue to work with local clinicians and service users to develop and refine this vision by:

- Engaging fully with local stakeholders to co-design services
- Undertaking further engagement on the proposed changes
- Starting to develop clinical models for the OBC

- Developing detailed implementations plans to set out how we can make the change happen.

1.6.13 As the clinical model is further defined, we will also refresh existing equalities analyses, to understand any additional impacts on the local population and to comply with our statutory obligations in this regard.

An accelerated timeline has been developed in order to address these issues as soon as possible and at an improved ROI

1.6.14 We would like to reconfigure the scope and scale of acute services currently delivered from Ealing Hospital as part of an accelerated timeline because under a traditional business case approval timeline, we would not be able to address the Ealing site issues, or fully deliver the new model of care, until 2024.

1.6.15 We have tested the options of how to fund and how quickly to deliver SaHF. We have developed an accelerated approach, which delivers the benefits earlier. This reduces the time taken to develop, assure and approve business cases by one year and four months. It shows considerable opportunity to reduce the financial support required by the NW London health economy and to close the Finance and Efficiency gap in the STP much earlier than currently planned.

1.6.16 We are seeking approval for the accelerated approach, given that this delivers benefits earlier.

1.6.17 Typically significant acute hospital transformation schemes require a five-year period to develop and refine business cases, and ensure that these pass through the relevant approval mechanisms. This must happen before any change may occur. This assumes the development and approval of the Outline Business Cases (OBC) and Full Business Case (FBC) happens in sequential stages. If this timeline were followed in NW London then the proposed transformational changes would not be realised within the time scope of the STP. The case for change and challenges described in Section 1.2 would not be addressed, patients would continue to receive care below the standards we believe they should expect and the system would become financially unsustainable.

1.6.18 An alternative accelerated timeline has been developed based on the altered assumption that business case development and approval can be achieved more quickly, which has been set out in the table below.

1.6.19 The accelerated timelines are based on parallel running of the business cases and a faster approval and assurance route. This will require:

- Trusts preparing documentation and undertake soft marketing to go to market prior to FBC approval (FBC approval remains a requirement before actually issuing ITTs)
- Assurers co-ordinating their review activity so that each stage of the process builds on the work of others and that key issues for all approvers are identified at the beginning of the assurance process

Table 9: Comparison of traditional and accelerated timeline for OBC and FBC approval

Hospital Business Case	Estimated timeline (traditional)		Estimated timeline (accelerated)	
	OBC approval	FBC approval	OBC approval	FBC approval
Hillingdon	Sept 2018	March 2022	September 2017	March 2019
West Middlesex	Sept 2018	March 2022	September 2017	March 2019
Central Middlesex	August 2018	April 2020	August 2017	December 2018
Northwick Park	January 2019	November 2020	January 2018	March 2019
Ealing	February 2019	May 2021	February 2018	April 2019

1.6.20 The accelerated timeline will enable improved SaHF clinical models and their associated benefits, such as improved patient care and services, to be made available much earlier. The accelerated timeline will reduce the risk of clinical unsustainability.

1.6.21 The accelerated timeline conflates reduced capital cost with bringing forward benefits. There will be an earlier delivery of reconfiguration savings, improving the financial position of the sector. There will also be further work on the critical path for buildings to reduce the build timescales.

1.7 This case sets out the requirement of £513m of capital investment to deliver these changes in an accelerated timeline. This is essential to enable delivery of our STP.

1.7.1 This section summarises the capital required to deliver the requirement for Ealing using the accelerated timeline. It sets out the capital requirement over the full period, year by year.

1.7.2 It emphasises that this represents a strong ROI and is essential to address the issues cited above.

Summary of the capital requirement for the traditional timeline identified in SOC part 1

1.7.3 We have provided detail of the net capital requirement for SOC part 1. The total net capital investment required in the traditional timeline is £529m which comprises £69m for the primary care estate, £319m for acute services and £141m for the out of hospital hubs. This is based on the traditional timeline.

1.7.4 We have set out an accelerated timeline for the capital requirement. The accelerated timeline reduces the overall capital requirement from £529m to **£513m**, a reduction of £16m (attributable to acute services) and substantially changes the phasing of the capital requested in each CSR period. This case is requesting funding on the basis of an accelerated timeline given the urgency of the challenges at Ealing.

Table 10: Summary of net capital requirement for SOC part 1 accelerated timeline

	2016/17	2017/18	2018/19	2019/20	2020/21	Total CSR 1	Total CSR 2	Total 10year
Primary care estate								
Total primary care estate for refurbishment of GP premises		13	56			69		69
Acute services								
Total acute services net capital	0	1	4	18	149	172	131	303
Out of hospital								
Total out of hospital net capital	6	16	38	68	8	136	5	141
Total net SOC part 1 capital	**6**	**30**	**98**	**86**	**157**	**377**	**136**	**513**

Capital requirement for the accelerated timeline which is the basis of funding being requested

1.7.5 The table below indicates the phasing of the capital requested in each CSR period for the traditional and accelerated timeline.

Table 11: Phasing of capital requested in each CSR period for the traditional and accelerated timeline

	CSR 1 (2016/17 to 2020/21) Capital Funding (£m)	CSR 2 (2021/22 to 2025/26) Capital Funding (£m)	Total Capital Funding (£m)
Traditional	272	257	529
Accelerated	377	136	513

Return on investment

1.7.6 The proposals deliver a compelling return on investment over 32 years. We are asking for investment over the next ten years. The transition costs are affordable.

Economic appraisal and value for money assessment

1.7.7 This demonstrates an overall benefit (in EAC terms) of the investment of £181m per year. This analysis shows that the combined out of hospital and acute reconfiguration delivers an equivalent annual benefit of £181m. This is explained in further detail in the Economic Case.

1.7.8 This is set out further in the Economic and Financial cases.

1.8 Conclusion

1.8.1 Our Sustainability and Transformation Plan sets out our aim to help people to be well and to live well. We aim to close the three gaps identified in the Forward View: the health and wellbeing gap; the care and quality gap and the finance, efficiency and sustainability gap.

1.8.2 However, our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care, given the population health trends, coupled with our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.

1.8.3 In order to address this, we have a strategy to meet our residents' clinical and social care needs in the right place at the right time. We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care. We are confident that based on our experience of successfully delivering change and identified opportunities, our new model of care will address the key issues. Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.

1.8.4 Our proposed new model of care will require major change. Our Shaping a Healthier Future (SaHF) proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which: retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale; and reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites.

1.8.5 In order to complete our implementation and fully realise the benefits for our local population we require a significant capital investment to: fully implement our out of hospital hubs across the eight CCGs in NW London; make the necessary investment in primary care estate; and redevelop our acute sites, including the development of the local hospital at Ealing, an elective hospital at Central Middlesex and investment in the major acute sites at Hillingdon, Northwick Park and West Middlesex hospitals. We now urgently need to complete implementation of our strategy but require capital investment to achieve this.

1.8.6 We have already made significant progress in implementing our SaHF strategy in a capital constrained environment. We have closed two A&Es that cannot meet NW London standards of care and transformed our maternity and paediatric services. There is now an urgent need for change at Ealing hospital therefore an accelerated timeline has been developed to address issues as soon as possible.

1.8.7 This case sets out the requirement of £513m of capital investment to deliver these changes in an accelerated timeline of which £377m is within this CSR period. This is essential to enable delivery of our STP.

Chapter 2

Economic Case

The Economic Case sets out the value for money case for the proposed capital investment, through a structured comparison of costs and benefits, including quantifiable and non-quantifiable financial and health benefits.

1. We have compared the additional costs and benefits of the proposed capital investment against a scenario without investment to test whether the proposed capital investment provides value for money.

2. We have used the 'Equivalent Annual Cost' (EAC) to enable a combined economic assessment to be undertaken across the various capital investment schemes within the SOC. This economic appraisal methodology follows NHS and public sector guidance.

3. The changes in capital and revenue costs of both hub and hospital schemes equates to a £43m EAC per annum benefit, demonstrating value for money.

4. The capital investment is calculated to provide wider economic benefits of £44m (in EAC terms).

5. The capital investment is projected to result in health benefits equivalent to 334 lives saved per year, equivalent to £94m (in EAC terms), using the Quality Adjusted Life Year approach used by the NHS to calculate health benefits.

6. The capital investment brings further benefits, including improvements to the quality of the patient environment and quality of care able to be provided. These are non-quantifiable and so have not been costed in the value for money analysis.

7. The economic appraisal and value for money assessment demonstrates an overall benefit (in EAC terms) of the investment of £181m (£43m from hub and acute, £44m from wider economic benefit and £94m from Health Benefits). The investment offers a positive return of 5 times the capital invested based on EAC excluding wider economic benefits and health benefits, and 16 times the capital invested based on EAC including wider economic benefits and health benefits.

8. We have demonstrated that the case represents value for money under a range of scenarios by conducting sensitivity analyses.

2.1 Approach to the economic case

We have compared the additional costs and benefits of the proposed capital investment against a scenario without investment to test whether the proposed capital investment provides value for money

Approach

2.1.1 The Economic Case appraises the costs and benefits of both out-of-hospital ("OOH") and acute hospital capital investments.

2.1.2 The acute investment impacts are compared to a non-investment option in the economic analysis and the OOH impacts are compared to a non-hub investment option. The definition of the comparator is explained in Figure 1 overleaf.

2.1.3 Figure 1 overleaf shows how the economic and financial analysis for the business case has been performed, including both OOH and acute investments, and though analysed separately, demonstrates how they are part of a connected whole programme.

2.1.4 Figure 1 also shows how the comparator and do something scenarios are built up. For each of these the figure shows what is included within the 'comparator' and what is included within the 'do something' option, in order to describe the incremental aspect (i.e. benefits / costs) of the capital investment being assessed (which are highlighted within the red-dashed line). This is explained below:

OOH Hubs

Comparator

- No hub investment, only the investment required in existing GP practices/ facilities for additional capacity to meet the need arising from population growth and to comply with standards or the suitability for the functions carried out within practices which are to be transferred into the new hubs.
- No commissioner QIPP delivered

Do Something

- OOH hubs capital investment takes place.
- QIPP savings delivered (comprised of both hub enabled QIPP and non-hub enabled QIPP). For the purposes of the Financial and Economic analysis, only the directly attributable hub enabled benefits are included within the incremental analysis (shown within the red-dashed line)

Acute hospitals

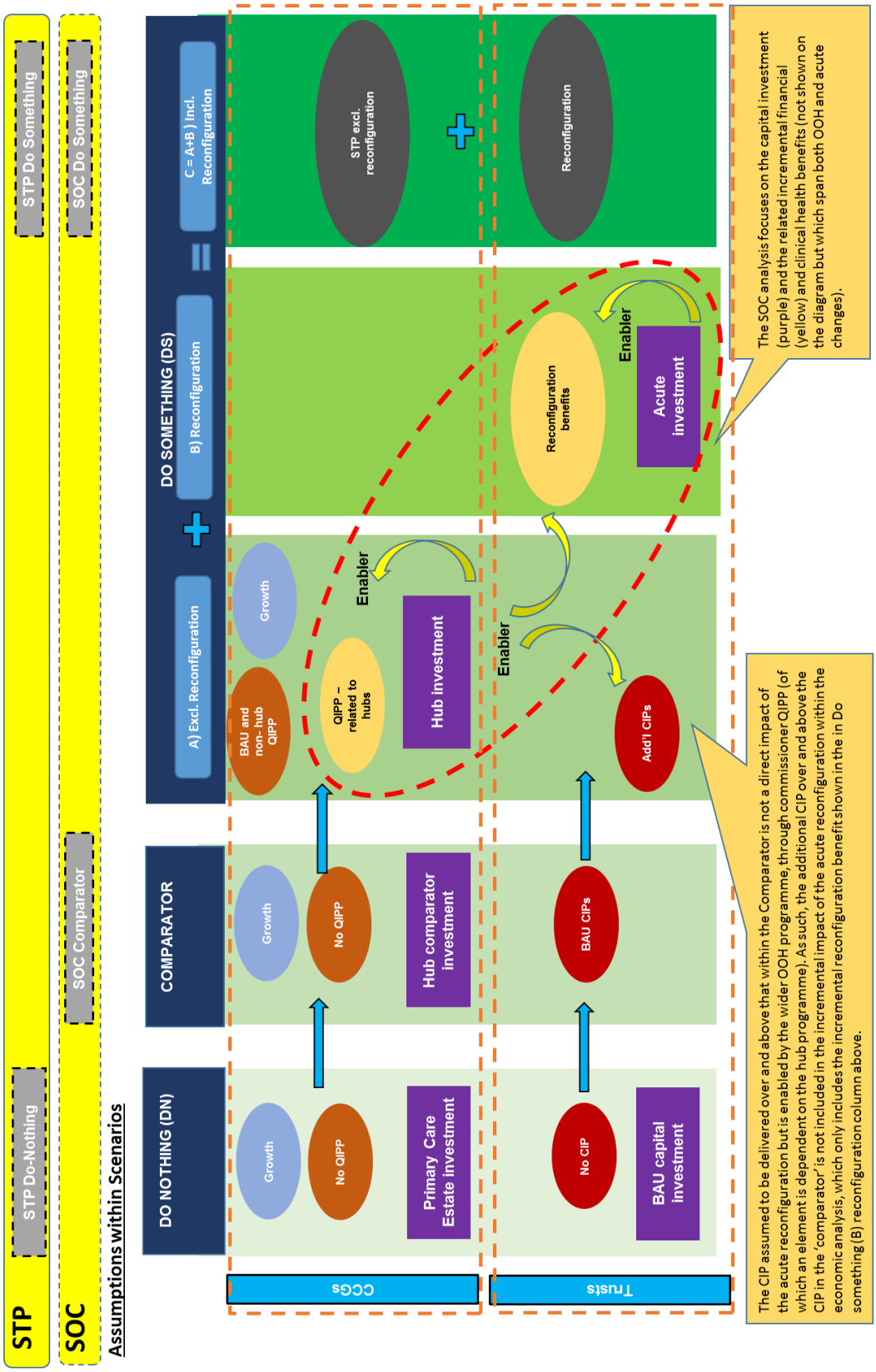
Comparator

- Business as usual ("BAU") capital only - no strategic capital investment
- No commissioner QIPP delivered and BAU CIPs delivered only
- No acute service reconfiguration

Do Something

- Additional CIP delivered as a result of commissioner QIPP being delivered. For the purposes of the Financial and Economic analysis, only the directly attributable benefits of the capital investment are included within the incremental analysis i.e. the reconfiguration benefit (shown within the red dashed line)
- Strategic capital invested for acute reconfiguration resulting in additional benefits.

Figure 1: Overall approach to financial and economic analysis



Analysis of options

2.1.5 For both the OOH hubs and the acute reconfiguration the capital options appraisal process and the options reviewed are as follows;

a. OOH Hubs

2.1.6 The CCGs are following a consistent approach to identifying and evaluating potential locations for the hubs that is being led by their estate leads and clinical commissioners. Further engagement is planned as proposals are developed to OBC and FBC stages.

2.1.7 CCGs have Strategic Service Development Plans that include an assessment of the need for estate based facilities to support the CCG's out of hospital strategy.

2.1.8 The detailed estate plans for the hubs have been developed working closely with NHS Property Services (NHS PS) and engagement with LIFT Co's where appropriate.

2.1.9 The assumptions in the process are:

- There is one hub per locality unless the activity analysis suggests another approach;
- Existing sites are utilised before building new sites; and
- NHS property is prioritised above other public sector or commercial properties.

2.1.10 A selection process has been developed with NHS Property Services to allow each CCG to short-list suitable hub properties. The stages are:

- The total CCG / borough wide NHS (and available local authority) estate;
- The possible hub estate – any clinical property >500m2 GIFA, with available space; and
- Hub estate options – shortlist of hub estates taking into account size and the evaluation criteria.

2.1.11 To be considered as a hub the properties must first meet specified threshold criteria,

- Population size
- Space utilisation flexibility
- Condition of the estate
- Scope for expansion

2.1.12 The preferred options for hub sites are then based on the following prioritisation criteria,

- Fit with OOH strategy
- Affordability and value for money
- Accessibility (public transport, DDA requirement)
- Space utilisation flexibility
- Population size
- Condition of the estate
- Deprivation in local area (higher deprivation areas are favoured)

2.1.13 More detail of the process followed are set out in Appendix H.

b. Acute reconfiguration

2.1.14

2.1.15 Table 1 below shows the acute trust short list options which have been derived directly from trust draft OBCs, where each trust has moved from their long list to their short list. The long list to short list by trust is summarised in Appendix I.

Table 1: Acute Trust short list options

Trust	Site		Option	Description	Option	Benefits Points	Risk adj. EAC £m	Risk adj. EAC per benefit point
THH	THH	1	Option 1 Do nothing	Backlog maintenance only.*	Comparator	290	235	0.8
		2	Option 2 Do minimum	This option entails: Maternity: 2 storey extension; Non-elective theatres: Reschedule sessions between HH and MVH; Non-elective critical care: ITU additional capacity (4 beds) + Drayton Ward bays for HDU use; Non-elective A&E: Increase cubicles by building into courtyard; BLM: Minimum Backlog maintenance; and BLM: Prioritised schedule of works to deliver SaHF.	Preferred Option	600	244	0.4

* Note Trust confirmed that there is zero differential in high and significant backlog maintenance between do nothing and do minimum options.

LNWH	Ealing	1	Do Nothing	This option would see the Trust continue with the 'status quo' and therefore not implement the proposed Local Hospital Model and consequently the requirements of the SaHF programme. Only high and significant risk backlog maintenance is performed of which the differential is reflected in the comparator.	Comparator	490	4,033**	8.2
		2	Refurbishment	This option retains the existing Ealing Hospital podium and tower and modernise the facility to accommodate the proposed activity for the Local Hospital within the lower floors of the tower with the remaining space either mothballed or utilised for other purposes. Various sub options around the scale of refurbishment (from minimal to full) were considered. In all variations, the refurbishment programme would be managed to ensure existing services remain operational through the use of decant and phased refurbishment of the various areas.	Preferred Option	610	1,952**	3.2***
		3	Part Refurbishment / New Build	This option would locate the Local Hospital, at the back of the site, utilizing the existing maternity building along with the surrounding space/ buildings. This option would use and refurbish the shell of the current maternity wing with the surrounding space and buildings around the Maternity wing to be demolished and used for the new build elements of the Local Hospital.		660	2,079**	3.2***
	NPH	1	Do nothing	Only high and significant risk backlog maintenance is performed of which the differential is reflected in the comparator.	Comparator	510	9,934**	19.5
		2	Updated 2016 Do Minimum:	This option would see a new build extension to ITU in order to provide a total of 32 high acuity beds (including HDU) Post reconfiguration NPH will have 42 of the 44 Trust critical care bed capacity (Currently NPH has 29 beds out of 45 Trust wide beds). Subsequently the existing ITU/HDU space would be reconfigured into an additional 12 recovery bays (resulting in a total 24 recovery bays). Pharmacy automation would be implemented so as to support efficient patient discharge and safety, as well as the MRI being relocated in order to support a) the new critical care build and improved imaging access.	Preferred Option	720	8,153**	11.3
		3	Original 2014 Do Minimum:	a new build extension to ITU to provide a total of 28 high acuity beds in total (including HDU). Subsequently reconfigure the existing ITU/HDU space into an additional 12 recovery bays (total 24). Implement pharmacy automation to support efficient discharge and safety. MRI relocation to support imaging access. Implement robotics and phased conversion of space in pharmacy.	-	620	8,097**	13.1
	CMH	1	Do Nothing	Services to remain as currently delivered (as required for the purposes of comparing against the status quo). Only high and significant risk backlog maintenance is performed of which the differential is reflected in the comparator.	Comparator	0	2,173**	4.0
		2	Do minimal	CMH disposal and dispersal of services	-	290	2,785**	9.6
		3	Lower Capital Option	Develop CMH to include the additional activity : a. Development of the Health & Wellbeing Centre (including GP practice) b. Relocation of the Regional Genetics Service from Northwick Park to CMH c. Relocation of Willesden community beds. d. Expansion of existing theatre and supporting recovery capacity	Preferred Option	725	2,040**	2.8
	All LNWH sites	1	Do Nothing	Only high and significant risk backlog maintenance is performed.	Comparator	1000	587	0.4
		2	Preferred Option	Includes: 1. Refurbishment - Ealing 2. Updated 2016 Do Minimum - NPH 3. Lower Capital Option - CMH	Preferred Option	2,055	539	0.3

**For LNWH the risk adjusted EAC and benefits point analysis has not been undertaken on a site by site basis, however the NPC per site is presented by site for reference (based on the figures included within Trust's draft OBCs).

*** The economic case analysis shows that Options 2 and 3 are ranked broadly the same with option 3 (the new build/part refurbishment option) being marginally lower EAC. However, this option has been discounted by the Trust due the capital cost not being affordable for either the Trust or the health economy.

Trust	Site	Option		Description	Option	Benefits Points	Risk adjusted EAC £m	Risk adj. EAC per benefit point
CW	WM	1	Do nothing	Continuing to deliver the existing level of activity and no changes to estates or facilities.	Comparator	72	566	7.9
		2	A - Lowest Cost	ED - ED layout A (lowest cost): This option includes a reconfiguration of the current ED footprint so that it meets all activity requirements and space standards. There will be a total of 25 'majors' adult cubicles and eight paediatric cubicles. - This option includes adding a new resus area that will include an additional four resus cubicles (one of which is paediatric) and an ambulance handover area. It also involved displacement of the existing office space into the new build area in order to expand paediatric space in the department and converting existing adult space into one enlarged ED 'majors' area rather than the current split configuration. This option will include a link from UCC to imaging. Adult Inpatients - Reconfigure to add 72 beds (lowest capital cost): This option was developed to maximise the use of any existing clinical areas. This option involves utilising the existing footprint in East Wing and Marjory Warren. ITU / HDU (critical care) - ITU/HDU + 7 beds (lowest capital cost): Following consultation with clinicians working in critical care and allied healthcare services it was proposed that an additional seven ITU beds were required and space has been identified within the existing footprint to locate the additional beds. Paediatrics - Existing + 5 beds 2. WCU (lowest capital option): Adding 5 additional paediatrics inpatient beds within the current paediatric footprint on the 3rd floor.	Preferred Option	125	590	4.7

2.2 Methodology and definition of Equivalent Annual Cost (EAC)

We have used the Equivalent Annual Cost (EAC) to enable a combined economic assessment to be undertaken across the various capital investment schemes within the SOC. This economic appraisal methodology follows NHS and public sector guidance.

2.2.1 The Net Present Cost (NPC) Generic Economic Model (GEM) is used to measure the overall value of proceeding with the business case to the UK economy, in today's terms over the useful economic life of the assessment period. This is displayed in real terms and discounted in line with Treasury Green Book guidance and demonstrates if the investment will add a definitive projected economic value over the cost of investment, over the assessment period and also provides a measure for intangible unquantifiable benefits – scored under a points based system.

2.2.2 Where a business case comprises capital projects with different asset lifespans, guidance is that the EAC should be used (EAC being the annual cost of owning and using an asset over its useful economic life). EAC is therefore the appropriate measure in this case given the varying lengths of life of both the individual OOH hubs and the acute schemes, thereby allowing aggregation of the components.

2.2.3 The EAC is calculated in accordance with Green Book guidance, for example transfer costs (e.g. VAT) between government entities are excluded as well as any costs of capital or depreciation.

2.3 Assessment of the preferred option and the comparator

The changes in capital and revenue costs of both hub and hospital schemes equates to a £43m benefit (as measured by the EAC), demonstrating value for money

2.3.1 This section of the Economic Case covers both the capital costs and incremental service delivery costs of the SaHF and comparator options for both the OOH hubs and the acute schemes which are then used to assess the overall value between options.

Out of Hospital (see 2.3.5)

2.3.2 The EAC has been calculated for each individual hub (using the individual economic life of each hub) and then consolidated to produce an overall OOH EAC.

Acute (see 2.3.26)

2.3.3 The Useful Economic Life ("UEL") for each trust is based on the weighted average economic life of capital expenditure split between refurbishment and new build. The EAC has been calculated by individual trust (using the individual weighted average economic life of capital expenditure) and then consolidated to an overall acute EAC.

Overall (see 2.3.34)

2.3.4 The EAC of the OOH and acute schemes are then combined to get an overall EAC for the total investment.

OOH costs

a. OOH Capital

2.3.5 Table 2 below summarises the capital cost for the proposed OOH hubs of £148m.This table also includes the capital expenditure under the comparator for each hub.

2.3.6 The table below includes the proposed 18 hubs for which there is capital investment required. In addition there are four hubs already in existence which do not require capital. There are also two included within the outer NW London hospitals (Ealing and CMH), two within inner NWL hospitals (St Mary's and Charing Cross) and there is a further hub under review (West Middlesex), making 27 in total.

Table 2: Gross capital costs for the all hubs

CCG	Hub	Estimated capital cost incl VAT & inflation £m's	Comparator Capital £'m
Brent	Wembley Centre for Health and	2	0
Brent	Willesden Centre for Health and	4	0
Ealing	Ealing East	21	1
Ealing	Ealing North	15	1
Harrow	Alexandra Avenue	3	0
Harrow	NE Harrow	15	1
Harrow	The Pinn	1	0
Hillingdon	North Hillingdon	6	-
Hillingdon	Uxbridge and West Drayton	11	1
Hounslow	Chiswick	1	0
Hounslow	Heart of Hounslow	2	-
Hounslow	Heston	16	0
Hounslow	Brentford/West Middlesex	10	1
Central London	Church Street	15	1
Central London	Central Westminster	5	0
West London	Violet Melchett	13	1
West London	St Charles	4	0
Hammersmith and Fulham	Parsons Green	5	0
Total		**148**	**8**
Disposal (Note 1)		**(7)**	-
Net capital		**141**	**8**

Note 1. Disposals of £7m relate to the following locations - North Hillingdon (£3m), Ealing East (£2m), Church Street (£1.3m), Ealing North (£0.9m) and Harrow (£0.2m). These properties are currently owned by LNWH, CLCH and NHS Property Services.

2.3.7 The comparator capital expenditure is based on the estimated cost of adding additional capacity to meet the need arising from population growth and to comply with standards or the suitability for the functions carried out within these practices which are to be transferred into the new hubs. In the absence of building cost estimates the cost of the hubs has been used as the basis of calculating the cost of creating new capacity.

2.3.8 The approach to estimating the capital cost of the hubs is based on build type, area (m2) requirement and timing. For the majority of schemes, a build rate per m2 has been used, with the addition of on-costs, professional fees and project and equipment costs using benchmark percentages. In one specific case (Violet Melchett) costs from a local authority arm's length management organisation and its developer have been used. Costs have then been uplifted to take account of:

- Contingency at 15% and optimism bias at 25% which have been included as standard;
- Capital expenditure inflation based on the PUBSEC (Tender Price Index of Public Sector Building Non Housing published in December 2015). Capital inflation of 4% per annum is assumed for periods after 2017 to the anticipated start of construction; and
- VAT.

2.3.9 The capital cost rate and allowances used to cost the proposed hubs as above have been cross-checked against the actual cost of developing hubs to date. This approach takes into account:

- Build type (i.e. new build or refurbishment);
- Area (m^2);
- Inclusions and exclusions; e.g. Local Improvement Finance Trust (LIFT) construction costs do not include client project costs or loose furniture, fixtures and equipment; and
- Indexation adjustments, so that all costs are stated at the same price base.

b. OOH revenue costs - recurrent premises costs

2.3.10 Key assumptions used in developing the premises costs of the options include:

- Equipment lifecycle costs included in capital costs assuming replacement on a 10-year cycle,
- Comparator recurrent premises costs use average rent and rates reimbursement per patient on the list for each CCG multiplied by base year list size in the hub,
- Recurrent premises costs for the all hubs option reflects the increased rent chargeable by landlords to cover the refurbishment and/or increase in the space being occupied,
- The capital costs to the landlord arising from the investment are assumed to be passed onto the CCG tenant where the anticipated rental increase is less than the expected increase in rent,
- Market rents for non-NHS PS premises, guided by District Valuer Service advice, or other sources as applicable,
- Shadow unitary charge modelling used to estimate LIFT unitary charge for new schemes and variations or other sources as applicable,
- Benchmark rates for soft and hard facilities management and lifecycle maintenance, and
- Costs of space required to provide outpatient attendances are included in the property costs and are not recharged directly to new providers.

2.3.11 The cost of the above are summarised in the table below showing the projected ongoing revenue cost in the comparator and hub scenarios.

Table 3: Recurrent Premises Costs

(£000)	Property costs		
	Comparator	**Hubs**	**Change**
Brent	306	824	518
Harrow	510	1,902	1,392
Hillingdon	300	1,554	1,254
Central	302	1,859	1,557
West	815	2,492	1,677
H&F	72	433	361
Hounslow	399	2,432	2,032
Ealing	441	2,978	2,536
	3,145	14,473	11,328

2.3.12 As shown in the table above this results in a projected £11.3m increase in the OOH hub revenue costs.

c. OOH revenue costs - clinical service costs

2.3.13 The proposed hubs are planned to enable the CCGs to move activity from acute hospitals both by ensuring that patient needs can be met without involving hospital based services (both unscheduled care and planned care) or if an inpatient stay is involved then ensuring that the stay is as short as possible. The clinical service costs include all services within the hub, which include mental health, outpatient costs, primary care and other services.

2.3.14 Financial benefits to commissioners are expected for both unscheduled care (reduction in non-elective admissions) and planned care (reduction in volume and cost of outpatient activity). Other costs are assumed to be unchanged between the comparator and the Hubs.

c (i) Unscheduled care

2.3.15 As set out in the Strategic Case, the model of care of integrated primary and out of hospital care accelerates the momentum of primary care at scale through a hub and spoke model of delivery, providing both population and system sustainability benefits.

2.3.16 This model of care is a key driver of the reduction in non-elective admissions and the hubs play a key role in enabling the model of care to be implemented effectively.

2.3.17 The CCG's have identified the key drivers of non-elective admission reduction as;

- Reducing unwarranted variation in primary care
- Consistent team-based models of care
- Long-term care planning and case management
- Seven day extended access to primary care
- Rapid response services.

2.3.18 The modelling of the values attributable to the proposed hubs is based on the following:

- The hub share of CCG QIPP reflecting the population coverage of each hub
- Hubs enabling QIPP from the first year that they are operational
- Based on a CCG based analysis of the key drivers above, the hubs are expected to enable a proportion of the non-elective admission reduction once they are open.

- Once all hubs are operational an incremental annual saving of £44.7m is therefore forecast

2.3.19 Overall planned activity changes are shown within the Financial case (table 12 and table 13), which show both growth and admission avoidance projections. Table 4 below shows the total CCG activity reduction forecasts (as per the Financial case) for non-elective, and the element that is attributable to the hub investment, which represents 22% of the total non-elective overall reduction.

Table 4: NEL admissions avoided attributable to hubs

HUB NEL activity saving	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total activity (spells) - admissions avoided	**10,441**	**26,565**	**41,279**	**56,140**	**67,465**	**73,738**	**80,038**	**86,366**	**92,721**	**99,106**
Of which hub enabled - cumulative	0	631	3,171	6,450	10,948	13,292	15,645	17,804	20,067	22,378
Hub NEL activity (spells)										
-in year	0	631	2,540	3,279	4,498	2,344	2,353	2,159	2,263	2,311
- cumulative	**0**	**631**	**3,171**	**6,450**	**10,948**	**13,292**	**15,645**	**17,804**	**20,067**	**22,378**
Weighted average NEL tariff (£'000)	**n/a**	**2.3**	**2.1**	**2.1**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Hub enabled NEL admisions avoided saving (£'000)										
In year	0	(1,454)	(5,453)	(6,810)	(9,212)	(4,761)	(4,751)	(4,340)	(4,533)	(4,615)
Cumulative	**0**	**(1,454)**	**(6,808)**	**(13,397)**	**(22,422)**	**(26,996)**	**(31,587)**	**(35,786)**	**(40,194)**	**(44,689)**

c (ii) *Planned care*

2.3.20 For planned care a reduction in the number of outpatient attendances in acute settings is projected. Of the reduction we expect some attendances will not be needed due to more efficient pathways, some will be replaced by digital solutions and by other forms of care, e.g. better care planning and co-ordination that reduces the demand for outpatient appointments. For some attendances, care pathways are expected to involve care provided by healthcare practitioners other than a hospital consultant-led approach as currently practised. A proportion of this activity will be delivered through the out of hospital hubs.

2.3.21 The new pathways will be based on a new clinical skill mix and therefore a reduction in tariff of 20% is projected, based on experience elsewhere. Based on the average tariffs this equates to a saving of £24 per attendance.

2.3.22 Once all the proposed hubs are operational, a cost saving of £4.8m per annum in outpatient attendances is projected. The hubs provide capacity for c198k outpatients out of the overall reduction of c1m. Overall activity changes including both growth and this reduction are shown in the financial case (table 12 and 13).

Outpatient activity analysis

Table 5 – Outpatients savings attributable to Hubs

Hub OP activity saving	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total OP QIPP activity (attendances) - cumulative	**132,774**	**324,127**	**473,306**	**617,751**	**721,154**	**779,837**	**838,928**	**900,015**	**961,581**	**1,022,037**
Ceased / alternative (see note 1) - cumulative	(49,790)	(121,548)	(177,490)	(231,657)	(270,433)	(292,439)	(314,598)	(337,506)	(360,593)	(383,264)
Re-provision (see note 2) - cumulative	**82,984**	**202,579**	**295,816**	**386,095**	**450,722**	**487,398**	**524,330**	**562,509**	**600,988**	**638,773**
Of which hub capacity (see note 3) - cumulative	0	20,127	68,509	122,291	168,939	191,439	191,439	198,246	198,246	198,246
Hub OP activity - £000s										
Hub activity										
- in year	0	20,127	48,382	53,782	46,648	22,500	0	6,807	0	0
- cumulative	**0**	**20,127**	**68,509**	**122,291**	**168,939**	**191,439**	**191,439**	**198,246**	**198,246**	**198,246**
Tariff saving per attendance (£)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)
Hub enabled attendences avoided (£'000)										
In year	0	(483)	(1,161)	(1,291)	(1,120)	(540)	0	(163)	0	0
Cumulative	**0**	**(483)**	**(1,644)**	**(2,935)**	**(4,055)**	**(4,595)**	**(4,595)**	**(4,758)**	**(4,758)**	**(4,758)**

Notes:

1. *37% of the QIPP reduction in Outpatient activity that will either be avoided or delivered via alternative clinical pathways.*
2. *63% of QIPP the reduction in Outpatient activity is to be re-provided either in hubs or by alternative locations.*
3. *Activity to be undertaken in hubs as they become operational*

d. OOH Equivalent Annual Cost (EAC) analysis

2.3.23 The costs are calculated over the life of each scheme and include (as noted above):

a. Capital costs over the period of the scheme;

b. Increase in recurrent premises costs; and

c. Reduction in clinical service costs.

2.3.24 There is a favourable EAC cost variance of £29m per annum. A summary of the costs and quantified benefits of each option, in EAC terms, is shown in Table 6.

Table 6: EAC cost analysis of comparator and all hubs options (risk adjusted)

Cost type (see note 1 to 5)	Comparator	All hubs £'m	Difference to Comparator £'m
Capital	1	5	4
Recurrent premises costs	2	6	4
Sub-total before clinical service costs	**3**	**11**	**8**
Clinical services - outpatients (see note 4)	91	87	(4)
Non Elective savings attributable to OOH hubs (see note 3)	-	(33)	(33)
Total (see note 4)	93	65	(29)

Notes:

1. The risk associated with the implementation and subsequent operation of the OOH hubs have been assessed and mitigating actions identified. These have been quantified at Programme level with the risk adjusted within the EAC values above.
2. The values in the table are derived from the Generic Economic Models ("GEMs") developed to analyse the options.
3. The saving in non-elective admissions attributed to the hubs as described above (in EAC terms).
4. Clinical services fully costed in each option (including primary care, mental health, outpatients and other services): the cost analysis includes the benefits attributable to the hubs from a reduction in cost of outpatients.
5. Transition costs of £0.3m (on an EAC basis) have been included within the EAC calculation above (under the 'All hubs' option). More detail of the transitional costs are within the Financial case, section 3.6.3.

2.3.25 The detailed EAC analysis by hub is presented in the following Table 7.

Table 7: EAC of Comparator and All hubs options

Hub	OOH hubs - UEL (years)	OOH EAC £'m	Comparator EAC £'m	Variance EAC £'m
Wembley Centre for Health and Care	27	2	6	(4)
Willesden Centre for Health and Care	28	4	4	(0)
Ealing East	28	7	9	(2)
Ealing North	29	3	5	(2)
Alexandra Avenue	15	3	5	(2)
NE Locality Belmont/Kenmore	44	5	5	(0)
The Pinn	29	2	5	(3)
North Hillingdon	29	0	1	(1)
Uxbridge and West Drayton	29	3	4	(1)
Chiswick	28	3	5	(1)
Heart of Hounslow	15	7	9	(2)
Heston	28	4	5	(1)
Brentford/West Middlesex	30	4	6	(2)
Church Street	64	5	6	(1)
Central Westminster	28	1	3	(3)
Violet Melchett	28	6	7	(1)
St Charles	28	5	9	(3)
Hammersmith & Fulham	30	(0)	1	(1)
Total		**65**	**93**	**(29)**

Acute reconfiguration costs

2.3.26 Trust costs have been based on the costs calculated using a Generic Economic Model ("GEM") analysis for each individual trust. These are based on the Net Present Cost ("NPC") over the useful economic life ("UEL") of the trust's proposed capital assets (therefore specific to each trust). The NPC has been converted into an EAC for comparability between trusts to allow aggregation at programme level with the OOH hubs.

2.3.27 The UEL for each trust is based on the weighted average economic life of capital expenditure split between refurbishment and new build. As such it is assumed that refurbishment has a 25 year UEL beyond the eight year build period and new build has a 60 year UEL beyond the eight year build period. Each trust's weighted average UEL is show in the table below.

Table 8: UEL by organisation

	UEL years
Chelsea and Westminster (CWWM)	45
London North West Healthcare (LNWH)	44
Hillingon Hospital (THH)	41
Weighted average	**44**

2.3.28 Each trust has adjusted their estimated costs to account for quantifiable risks associated with each option based on a costed risk matrix.

2.3.29 The acute risk adjustments are based on trust risk registers which are assessed on the basis of a five by five matrix for likelihood of the risk occurring and impact of the risk.

2.3.30 Each trust has adjusted the costs to comply with the Green Book guidance. This includes adjusting for transfer payments (e.g. VAT, stamp duty land tax and rates).

2.3.31 Each trust has built up the associated costs as follows;

a. Acute capital costs

- These have been built up through projecting current activity levels to end state (including the reconfiguration) as set out in financial case, section 3.4.19.
- The activity baseline has been converted by trusts into a bed / capacity requirement which cost advisers have converted into OB1 capital requirement including necessary planning contingency and optimisation bias and Pubsec index inflation to construction date.
- There is £0.6bn of capital spend within the outer NWL acute trusts under the 'Business as Usual' capital (as defined by the STP), which would occur under the Acute reconfiguration option as well and therefore has not been included within the analysis as incremental. The capital included in the comparator is £3m on backlog maintenance at LNWH which would be avoided under the do something scenario.

b. Acute revenue / service costs

- Costs have been built up on the same activity baseline as the capital costs, and including programme agreed assumptions (see appendix K).
- The comparator, as defined in section 2.1, is based on a scenario under which reconfiguration does not occur so that the incremental differential is the reconfiguration only.

c. Acute reconfiguration EAC

2.3.32 The resulting incremental EAC of the proposed reconfiguration compared to non-reconfiguration is shown in Table 9.

Table 9: EAC of trust options (post risk adjustment)

£m	EAC		
	Post Risk Comparator EAC	Post Risk SaHF EAC	Incremental EAC
CWWM	566	590	24
THH	235	244	9
LNWHT	587	539	(48)
Total Acute EAC	**1,387**	**1,373**	**(15)**

Notes:

1. Transition costs of £1.6m (on an EAC basis) have been included within the EAC calculation above for the SaHF option. More detail of the transitional costs are within the Financial case, section 3.6.5.

2.3.33 There is a favourable EAC benefit of £15m for the acute reconfiguration. Both CW and THH have a positive EAC variance reflecting an increase in costs from the receiving activity (£24m and £9m respectively) which is more than offset by the cost reductions at LNWH following the reconfiguration (£48m).

Combined OOH hubs and acute reconfiguration EAC

2.3.34 The table below provides a summary of the EAC by acute trust and OOH hubs.

Table 10: Combined EAC of acute and hub options

£m	EAC		
	Comparator EAC	SaHF EAC	Annual Impact EAC
CWWM	566	590	24
THH	235	244	9
LNWHT	587	539	(48)
Total Outer Acute	**1,387**	**1,373**	**(15)**
Total Hubs	**93**	**65**	**(29)**
Total NWL	**1,481**	**1,438**	**(43)**

2.3.35 There is an overall, favourable EAC variance of £43m across the outer acute trusts and hubs split as follows;

- **Acute trusts** The EAC of the net cash releasing benefit is £15m which includes the EAC capital cost of £9m providing a gross cash releasing benefit of £24m. This results in an absolute value for money ratio based on the EAC of 2.67:1.
- **Hubs** The EAC of the net cash releasing benefits for the Hubs is £29m which includes the EAC capital cost of £4m providing a cash releasing benefit of £33m. This results in an absolute value for money ratio based on the EAC of 6.6:1.

2.4 Wider Economic and Health Benefits

The capital investment is calculated to provide wider economic benefits of £44m (in EAC terms). The capital investment is projected to result in health benefits equivalent to 334 lives saved per year in SOC1, equivalent to £94m (in EAC terms), using the Quality Adjusted Life Year approach used by the NHS to calculate health benefits.

Wider economic benefits

2.4.1 The wider quantifiable benefits are based on information contained within L.E.K Construction in the UK Economy, October 2009, and updated May 2012.

2.4.2 The quantifiable benefits are as follows:

- £1 spent on construction output generates a total of £2.84 in total economic activity (i.e. Gross Domestic Product increase), and
- In addition to the economic benefits, every £1 invested in construction provides financial returns to the Treasury in tax income and benefit savings totalling £0.56.

2.4.3 There is, therefore, a quantifiable benefit of £3.40 per £1 spent on construction output.

a. OOH Hubs – wider economic benefit

2.4.4 The total value of these benefits on the OOH hubs construction has been estimated based on the proposed capital investment, as shown in Table 11 (on an EAC basis).

Table 11: Wider economic benefits - out-of-hospital options (EAC)

	Comparator £'m	All hubs £'m	Incremental £'m
Wider Economic Benefits Total	1	17	(15)

2.4.5 The total incremental value of wider economic benefits on the proposed hub capital is £15.4m in EAC terms.

b. Acute reconfiguration - wider economic benefits

2.4.6 The wider economic benefits has been estimated based on the proposed capital investment, as shown in Table 12 (on an EAC basis).

Table 12: Wider economic benefits – Trusts (EAC)

	Comparator £'m	Acute reoconfig £'m	Incremental £'m
Wider Economic Benefits Total	-	29	(29)

Note: There is £0.6bn of capital spend within the outer acute trusts under the comparator, which would occur under the Acute reconfiguration option as well and therefore has not been included within the analysis. The only differential would be a £3m saving on backlog maintenance at LNWH which is immaterial in EAC terms.

2.4.7 The total of the wider economic benefits of the acute reconfiguration is £29m. The total of the wider economic benefits across the OOH hubs and the acute reconfiguration is £44m.

Health benefits (Acute reconfiguration and OOH hubs)

2.4.8 The capital investment is projected to result in health benefits equivalent to 334 lives saved per year in SOC1, equivalent to £94m (in EAC terms), using the Quality Adjusted Life Year approach used by the NHS to calculate health benefits.

2.4.9 This section provides an overview of the health benefits, which consists of additional health benefits from delivering improved standards of care. This includes an analysis of specific clinical areas of opportunity.

a. Identified benefits

2.4.10 By delivering care in the most appropriate setting, OOH services are an enabler to the health benefits of the reconfiguration programme.

2.4.11 The health benefits of the OOH capital investment have therefore been appraised together with the acute reconfiguration.

2.4.12 The reconfiguration of services will make a significant contribution to improving the consistency, quality and continuity of care, and thereby to reducing avoidable mortality. The health benefits of the proposed reconfiguration can be attributed to the following key themes:

- Seven day working;
- Larger clinical teams;
- Separation of elective and non-elective surgical care; and
- Better integration of services, including improved Long Term Condition management.

2.4.13 While clinical outcomes are multifactorial, it is anticipated that the cumulative impact of the changes will make a significant contribution to improving health outcomes across outer NW London, bringing mortality outcomes in line with upper decile across a range of specialties, diagnoses and procedures.

b. Clinical areas of opportunity

2.4.14 Specific clinical areas of opportunity have been identified, through the literature review and clinician input, where the cumulative impact of the health benefits of the proposals will make a significant contribution to improving outcomes. These are:

Septicaemia

2.4.15 The development of Major Hospitals, with larger clinical teams providing high-quality consultant-led care seven days a week will enable rapid review and recognition of at-risk patients.

Pneumonia

2.4.16 The development of Major Hospitals, with larger clinical teams providing high-quality consultant-led care seven days a week, will improve pneumonia management.

COPD

2.4.17 The development of Major Hospitals, with larger clinical teams providing high-quality consultant-led care 7 days a week, will improve and COPD management, including timely diagnostic and pharmaceutical input.

Acute kidney injury (AKI)

2.4.18 The development of Major Hospitals, with larger clinical teams providing high-quality consultant-led care seven days a week, will improve early detection of AKI, improving outcomes.

Emergency Surgery operations (emergency laparotomy)

2.4.19 The development of Major Hospitals, with larger clinical teams providing consultant-led care seven days a week, with consistently reliable access to interventional radiology and emergency surgery, as well as greater separation of elective and emergency surgical pathways, will improve outcomes in emergency surgery, including laparotomy.

Fracture of the neck of femur (NOF)

2.4.20 The increased separation of elective and emergency care, increased procedure volumes, and larger clinical teams providing high-quality consultant-led care seven days a week, will improve outcomes for NOF.

Long-term condition management, including diabetes complications

2.4.21 Local hospitals will improve the management of patients with LTCs, including diabetes (high prevalence in NW London) which in turn will reduce avoidable mortality from the complications of diabetes.

Quantification and monetisation of health benefits

2.4.22 These clinical areas are expected to be most amenable to reductions in avoidable mortality.

2.4.23 Analysis of mortality rates in NW London has been undertaken based on the day of hospital admission (i.e. comparing weekend and weekday emergency admissions). Enabling seven day working will reduce mortality for patients admitted to hospital on the weekends, bringing these mortality rates closer in line with those of patients admitted to hospital on a weekday.

2.4.24 Table 13 shows the estimated number of lives which would be saved each year across outer NW London as a result of SaHF. The table also shows the resulting benefit in Quality Adjusted Life Years (QALYs) and the corresponding financial value over the entire appraisal period (over 44 years, using the average project life within the acute reconfiguration investment). These are the incremental benefits above the comparator option.

Table 13: Quantification and monetisation of health benefits (SOC1 only)

1. Clincial Area	2. Lives saved per year	3. QALY - NPV of future life years (discounted and quality-adjusted) per person	4. QALYs per year	5. Monetary value of QALYs per year £m's	6. Discounted value of QALYs over lifetime of health benefit realisation £m's	EAC £m's
Septicaemia	41	6.7	274	16	393	12
Acute Kidney injury	3	5.4	16	1	24	1
COPD	23	6.9	160	10	228	7
Pneumonia	137	5.4	744	45	1081	33
Fracture neck of femur	26	6.9	181	11	258	8
Emergency surgery	5	6.7	33	2	48	1
Diabetes with complications	5	8.9	44	3	61	2
Weekend admissions	94	7.1	666	40	953	29
Total	**334**		**2,118**	**127**	**3,045**	**94**

2.4.25 The health benefits EAC are £94m over the average UEL of 44 years.

2.5 Non-quantifiable benefits

There are further benefits of the capital investment such as the quality of the patient environment and quality of care able to be provided. These are non-quantifiable and so have not been costed in the value for money analysis.

2.5.1 The non-quantifiable benefits assessed for the hub programme and for the acute investments are set out in Appendix J.

2.6 The overall economic appraisal and value for money assessment

The economic appraisal and value for money assessment demonstrates an overall benefit (in EAC terms) of the investment of £181m. The investment offers a positive return of 5 times the capital invested based on EAC excluding wider economic benefits and health benefits, and 16 times the capital invested based on EAC including wider economic benefits and health benefits

2.6.1 The EAC analysis bringing together the component elements described above in sections 2.3 to 2.5 are summarised below.

Table 14: Summary of costs and quantified benefits

£m	EAC			
	Comparator EAC	SaHF EAC	Annual Impact EAC	Source
CWWM	566	590	24	2.3.26: Acute Reconfiguration
THH	235	244	9	2.3.26: Acute Reconfiguration
LNWHT	587	539	(48)	2.3.26: Acute Reconfiguration
Total Outer Acute	**1,387**	**1,373**	**(15)**	**2.3.26: Acute Reconfiguration**
Total Hubs	**93**	**65**	**(29)**	2.3.5: OOH hubs
Total NWL	**1,481**	**1,438**	**(43)**	
1. Wider economic benefits Acute		(29)	(29)	2.4.6 Wider economic benefits
2. Wider economic benfits Hubs	(1)	(17)	(15)	2.4.4 Wider economic benefits
3. Health benefits		(94)	(94)	2.4.25 Wider economic benefits
Grand total	**1,480**	**1,298**	**(181)**	

2.6.2 This analysis shows that the combined proposed OOH and acute reconfiguration delivers an equivalent annual benefit of £181m.

2.6.3 Table 15 shows a summary of the incremental economic benefit (the incremental programme level EAC benefit, as shown in Table 14 above), along with the associated capital investment to calculate the ratio of economic benefits to capital costs for i) EAC, excluding wider economic and health benefits and ii) EAC including wider economic and health benefits.

Table 15: Ratio of EAC to capital investment

	Annual impact excluding wider economic and health benefits	Annual impact including wider economic and health benefits
Grand total EAC - annual impact	(43)	(181)
Incremental capital	12	12
Ratio of return on capital*	**5**	**16**

*EAC less EAC of capital to show return, divided by Capital to calculate the ratio

2.6.4 The investment offers a positive return of 5 times the capital invested based on EAC excluding wider economic benefits and health benefits, and 16 times the capital invested based on EAC including wider economic benefits and health benefits.

2.7 Sensitivity analysis

We have demonstrated that the case represents value for money under a range of scenarios by conducting sensitivity analyses.

2.7.1 To review whether the results are sensitive to the inputs into the Generic Economic model (which drives the EAC), we have carried out sensitivity tests on the outcomes in 2 stages.

- OOH and Acute - without the wider economic benefits and health benefits
- Overall Programme level - with and without the wider economic benefits and health benefits

Out of hospital

2.7.2 The sensitivity of the economic appraisal for the OOH has been tested as follows with the results shown in Table 16 below.

2.7.3 The EAC for the OOH hubs has been tested by modelling changes to the key drivers of the EAC:

- **Capital costs increase by 30%**
  This could reflect higher material costs, higher capital inflation, the impact of a delay in the construction timetable
- **Premises costs increase by 20%**
  Higher rent charged by landlords, including unitary payments for LIFT scheme, to reflect investment in the facilities and the NHS taking greater capacity
- **Outpatient savings attributable to OOH hubs reduce by 10%**
  This would be caused by not being able to reduce the tariff by 20%
- **Non-elective savings attributable to OOH hubs reduce by 20%**
  This would be caused by the hub having less of an impact on non-elective admissions avoided

Table 16: OOH sensitivities

Change in EAC (£m)		Total
EAC benefit (OOH)		(29)
Capital costs increase	30%	1
Premises costs increase	20%	1
Outpatient saving reduction	10%	0.4
Non-elective savings reduction	20%	7
Combined total		(18)

Conclusion

2.7.4 The business case is shown to be robust in the face of the combined change in assumptions tested above.

2.7.5 The non-elective admissions avoided are the most sensitive value and would need to reduce by 88% to turn the EAC positive.

Acute reconfiguration

Individual trust sensitivities

2.7.6 A number of sensitivities have been run through the GEMs/NPC analysis to calculate the impact to the EAC. These are individually listed in the table below.

Table 17: Individual trust sensitivities

GEM sensitivities				
£'m	CWH	LNWHT	THH	Total
Comparator EAC	566.0	586.5	235.0	1,387.5
SaHF EAC	589.6	538.9	244.2	1,372.7
EAC (incremental)	**23.7**	**(47.7)**	**9.2**	**(14.8)**
Capital 30% higher	0.3	1.8	0.7	2.8
Reconfiguration Benefit - 20% lower	(4.3)	12.1	(1.4)	6.5
Total	**19.7**	**(33.8)**	**8.5**	**(5.5)**

2.7.7 The analysis demonstrates that the business case has a sensitised incremental EAC of £5.5m if both of the above sensitivities were to happen concurrently.

2.7.8 In addition, a switching point has been calculated on the reconfiguration benefit. The financial benefit of the reconfiguration is c£50m pa, which in EAC terms is c£29m (with the capital, lifecycle and transition costs c£14m EAC, resulting in the net EAC benefit shown of £15m). The reconfiguration benefit this would need to reduce by c50% to switch the positive EAC.

Combined out of hospital and acute sensitivities

2.7.9 The programme-wide analysis has been undertaken on the risk adjusted EAC for both the comparator and the SaHF both 'with' and 'without' the wider economic and health benefits.

2.7.10 Table 18 below shows the following impacts on the EAC, including the wider economic benefits and health benefits:

- Testing the sensitivity of the option ranking (based on programme level EAC) to changes in the main cost and savings drivers; and
- Testing the impact of reduced health benefits

2.7.11 The sensitivity of the EAC of each option to changes in a number of cost drivers has been tested:

- 20% lower reconfiguration savings
- Increase in capital costs of 30%;
- Increase in lifecycle costs of 30%; and
- Reduce Health benefits by 10%.

2.7.12 A further scenario was run combining 20% lower reconfiguration savings and Increase in lifecycle costs of 30%

Table 18: Programme level sensitivities (With Wider Economic Benefits and Health Benefits)

Programme level sensitivities		Comparator	SaHF
Programme Wide EAC (with wider economic benefits and health benefits)		1,480	1,298
	Rank	2	1
Acute reconfiguration savings 20% lower		1,480	1,304
	Rank	2	1
Increase Capital Costs by 30%		1,480	1,303
	Rank	2	1
Increase Lifecycle Costs by 30%		1,480	1,300
	Rank	2	1
Reduce Health benefits by 10%		1,480	1,308
	Rank	2	1
Acute reconfiguration savings 20% lower and lifecycle costs increased by 30%		1,480	1,305
	Rank	2	1

2.7.13 Under all of the sensitivity cases tested the SaHF option continues to have the lowest Programme level EAC.

Switching analysis

2.7.14 Switching analysis has been conducted on the following input variables to determine the scale of change required to change the choice of the preferred option based on the EAC:

- Capital costs; and
- Lifecycle costs; and
- Acute reconfiguration savings.

2.7.15 Table 19 shows the impact on both the comparator and SaHF.

Table 19: Switching analysis base case

Programme level Switching Analysis	Comparator	SaHF
Programme Wide EAC	1,480	1,298
Capital Costs starting point SaHF Option		10
Switching Point Needed		192
% movement		1838.6%
Lifecycle Costs starting point		5
Switching Point Needed		187
% movement		4043.4%
Acute Reconfiguration Savings		(29)
Switching Point Needed		181
% movement		-716.5%

2.7.16 The switching analysis shows significant robustness to changes in capital costs, lifecycle costs and acute reconfiguration savings prior to the comparator scenario becoming the preferable option.

2.7.17 The sensitivity analysis has been run, excluding the wider economic benefits and health benefits as set out in table 20 below.

Table 20: Programme level sensitivities (Without Wider Economic Benefits and Health Benefits)

Programme level sensitivities (without Health and Wider economic benefits)	Comparator	SaHF
Programme Wide EAC	1,481	1,438
Rank	2	1
Acute reconfiguration savings 20% lower	1,481	1,444
Rank	2	1
Increase Capital Costs by 30%	1,481	1,442
Rank	2	1
Increase Lifecycle Costs by 30%	1,481	1,439
Rank	2	1
Acute reconfiguration savings 20% lower and lifecycle costs increased by 30%	1,481	1,445
Rank	2	1

2.7.18 Under all of the sensitivity cases tested the SaHF Option continues to have the lowest Programme level EAC.

Switching analysis

2.7.19 Switching analysis has been conducted on the following input variables to determine the scale of change required to change the choice of the preferred option based on the EAC:

- Capital costs; and
- Lifecycle costs; and
- Acute reconfiguration savings.

2.7.20 Table 21 shows the impact on both the comparator and SaHF.

Table 21: Switching analysis base case

Programme level Switching Analysis (without Health and Wider economic benefits)	Comparator	SaHF
Programme Wide EAC	1,481	1,438
Capital Costs starting point SaHF Option		10
Switching Point Needed		54
% movement		440.2%
Lifecycle Costs starting point		5
Switching Point Needed		48
% movement		968.2%
Acute Reconfiguration Savings		(29)
Switching Point Needed		43
% movement		-246.5%

2.7.21 The switching analysis shows significant robustness to changes in capital costs, lifecycle costs and acute reconfiguration savings prior to the comparator scenario becoming the preferable option.

2.8 Conclusions

2.8.1 We have compared the additional costs and benefits of the proposed capital investment against a scenario without investment to test whether the proposed capital investment provides value for money.

2.8.2 We have used the 'Equivalent Annual Cost' (EAC) to enable a combined economic assessment to be undertaken across the various capital investment schemes within the SOC. This economic appraisal methodology follows NHS and public sector guidance.

2.8.3 The changes in capital and revenue costs of both hub and hospital schemes equates to a £43m benefit (as measured by the EAC), demonstrating value for money.

2.8.4 The capital investment is calculated to provide wider economic benefits of £44m (in EAC terms).

2.8.5 The capital investment is projected to result in health benefits equivalent to 334 lives saved per year, equivalent to £94m (in EAC terms), using the Quality Adjusted Life Year approach used by the NHS to calculate health benefits.

2.8.6 There are further benefits of the capital investment such as the quality of the patient environment and quality of care able to be provided. These are non-quantifiable and so have not been costed in the value for money analysis.

2.8.7 The economic appraisal and value for money assessment demonstrates an overall benefit (in EAC terms) of the investment of £181m. The investment offers a positive return of 5 times the capital invested based on EAC excluding wider economic benefits and health benefits, and 16 times the capital invested based on EAC including wider economic benefits and health benefits.

2.8.8 We have demonstrated that the case represents value for money under a range of scenarios by conducting sensitivity analyses.

Chapter 3

Financial Case

The Financial Case assesses the affordability of the proposed capital investment to CCGs and trusts. It sets out proposed funding routes for the capital investment and for transition costs that are affordable.

1. We have analysed the capital investment requirement by year and assumed funding source (on the basis of loan funding and on the traditional timetable) showing the required funding by CSR period and source, and later (see point 8 below) explored an alternative affordable funding option and an accelerated timetable.
2. A sustainable financial position for North West London CCGs is demonstrated through 10 year financial projections.
3. Within the CCG projections the affordability of the hub capital investment to the CCGs is demonstrated
4. Under the 'comparator' all trusts will be in financial deficit, with a combined deficit of £114m at 24/25, which would improve to £18.4m deficit under the SaHF scenario before the reconfiguration (with the hub investment). After reconfiguration the Trust financial projections demonstrate that trusts have an I&E surplus position of £27.6m at 24/25, with the reconfiguration contributing a c.£50m benefit. However if the capital investment was funded by loans, two of the trusts would have a below target Financial Sustainability Risk Rating (FSRR) and be unable to meet loan repayments
5. Currently the trusts are running in-year deficits which would require an estimated cash support of £1.1bn over the next 10 years (and continue thereafter), which would reduce to £0.5bn under the SaHF scenario before the acute reconfiguration (where additional CIPs are delivered, partly due to hub investment to enable QIPP delivery). Under the SOC part 1 option ('SaHF scenario after reconfiguration'), the cash deficit support in the 10-year period would reduce further to £0.4bn and is eliminated post reconfiguration.
6. Under reconfiguration, these reduce further to £0.4bn and are eliminated post-reconfiguration.
7. The transitional cost projections are set out, together with confirmation of affordability to NWL.
8. The financial rate of return measures the overall value of the investment to the NHS over the period of the investment, which is calculated at £828m, with a payback period of eight years for hubs and nine years for the acute reconfiguration.
9. The loan funding scenario is unaffordable (from a liquidity perspective), so we have explored two scenarios:
   a) In order to have an affordable FSRR and optimise the benefits, Public Dividend Capital (PDC) rather than loan funding for two trusts' capital is proposed to ensure the FSRR remains at a three or above; and
   b) An accelerated approval and delivery timeline (as set out in the strategic case), which reduces capital by £16m, and accelerates the financial benefits.

   The PDC funded scenario under an accelerated timeline is our preferred option.
10. We have demonstrated that the case is affordable under a range of scenarios by conducting sensitivity analysis.

3.1 Capital investment and funding

We have analysed the capital investment requirement by year and assumed funding source (on the basis of loan funding and on the traditional timetable) showing the required funding by CSR period and source, and later (see section 3.8 below) explored an alternative affordable funding option and an accelerated timetable.

3.1.1 This section provides a summary of the total capital investment required to deliver the SaHF option (SOC1) under the traditional timeline and loan funding scenario, setting this in the context of the total NWL capital requirement included in the STP (see section 3.1.5).

3.1.2 The traditional timeline is based on the prescribed approach to the development and approval of a major business cases in the NHS.

3.1.3 The subsequent sub-sections provide more detail on the SOC1 capital options (as set out in the Economic Case) based on the traditional timetable of each element of the programme and funded by loans:

- **Out of hospital hubs (OOH)** – see section 3.1.7 for the OOH investment**,** compared to the 'comparator' investment (£69m of Primary Care estate investment is also within the 'Do Nothing' scenario);
- **Hospital reconfiguration (SaHF Option)** – see section 3.1.13 for the investment**,** as compared to the 'comparator'. Based on national guidance the investment has initially been modelled under a loan funding scenario with additional analysis to assess the affordability of this (the 'Business as Usual' and 'other priority capital investment are within the 'Do Nothing' capital); and
- **Overall OOH and hospital capital** – see section 3.1.15 for total investment.

3.1.4 Sections 3.1 to 3.7 are presented on the traditional timetable and on the loan funded basis for SOC1. Later in this section we look into different loan/PDC mix options at an accelerated timeline (see section 3.8 for more detail). Tables 1 and 2 show the capital on both a traditional and accelerated basis.

SOC1 in context of overall NW London STP capital

3.1.5 The SOC1 capital forms a sub-part of the total North West London STP full capital requirement submitted to NHS England. SOC1 and SOC2 include all SaHF capital.

3.1.6 The STP has three sub-parts being SOC1, SOC2 and additional priority capital:

- SOC1 – Gross Capital £545m with disposals of £16m to a net £529m for the Outer North West London SaHF SOC part 1 business case which includes the acute reconfiguration, out of hospital strategy and primary care investment (on an accelerated basis this is £513m net capital requirement);
- SOC2 - Outlines a potential need for a further £314m net capital for SaHF SOC2 for Inner North West London (ICHT and CWFT); and
- Other priority capital – includes additional provider capital, for example, digital roadmap and Specialist trust 'Do Something' capital (as defined by the STP).

3.1.7 In addition to the STP and SaHF capital requirements there is a "business as usual" estimated health economy capital requirement of £1,592m. This is included in the "do nothing" scenario and is set out in Table 1.

Table 1: Full NWL Health Economy Capital funding summary (including expected Business as Usual) (notes below table relate to 16/17 to 20/21 STP period)

Capital spend net of disposal proceeds	16/17	17/18	18/19	19/20	20/21	Total 16/17 to 20/21	21/22	22/23	23/24	24/25	25/26	Total 21/22 - 25/26	10-Year Total
Business as usual (note 1)	231	234	161	146	170	942	145	122	127	128	128	650	1,592
SOC1 net (note 2)	6	29	98	80	59	272	67	110	80	-	-	257	529
SOC2 net (note 3)	-	8	55	(137)	73	(0)	230	311	102	203	(532)	314	314
Other priority capital net (note 4)	6	54	53	(65)	13	60	-	-	-	-	53	53	113
Total Net (traditional timeline)	243	324	367	25	315	1,274	442	543	309	331	(351)	1,273	2,547
Impact of acceleration (SOC1) (note 2)	0	0	1	6	98	105	46	(87)	(80)	0	0	(121)	(16)
SOC1 net accelerated	243	325	368	31	413	1,379	487	456	229	331	(351)	1,153	2,532

Note 1: Disposals of £37m are within the 'Business as usual' capital (gross £978m, net £942m). This reconciles to the Oct 16 STP

Note 2: SOC1 capital under accelerated timeline includes the SOC 1 net capital of £272m plus the £105m capital to give a total of £377m (after disposals of £7m i.e. gross £384m). This reconciles to the Oct '16 STP after reflecting a £2m reduction to disposal proceeds.

Note 3: SOC2 capital includes £222m of gross capital offset by £222m of disposal proceeds. This reconciles to the Oct '16 STP.

Note 4: Other capital includes the IT digital roadmap (£60m) and other investments for CNWL and Royal Brompton which are both offset by disposal / other funding sources.

The above table shows that the overall capital for the full NWL Health Economy capital is £2,547m on the traditional timeline and £2,532m on the accelerated timeline. Further detail on the SOC1 scheme including phasing on the traditional timeline (£529m) and accelerated timeline (£513m) is shown below.

Table 2: SOC1 Capital funding summary

SOC1 Gross	16/17	17/18	18/19	19/20	20/21	Total 16/17 to 20/21	21/22	22/23	23/24	24/25	25/26	Total 21/22 - 25/26	10-Year Total
ChelWest - WMUH	-	-	-	-	0.9	**0.9**	2.1	20.0	20.1	-	-	**42.2**	**43.1**
LNWHT	-	0.2	2.4	12.4	51.0	**66.0**	64.9	46.6	28.9	-	-	**140.4**	**206.4**
THH	-	-	-	-	-	**-**	-	39.1	39.1	-	-	**78.2**	**78.2**
SOC1 Acute	**-**	**0.2**	**2.4**	**12.4**	**51.9**	**67.0**	**66.9**	**105.7**	**88.6**	**-**	**-**	**261.2**	**328.2**
SOC1 Hubs	5.8	16.4	38.8	67.7	14.7	**143.4**	-	4.5	-	-	-	**4.5**	**147.9**
SOC1 Primary Care	-	12.6	56.5	-	-	**69.1**	-	-	-	-	-	**-**	**69.1**
SOC1 Gross	**5.8**	**29.2**	**97.7**	**80.1**	**66.6**	**279.5**	**66.9**	**110.2**	**88.6**	**-**	**-**	**265.7**	**545.2**
SOC 1 receipts	-	-	-	-	(7.4)	**(7.4)**	-	-	(9.0)	-	-	**(9.0)**	**(16.4)**
SOC 1 net	**5.8**	**29.2**	**97.7**	**80.1**	**59.2**	**272.1**	**66.9**	**110.2**	**79.6**	**-**	**-**	**256.7**	**528.8**
Note: Impact of acceleration	0.0	0.3	1.3	6.0	97.6	105.2	45.8	(86.9)	(79.6)	0.0	0.0	(120.7)	(15.5)
SOC1 net accelerated	**5.8**	**29.5**	**99.0**	**86.1**	**156.8**	**377.3**	**112.7**	**23.3**	**- 0.0**	**-**	**-**	**136.0**	**513.3**

The total SOC 1 capital on the traditional timeline is explained over the next few pages.

Table 3: SOC1 Capital (net)

Organisation	£'m	Reference
Hubs	141	See section 3.1.7
Acute trusts	319	See section 3.1.13
Primary care	69	See section 3.1.15
Total SOC1 (net)	**529**	**Traditional timeline**

The total SOC1 capital ask of £529m shown above compares to the DMBC capital of £292m, which is shown below, along with an analysis of the movement.

Table 4: SOC1 Capital (net)

£'m	TOTAL	Comment
DmBC	292	This includes outer trusts, hubs and primary care from the DMBC.
JCPCT	64	This is the additional indicative capital for local hospitals (Ealing (£60m) and CMH (£4m)) within the JCPCT papers.
Total DmBC and JCPCT (net)	356	
Variance to SOC1	173	Predominantly comprises inflation impact
Total SOC 1 (net)	529	

Capital investments for out of hospital hubs

3.1.8 The breakdown of expected funding and phasing for out of hospital is shown in Table 5.

Table 5: Funding breakdown and phasing for out of hospital hubs

Capital costs	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m	21/22 £m	22/23 £m	Total £m
Hubs								
Dept. of Health	3.8	12.0	22.0	27.8	12.4	-	3.8	81.7
ETTF	0.6	0.4						1.0
NHS E	1.4	4.1	3.7	7.0	2.3	-	0.7	19.2
LIFTCo	-	-	13.2	32.4	-	-	-	45.6
LA/s106 funded by developer	-	-	-	0.5	-	-	-	0.5
Hubs total	**5.8**	**16.4**	**38.8**	**67.7**	**14.7**	**-**	**4.5**	**147.9**
Potential capital receipts	-	-	-	-	(7.4)	-	-	(7.4)
Total capital spend	**5.8**	**16.4**	**38.8**	**67.7**	**7.3**	**-**	**4.5**	**140.5**

Note: Disposals of £7m relate to North Hillingdon (£3m), Ealing East (£2m), Church Street (£1.3m), Ealing North (£0.9m) and Harrow (£0.2m).

3.1.9 The above represents the best current estimate of how the capital will be profiled and funded. Within the total capital requirement of £147.9m, it is assumed that the capital receipts from the disposal of property can be retained (£140.5m net of receipts).

3.1.10 Negotiations continue with local authorities for support from s106 contributions from property developers. The sum included is based on firm agreements achieved to date and it is expected this position will improve. The ETTF items reflect bids that have been successful. Any unsuccessful bids have been included within the Dept. of Health source.

3.1.11 Subject to the above, the capital funding sought as part of SOC part 1 expected from the DH is £81.7m. Until the development approach (e.g. LIFT, NHS Property services, etc.) is agreed for each hub the funding structure cannot be confirmed and the SOC analysis is presented as indicative, pending OBC and FBC work up.

3.1.12 The table below shows the current expected Hub funding source and the expected date that the hub will come online.

Table 6: Hub breakdown

Build Type	Hub Name	Capital Investment Required (£m)	Likely Funding Source	CCG	Effective Year
Operational and no new investment (4)	Hesa	N/A	N/A	Hillingdon	2015/16
	Parkview	N/A	N/A	H&F	2014/15
	South Westminster	N/A	N/A	Central	2009/10
	Feltham	N/A	N/A	Hounslow	2007/08
Existing but need new investment (10)	The Pinn	1	DH	Harrow	2017/18
	Alexandra Avenue	3	LIFT	Harrow	2017/18
	Wembley	2	DH	Brent	2017/18
	Willesden	4	DH	Brent	2023/24
	Heston	16	LIFT	Hounslow	2019/20
	Heart of Hounslow	2	LIFT	Hounslow	2018/19
	Brentford	10	DH	Hounslow	2019/20
	Chiswick	1	ETTF	Hounslow	2018/19
	St Charles	4	DH	West	2018/19
	Parsons Green	5	DH	H&F	2018/19
New (8)	North Hillingdon	6	Trust Capital (THH)	Hillingdon	2020/21
	Uxbridge & West Drayton	11	LA/DH	Hillingdon	2020/21
	Ealing North	15	LIFT	Ealing	2020/21
	Ealing East	21	LIFT	Ealing	2020/21
	NE Harrow	15	DH	Harrow	2020/21
	Church Street	15	DH	Central	2021/22
	Central Westminster	5	DH	Central	2018/19
	Violet Melchett	13	DH	West	2019/20
Total		**148**			
Receipts		(7)			
Total net capital investment		**141**			

3.1.13 In addition to the 22 hubs above (18 of which are requiring capital investment), there are also an additional 2 hubs included within outer NW London hospitals at Ealing and Central Middlesex Hospital sites and an additional 2 hubs to be included within inner NW London hospitals at St Marys and Charing Cross Hospital sites. There is a further hub still under review (West Middlesex hospital site) to give a total of 27 hubs.

Capital investments for hospital reconfiguration

3.1.14 We set out below further information on the capital investment required to deliver the proposed approach to the reconfiguration of the acute hospitals in outer NW London. We summarise the total capital, funding source and the profile by year.

3.1.14.1 The table below outlines the potential profile of acute capital, which is assumed to be funded by £319m of loans and £9m of disposal receipts.

Table 7: Acute Capital breakdown

Gross Capital requirement (£m)	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	Total
CWWM	-	-	-	0.8	1.2	16.8	24.3	-	**43.1**
LNWH	**0.2**	**2.4**	**12.4**	**51.0**	**64.9**	**46.6**	**28.9**	-	**206.4**
THH	-	-	-	-	-	39.1	39.1	-	**78.2**
TOTAL	**0.2**	**2.4**	**12.4**	**51.8**	**66.1**	**102.5**	**92.2**	-	**327.7**
Disposals (£m)	-	-	-	-	-	-	(9.0)	-	**(9.0)**
Net capital requirement (£m)	**0.2**	**2.4**	**12.4**	**51.8**	**66.1**	**102.5**	**83.2**	-	**318.7**

3.1.15 Further detail on the individual trust schemes is included within Appendix E.

Overall OOH and Hospital reconfiguration

3.1.16 The total SOC1 of £529m capital under the traditional timeline is therefore:

- Hubs - Total of £140.5m capital (of which £81.7m is assumed to be funded by the Department of Health), with the remaining funded by alternative sources.
- Acute capital - £319m for the acute capital (all assumed funded through loans), which is in addition to the 'Do Nothing' business as usual capital (as shown in Table 1);
- Primary Care - £69m of funding for primary care, which is within both the 'comparator' and the 'do something' options (thus on an incremental basis is not reflected as part of the economic and financial analysis). This investment relates to the capital costs required to improve/replace existing premises to increase capacity and develop a wider range of services where a hub is not planned.

3.2 CCG financial projections

A sustainable financial position for North West London CCGs is demonstrated through 10 year financial projections.

Surplus / deficit of CCGs over 10 year period

3.2.1 The CCGs have developed 10 year financial models using a common set of assumptions (See Appendix K). As part of this, CCGs have reviewed population growth projections to ensure that they are built into their finance and activity projections.

3.2.2 The methodology used for population projections is:

- Years 1-5 Higher of ONS and GLA forecasts
- Years 6-10 Higher of Housing development based estimates and GLA forecasts

3.2.3 The Housing Development based estimates of population growth are based on the major housing developments for each NWL borough that were identified in the 2015 London Plan published by the London Mayor's office.

3.2.4 These population forecasts have been shared with all eight local authorities and specific comments incorporated. Years 6-10 specifically incorporate all housing developments that have been identified in the London Plan.

Table 8: Population forecasts (000's)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
TOTAL	2,086	2,111	2,135	2,159	2,181	2,204	2,237	2,271	2,306	2,340	2,375

3.2.5 The overall growth in population represents a 14% increase over the period.

3.2.6 The CCGs financial position is presented over the next few pages both 'in year' (which is the CCG reported position including non-recurrent items) and on an 'underlying' basis (after removing non-recurrent items). Table 9 is a summary of the above eight CCGs on an 'in year' basis.

Table 9: Total NWL CCG 'in year' position

Total (£m) (In Year)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Opening RRL	2,639	2,716	2,763	2,814	2,868	2,971	3,036	3,105	3,178	3,253	3,331
Running cost allocation	47	51	46	46	47	47	46	46	47	47	48
Non-recurrent	141	80	48	40	17	13	17	20	20	21	23
Total RRL	**2,827**	**2,848**	**2,857**	**2,900**	**2,932**	**3,031**	**3,099**	**3,172**	**3,245**	**3,322**	**3,402**
Baseline cost	2,738	2,637	2,700	2,735	2,782	2,830	2,931	3,021	3,091	3,165	3,239
Recurrent Growth		83	89	87	86	88	106	109	112	114	116
Tariff Inflation/Deflation		42	11	11	11	11	9	9	10	10	10
Other		30	52	48	45	73	64	47	50	50	51
QIPP Saving		(94)	(116)	(98)	(95)	(71)	(92)	(97)	(100)	(102)	(103)
Non-recurrent spend		86	67	82	72	71	51	54	52	53	55
Total costs	**2,738**	**2,785**	**2,801**	**2,864**	**2,902**	**3,002**	**3,069**	**3,142**	**3,215**	**3,290**	**3,370**
Net Surplus	**89**	**63**	**56**	**36**	**30**	**29**	**29**	**30**	**31**	**32**	**32**
	3.1%	2.2%	2.0%	1.2%	1.0%	0.9%	0.9%	0.9%	1.0%	1.0%	1.0%

The Total NWL CCG underlying position by year is shown in Table 10 and by CCG in Table 11.

Table 10: Total NWL CCG underlying position

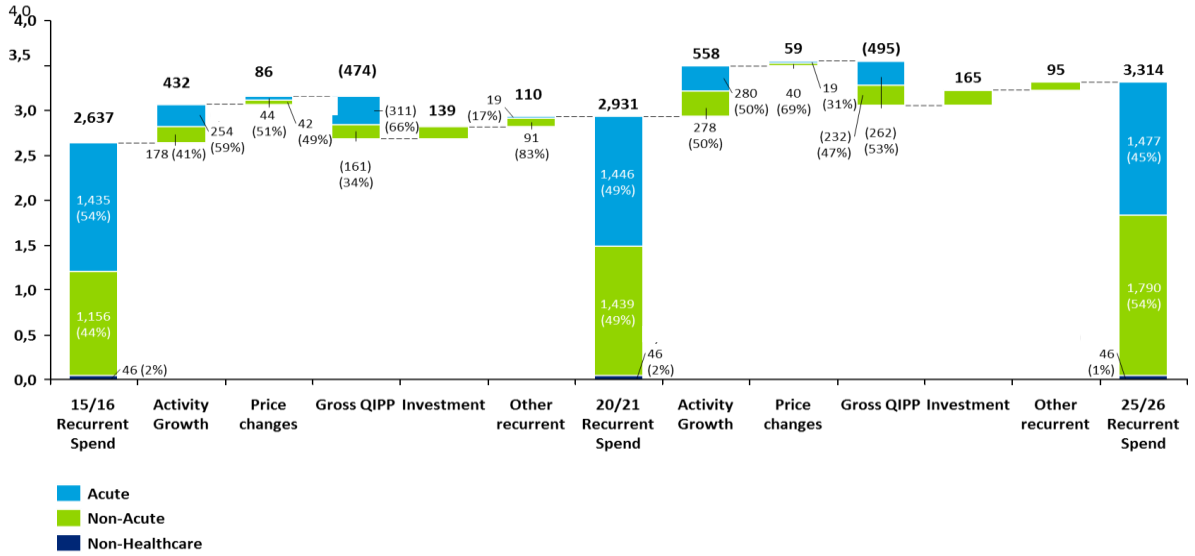
Total (£m) (Underlying)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Opening RRL	2,639	2,716	2,763	2,814	2,868	2,971	3,036	3,105	3,178	3,253	3,331
Running cost allocation	47	51	46	46	47	47	46	46	47	47	48
Total RRL	**2,686**	**2,767**	**2,809**	**2,860**	**2,915**	**3,018**	**3,082**	**3,152**	**3,225**	**3,301**	**3,379**
Baseline cost	2,637	2,637	2,700	2,735	2,782	2,830	2,931	3,021	3,091	3,165	3,239
Recurrent Growth		83	89	87	86	88	106	109	112	114	116
Tariff Inflation/Deflation		42	11	11	11	11	9	9	10	10	10
Other		30	52	48	45	73	64	47	50	50	51
QIPP Saving		(94)	(116)	(98)	(95)	(71)	(92)	(97)	(100)	(102)	(103)
Total costs	**2,637**	**2,699**	**2,735**	**2,782**	**2,830**	**2,931**	**3,018**	**3,088**	**3,163**	**3,237**	**3,314**
Net Surplus	**49**	**69**	**75**	**78**	**85**	**87**	**64**	**63**	**62**	**64**	**65**
	1.8%	2.5%	2.7%	2.7%	2.9%	2.9%	2.1%	2.0%	1.9%	1.9%	1.9%

Table 11: NWL CCG underlying position – by CCG

Total (£m) (Underlying by CCG)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Hounslow	8	8	10	10	10	11	8	8	8	8	8
West London	19	17	19	15	15	15	6	6	7	7	7
Hammersmith & Fulham	4	6	8	8	8	9	6	6	7	7	7
Hillingdon	2	7	11	12	12	10	10	9	9	9	8
Central London	(1)	3	6	8	9	9	5	6	6	6	6
Harrow	(11)	1	3	5	5	5	6	4	5	5	5
Ealing	25	19	13	13	16	16	11	11	11	11	11
Brent	3	7	5	7	10	12	12	13	11	11	12
Total Underlying Surplus	**49**	**69**	**75**	**78**	**85**	**87**	**64**	**63**	**62**	**64**	**65**

The bridge shown in Figure 1 summarises CCGs recurrent spend over the 10 year period for the eight NWL CCGs to 25/26.

Figure 1: CCG Strategic Plans - Commissioner Bridge (15/16 – 25/26)



3.2.7 The above bridge presents the underlying position for the NW London CCGs and excludes the planned STF funding described within the NW London STP which is planned for investment in prevention, social care, investment in 5 Year Forward View priorities, and additional investment in primary care.

3.2.8 Within the CCG plans acute spend is broadly constant over the period representing the net impact of growth and QIPP, with non-acute spend increasing materially to reflect the shift of services out of hospital.

3.2.9 The activity plans by 'Point of Delivery' (POD) are summarised below, and the growth allowed for in the plans exceeds the raw population growth shown in Table 8 as it ranges

from 35-45% over the 10 year period. This reflects additional projected growth in demand due to the relative increase in different age groups in the population, in particular the increase in the elderly.

3.2.10 The table also reflects the reduction in activity due to the changes in service models including the out of hospital investments, plus other QIPP interventions.

Table 12: Total CCG forecast activity (all Trusts) (000s)

	Activity				
POD	2015 /16	Growth	QIPP	2025 /26	% Change
Non-elective	179	74	(100)	153	-14%
Outpatients	2,036	684	(1,022)	1,698	-17%
Elective and daycase	217	75	(55)	238	9%
A&E	519	233	(199)	553	6%

3.2.11 The total NW London CCG QIPP is analysed further by year in Table 13.

Table 13: Total NWL CCG QIPP

	Activity										
	2016/17	2017/18	2018/19	2019/20	2020/21	2021 /22	2022 /23	2023 /24	2024 /25	2025 /26	Total
QIPP (£m)											
A&E	(1)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(21)
NEL	(14)	(32)	(30)	(30)	(23)	(13)	(13)	(13)	(13)	(13)	(193)
EL & DC	(0)	(6)	(4)	(4)	(4)	(10)	(11)	(11)	(11)	(11)	(71)
Outpatients	(14)	(25)	(19)	(18)	(13)	(6)	(6)	(7)	(7)	(6)	(122)
Other	(9)	(17)	(15)	(15)	(9)	(19)	(19)	(19)	(19)	(20)	(160)
Total acute QIPP	**(39)**	**(83)**	**(70)**	**(69)**	**(50)**	**(51)**	**(51)**	**(51)**	**(52)**	**(52)**	**(567)**
Total non acute QIPP	**(54)**	**(33)**	**(28)**	**(26)**	**(21)**	**(42)**	**(46)**	**(49)**	**(51)**	**(51)**	**(400)**
Total QIPP	**(93)**	**(116)**	**(98)**	**(95)**	**(71)**	**(92)**	**(97)**	**(100)**	**(102)**	**(103)**	**(967)**
QIPP Activity (000's)											
A&E	(24)	(19)	(16)	(17)	(13)	(22)	(22)	(22)	(23)	(22)	(199)
NEL	(10)	(16)	(15)	(15)	(11)	(6)	(6)	(7)	(7)	(6)	(100)
EL & DC	(0)	(4)	(3)	(3)	(3)	(8)	(8)	(9)	(9)	(9)	(55)
Outpatients	(133)	(191)	(149)	(144)	(103)	(59)	(59)	(61)	(62)	(60)	(1,022)

3.2.12 Reinvestment of £304m over the 10 year period is projected, as shown in the table below, reflecting the figures included within the financial bridge above. The reinvestment overall is calculated at 50% of the gross saving for the main PODs listed, with the profile by CCG and by year being variable within this to reflect local circumstances.

Table 14: Total NWL Reinvestment

£'m	Reinvestment total
A&E	10
NEL	96
Elective	36
Outpatients	61
Other	101
Total Reinvestment	**304**

3.2.13 In addition to the £304m investment there is further investment included within the bridge of £205m to cover double running costs as well as other required infrastructure investments to deliver the out of hospital transformation.

3.2.14 This is in addition to the STF funding described above in 3.2.7.

3.2.15 The non-recurrent funding set aside as part of the NW London collaborative financial strategy is described further in section 3.6.

3.3 Out of hospital hub affordability

The CCG projections demonstrate the affordability of the hub capital investment.

Hub affordability

3.3.1 The changes in recurrent costs associated with the hubs comprise a) an increase in property costs offset by b) savings in outpatients (OP); and c) savings in non-elective spend. The increase in property costs are reflected within the investment provision included within the CCG plans of £305m (which are within the 'investment' bar of the CCG bridge above). Further details of the calculations of the outpatient saving and Non-elective admission avoidance assumptions are set out in section 2.3.13 of the economic case.

Table 15: Hub affordability

CCG	Change in Property costs	OP activity Saving	NEL Savings	Total
	£'m	£'m	£'m	£'m
Brent	0.5	(0.3)	(4.7)	(4.5)
Harrow	1.4	(0.5)	(7.0)	(6.1)
Hillingdon	1.3	(0.4)	(3.1)	(2.2)
Central	1.6	(0.8)	(5.2)	(4.5)
West	1.7	(1.0)	(6.9)	(6.3)
H&F	0.4	-	(2.6)	(2.3)
Hounslow	2.0	(1.1)	(8.8)	(7.9)
Ealing	2.5	(0.6)	(6.4)	(4.4)
Total	**11.3**	**(4.8)**	**(44.7)**	**(38.1)**

Note 1: The values above relates to the 18 hubs only that have a capital requirement within this business cases (as described in Table 6).

3.3.2 Table 15 shows the total increase in property costs (i.e. rent, LIFTCO unitary charge etc.) resulting from the investment in the hub environment and the increase in space utilised

3.3.3 The total cost of £11.3m includes £3.3m of costs that under current contractual arrangements would be borne by other parties. Of the £3.3m, £2.3m would be funded by NHSE and £1.0m is funded by GPs.

3.3.4 The CCGs have confirmed that in the event that contractual arrangements change, the savings from the outpatients or non-electives would enabled these to be affordable.

3.4 Trusts' financial projections and affordability

Under the 'comparator' all trusts will be in financial deficit, with a combined deficit of £114m at 24/25, which would improve to £18.4m deficit under the SaHF scenario before the reconfiguration (with the hub investment). After reconfiguration the Trust financial projections demonstrate that trusts have an I&E surplus position of £27.6m at 24/25, with the reconfiguration contributing a c.£50m benefit. However if the capital investment was funded by loans, two of the trusts would have a below target Financial Sustainability Risk Rating (FSRR) and be unable to meet loan repayments.

Normalised income and expenditure

3.4.1 The trusts have developed 10 year plans for the period up to (and post) the SaHF reconfiguration. The key planning assumptions in developing these plans are summarised in Appendix K, together with detailed individual trust I&Es and balance sheets (see Appendix M). The summarised trust normalised I&Es are presented below.

3.4.2 The clinical income assumptions have been triangulated with commissioner assumptions – see Appendix L.

Underlying surplus

3.4.3 Table 16 provides a summary of the overall effect on each individual trust's normalised surplus for the comparator option, the SaHF scenario before the reconfiguration and the SaHF scenario after the reconfiguration.

Table 16: Net surplus/(deficit) by trust for each option (normalised)1

	Current Submission - Surplus / (deficit)										
	£'m	15/16 Surplus / (deficit)	16/17 Surplus / (deficit)	17/18 Surplus / (deficit)	18/19 Surplus / (deficit)	19/20 Surplus / (deficit)	20/21 Surplus / (deficit)	21/22 Surplus / (deficit)	22/23 Surplus / (deficit)	23/24 Surplus / (deficit)	24/25 Surplus / (deficit)	End State Surplus / (deficit)*
Comparator	Chelwest	(19.3)	(25.1)	(21.7)	(20.4)	(15.0)	(15.6)	(15.6)	(16.2)	(13.8)	(9.1)	(9.1)
	LNWH	(100.7)	(97.3)	(91.0)	(90.5)	(93.0)	(99.0)	(93.9)	(94.2)	(96.8)	(98.0)	(98.0)
	THH	(12.4)	(7.9)	(7.9)	(7.3)	(7.4)	(6.4)	(6.3)	(7.0)	(7.1)	(7.1)	(7.1)
	TOTAL	**(132.4)**	**(130.3)**	**(120.6)**	**(118.2)**	**(115.4)**	**(121.0)**	**(115.8)**	**(117.4)**	**(117.7)**	**(114.2)**	**(114.2)**
SaHF scenario (excluding reconfiguration)	Chelwest	(19.3)	(25.1)	(17.0)	(8.7)	4.1	4.3	5.1	5.6	8.8	14.3	14.3
	LNWH	(100.7)	(97.3)	(69.0)	(55.6)	(47.8)	(44.5)	(37.2)	(35.7)	(36.3)	(35.2)	(35.2)
	THH	(12.4)	(7.9)	(7.6)	(6.1)	(5.3)	(2.9)	(0.8)	0.2	1.5	2.5	2.5
	TOTAL	**(132.4)**	**(130.3)**	**(93.6)**	**(70.4)**	**(49.0)**	**(43.1)**	**(32.9)**	**(30.0)**	**(26.0)**	**(18.4)**	**(18.4)**
SaHF (with reconfiguration)	Chelwest	(19.3)	(25.1)	(17.0)	(8.7)	4.1	4.3	5.3	5.2	7.7	16.8	16.8
	LNWH	(100.7)	(97.3)	(69.0)	(55.6)	(47.8)	(44.5)	(37.6)	(38.6)	4.1	4.5	4.5
	THH	(12.4)	(7.9)	(7.6)	(6.1)	(5.3)	(2.9)	(0.8)	(1.1)	0.0	6.2	6.2
	TOTAL	**(132.4)**	**(130.3)**	**(93.6)**	**(70.4)**	**(49.0)**	**(43.1)**	**(33.1)**	**(34.5)**	**11.8**	**27.5**	**27.5**

3.4.4 From this analysis, it can be seen that the comparator has:

- A normalised deficit position of £114.2m.
- THH, CWFT and LNWHT are all in a deficit situation and therefore fail to meet the sustainability criteria;

3.4.5 The SaHF scenario before the reconfiguration benefit has a consolidated I&E deficit of £18.4m, with only Chelwest achieving the 2% surplus target. The CIP assumed to be delivered over and above the comparator is not a direct impact of the SaHF reconfiguration but is enabled by the wider SaHF programme (as a result from the out of hospital strategy being delivered). The additional CIP over and above the BAU CIP in the 'comparator' is not included in the incremental impact of SaHF reconfiguration within the financial (NPV) or Economic (NPC/EAC) analysis.

3.4.6 After reconfiguration the system wide surplus is £27.5m, with THH and ChelWest meeting the sustainability criteria of 2%, and LNWH meeting 1% surplus.

[1] Note: Whilst the post reconfiguration 'end state' is consistent across organisations it should be noted that LNWH have modelled the SaHF reconfiguration a year earlier than the other organisations. This does result in a timing difference between organisations (which is aligned in the following year), however the other organisations (THH and ChelWest) have confirmed an ability to adjust their timeline in line with LNWHT which creates an upside to the traditional timeline.

Drivers affecting trusts' costs and income

3.4.7 The difference between the I&E and comparator options of £142m is predominantly attributable to:

- additional Cost Improvement Programmes (CIPs) of £69m (see Table 17 below) – which shows the CIP delivered within the 'Comparator' compared to the CIP delivered within the SaHF option before the reconfiguration (see 3.4.5); and
- Reconfiguration benefit of £53m (see table 18 below) – reflecting the benefit based on the net difference between the increase in costs of receiving sites and the savings in transferring sites trusts.

3.4.8 The balance (£20m) is predominantly attributable to the modelling impact of the above, e.g. differential on cost inflation on the CIP savings (which are within the 'SaHF before the reconfiguration), with some further modelling impacts relating to the SaHF scenario after reconfiguration.

Cost Improvement Programmes (CIPs)

3.4.9 The additional CIP delivered over and above the 'comparator' option is enabled by the wider SaHF out of hospital changes, as explained above.

3.4.10 We set out below the assumed levels of savings to be achieved by each trust through their respective CIPs. Table 17 shows the amount of savings which the trusts forecast to deliver in the comparator scenario and the SaHF scenario before reconfiguration.

Table 17: CIP analysis by year

		Current Submission - CIPS										
	% and £ ('m)	15/16 CIP	16/17 CIP %	17/18 CIP %	18/19 CIP %	19/20 CIP %	20/21 CIP %	21/22 CIP %	22/23 CIP %	23/24 CIP %	24/25 CIP %	CIPs 16/17 to end state £'m	CIP 16/17 to end average %
ChelWest	**Comparator (£)**		21.6	18.9	18.2	18.7	16.2	16.2	16.3	16.3	17.3	159.8	2.9%
	Comparator (%)		*3.9%*	*3.3%*	*3.1%*	*3.1%*	*2.6%*	*2.5%*	*2.5%*	*2.5%*	*2.6%*		
	Do Something excluding reconfiguration		21.6	23.3	25.2	25.9	16.2	16.2	16.2	16.2	17.3	178.3	3.5%
	Do Something excluding reconfiguration (%)		*3.9%*	*4.1%*	*4.4%*	*4.6%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*		
	Variance between scenarios		*0.0%*	*0.8%*	*1.3%*	*1.5%*	*0.3%*	*0.3%*	*0.4%*	*0.4%*	*0.2%*	**18.5**	**0.6%**
LNWH	**Comparator (£)**		34.4	15.9	16.9	14.3	11.4	12.0	12.5	10.5	12.0	139.9	2.0%
	Comparator (%)		*4.7%*	*2.2%*	*2.2%*	*1.8%*	*1.3%*	*1.4%*	*1.4%*	*1.2%*	*1.4%*		
	Do Something excluding reconfiguration		34.4	29.6	28.5	24.0	20.0	14.0	12.5	10.5	12.0	185.5	3.1%
	Do Something excluding reconfiguration (%)		*4.7%*	*4.2%*	*4.2%*	*3.6%*	*3.0%*	*2.1%*	*1.9%*	*1.8%*	*2.1%*		
	Variance between scenarios		*0.0%*	*2.0%*	*2.0%*	*1.8%*	*1.7%*	*0.7%*	*0.4%*	*0.6%*	*0.7%*	**45.6**	**1.1%**
THH	**Comparator (£)**		9.0	8.5	8.0	8.1	7.2	6.3	6.8	6.4	4.5	64.8	2.8%
	Comparator (%)		*3.8%*	*3.5%*	*3.2%*	*3.2%*	*2.8%*	*2.3%*	*2.4%*	*2.2%*	*1.6%*		
	Do Something excluding reconfiguration		9.0	9.0	9.0	9.0	8.0	7.0	7.0	7.0	4.5	69.5	3.4%
	Do Something excluding reconfiguration (%)		*3.8%*	*3.8%*	*3.9%*	*3.9%*	*3.5%*	*3.1%*	*3.2%*	*3.2%*	*2.0%*		
	Variance between scenarios		*0.0%*	*0.3%*	*0.7%*	*0.7%*	*0.8%*	*0.8%*	*0.7%*	*0.9%*	*0.4%*	**4.7**	**0.6%**
Total	Comparator		65.1	43.3	43.1	41.1	34.8	34.5	35.6	33.2	33.8	364.5	
	Do Something excluding reconfiguration		65.1	61.9	62.7	58.9	44.2	37.2	35.7	33.7	33.8	433.3	
	Varance		**0.0**	**18.6**	**19.6**	**17.8**	**9.4**	**2.7**	**0.1**	**0.5**	**0.0**	**68.9**	

3.4.11 The BAU CIP planned by providers within the comparator ranges between 2.0% and 2.9% per year and includes plans to deliver Carter initiatives e.g. workforce efficiencies, estates optimisation and procurement and other trust specific CIPs. The additional CIPs planned within the 'Do Something' scenario (SaHF before reconfiguration) increase the CIP percentage to between 3.1% and 3.5% and includes additional CIPs that trusts can deliver if the wider SaHF out of hospital changes are delivered and through more collaborative working together.

Impact of contribution margin and reconfiguration benefit

3.4.12 Table 18 below sets out the movement in cost and income by trust specifically as a result of the SaHF reconfiguration. The income and cost implications have been identified at site level. This shows a net benefit overall of £53.3m, which forms the major part of the movement between the 'Do Something before reconfiguration' deficit of £18.4m and the ' Do Something after reconfiguration' surplus of £27.4m as set out in 3.4.3, with the balance reflecting other modelling changes.

Table 18: SaHF reconfiguration benefits

	Net contribution						
	WMUH	NPH	EH	CM	LNWHT Total	THH	Total
Impact on clinical income (NHS)	36.3	14.4	(54.8)	(5.1)	(45.5)	12.7	3.5
Impact on costs and other income	(33.1)	(11.6)	94.5	9.0	91.9	(9.1)	49.7
Impact on contribution margin	3.2	2.8	39.7	3.9	46.4	3.6	53.3
% contribution margin	8.8%	19.4%	(72.6%)	(76.7%)	(102.1%)	28.5%	

3.4.13 This table shows that the net income impact of the transferring activity across all three trusts is £3.5m, which explained by differing MFFs (£1.8m) and case-mix / other reclassification changes (£1.7m).

3.4.14 The table above shows that all trusts have a positive contribution margin, with both CWWM (WMUH) and THH being a net receiver of activity/expenditure with an assumed margin, and LNWH planning to take out more cost for the transferring activity/income.

Financial Sustainability Risk Rating (FSRR)

3.4.15 The FSRR comprises four equally weighted financial metrics. These are:

- Capital Service Capacity: days of operating costs held in cash (or equivalent);
- Liquidity: the degree to which a trust's income covers its financing obligations;
- I&E Margin: the degree to which a trust is operating at a surplus / deficit; and
- Variance in I&E margin as a % of income: variance between planned I&E margin and actual I&E margin.

3.4.16 The definition of each metric, along with the thresholds for each risk category – with '1' representing the highest risk and '4' the lowest risk – is shown below in Table 19.

Table 19 Definition of FSRR

	Financial Criteria	Metric	Description of Measure	Weight (%)	1*	2	3	4
Continuity of services	Balance sheet sustainability	Capital service capacity (times)	days of operating costs held in cash or equivalent forms, including wholly committed lines of credit available for drawdown	25	<1.25x	1.25x - 1.75x	1.75x - 2.5x	>2.5x
	Liquidity	Liquidity (days)	the degree to which a trust's income covers its financing obligations	25	< -14 days	-14 to -7days	-7 to 0 days	> 0 days
Financial efficiency	Underlying performance	I&E margin (%)	the degree to which a trust is operating at a surplus/deficit	25	≤ -1%	-1% to 0%	0% - 1%	> 1%
	Variance from plan	**Variance in I&E margin as a % of income	variance between a trust's planned I&E margin and its actual I&E margin	25	≤ -2%	-2% to -1%	-1% to 0%	≥ 0%

The FSRR under the three options is presented below in Table 20 to Table 22.

Table 20: Analysis of FSRR - Comparator

Comparator Overall Financial Sustainability Risk Rating (FSRR)

	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
ChelWest	4	3	3	3	2	2	2	2	2
LNWHT	2	2	2	2	2	2	2	2	2
THH	3	2	2	2	2	2	2	2	2

Table 21: Analysis of FSRR – SaHF before reconfiguration

SaHF Scenario excluding reconfiguration (FSRR)

	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
ChelWest	4	3	4	4	3	3	4	4	4
LNWHT	2	2	2	2	2	2	2	2	2
THH	2	2	2	2	2	2	2	2	2

Table 22: Analysis of FSRR – SaHF after reconfiguration

SaHF Overall Financial Sustainability Risk Rating (FSRR)

	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
ChelWest	4	3	4	4	3	3	3	3	4
LNWHT	2	2	2	2	2	2	2	2	2
THH	3	2	2	2	2	2	2	2	2

3.4.17 The above analysis of the underlying surplus and FSRR shows the following:

- Underlying surplus of at least 2% of total revenue – all trusts are in a sustainable surplus position by end state under the SaHF scenario, with THH and CWWM meeting the 2% threshold with LNWH achieving just over 1%.
- FSRR of 3 or above – CWFT meets an FSRR of 4 by end state, however LNWH and THH are only able to achieve a 2 which is due to the loan funding requirements under the SaHF option (a variant option scenario that provides further analysis of an affordable PDC / loan funding mix is presented in Section 3.8)

Conclusion

3.4.18 The analysis performed demonstrates that the capital required is not affordable from a liquidity perspective if funded through loans for both THH and LNWH. An alternative scenario that looks at the PDC / loan funding mix has been presented in Section 3.8.

Due to CWWMs recent (and ongoing) discussion with regulators concerning their 17/18-18/19 control total and (any resulting implications to receipt of STF funding), there is a risk that CWWM may not be able to afford loan funding (due to liquidity issues) which would result in the need for PDC funding. This will need to continue to be reviewed.

Activity and Beds

3.4.19 The Trust activity and bed projections are summarised below. These reflect total Trust activity with all commissioners.

Table 23: Outer Trusts (total activity)

WESTMID	Activity Mar-2016	Activity Mar-2026	% change
Elective and DC	14,208	29,937	**111%**
Non elective	28,640	30,544	**7%**
Outpatient	196,403	208,998	**6%**
A&E	58,870	78,315	**33%**
LNWHT	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective and DC	71,970	68,446	**-5%**
Non elective	69,453	44,396	**-36%**
Outpatient	549,272	544,663	**-1%**
A&E	132,352	116,122	**-12%**
THH	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective and DC	26,231	32,426	**24%**
Non elective	31,273	27,936	**-11%**
Outpatient	341,749	347,263	**2%**
A&E	84,661	89,651	**6%**
TOTAL	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective and DC	**112,409**	**130,810**	**16%**
Non elective	**129,366**	**102,876**	**-20%**
Outpatient	**1,087,424**	**1,100,923**	**1%**
A&E	**275,883**	**284,089**	**3%**

3.4.20 The trust changes above include the impact of reconfiguration that has been modelled based on the table below.

Table 24: Reconfiguration Activity flows

	Retained	West Middlesex	Central Middlesex	Northwick Park	Hillingdon
A&E / UCC	32%	40%	-	19%	10%
Critical care	-	58%	-	28%	14%
Elective	-	43%	26%	3%	28%
Non-elective	-	58%	-	28%	14%
Outpatients	86%	6%	-	4%	4%

3.4.21 The table below shows the bed modelling undertaken by the trusts, which shows a net 364 bed reduction (16%).

Table 25: Bed Forecasts

	Opening	Growth and QIPP (net)	Length of Stay	Reconfiguration	Other	Closing
LNWHT	1,187	(184)	(51)	(183)	-	769
WMUH	483	(60)	(47)	156	38	570
THH	569	(56)	(23)	28	18	536
Total Beds	**2,238**	**(300)**	**(121)**	**1**	**56**	**1,874**

3.4.22 The net growth/QIPP reduction of 300 beds (13.4%) reflects the net impact of the activity changes, pre-reconfiguration.

The length of stay adjustment reflects the impact on beds from projected length of stay improvements as assessed by each trust.

The reconfiguration reflects the net bed change from the activity changes in Table 24.

Other changes reflect other modelling changes not covered by the other columns.

3.5 Cash deficit support

Currently the trusts are running in-year deficits which would require an estimated cash support of £1.1bn over the next 10 years (and continue thereafter), which would reduce to £0.5bn under the 'SaHF scenario before reconfiguration' (where additional CIPs are delivered, partly due to hub investment to enable QIPP delivery). Under the SOC part 1 option ('SaHF scenario after reconfiguration'), the cash deficit support in the 10-year period would reduce further to £0.4bn and is eliminated post reconfiguration.

3.5.1 Trusts will require cash support for forecast deficits under both the comparator (in perpetuity) and SaHF (until the reconfiguration).

3.5.2 Table 16 showed the forecast normalised trust deficits by year under both the comparator, the SaHF scenario before the reconfiguration and SaHF scenario after the reconfiguration.

3.5.3 The tables below present the cash deficit support required to maintain a positive cash balance (circa minimum £3m cash) over the period under both the comparator and SaHF scenario (which is driven by the above I&E analysis).

3.5.4 The cash deficit support required under the Comparator is significantly higher (£1.1bn) than under SaHF after reconfiguration (£0.4bn). The following tables provide a summary of the cash support required under both scenarios. The guidance taken by trusts was to reflect deficit support as a non-amortising loan basis in their balance sheets.

Table 26: Comparator deficit support

Loan type £'m	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total
ChelWest	-	-	-	-	21	23	28	20	16	-	**107**
LNWHT	90	94	93	95	100	94	94	96	97	91	**943**
THH	-	8	7	8	7	6	7	7	7	-	**57**
Total	**90**	**101**	**100**	**102**	**127**	**123**	**129**	**123**	**120**	**91**	**1,107**

Table 27: SaHF (after reconfiguration) deficit support

Loan type £'m	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total
ChelWest											**-**
LNWHT	90	72	58	50	46	40	44	-	-	-	**398**
THH	-	8	7	6	3	1	2	-	-	-	**26**
Total	**90**	**80**	**65**	**55**	**49**	**41**	**45**	**-**	**-**	**-**	**424**

3.5.5 The cash deficit support that is estimated to be required under the SaHF scenario before the reconfiguration is £517m, thus the differential between the £424m and the £517m (£93m) reflects the impact of reconfiguration benefit over the period to 25/26 (there would also be a cash benefit into perpetuity).

3.6 Transitional cost projections and affordability

The transitional cost projections are set out, together with confirmation of affordability to NWL

Transitional cost projections and affordability

3.6.1 The costs of transition have been identified through a bottom up process by each trust and hub on a site basis, as well as an assessment of programme-wide costs undertaken by the SaHF programme team. They include the following main categories:

- Business Case development;
- Service transition costs including staffing changes;
- Double running; and
- Estates related costs.

3.6.2 The following sections provide a summary of the transitional funding requirements for both the comparator and the SaHF option.

a. Hub transition costs

3.6.3 It is estimated that the non-recurrent transition costs for all hubs will total £6.5m (Brent £0.2m; Harrow £1.1m; Hillingdon £1.0m; Ealing £1.0m; Hounslow £1.1m; Central £1.0m; West £0.6m; H&F £0.5m).

3.6.4 The transition costs relate to the setup costs of the hubs and have been calculated on an individual hub basis. The affordability of all transition costs is assessed in section 3.6.7.

b. Acute reconfiguration transitional costs

3.6.5 The acute reconfiguration will require transitional funding of £125m, £113m of which falls in the years to 17/18 to 25/26. This is shown in Table 28.

Table 28: Transitional funding requirement for SaHF option

Total Summary

Total Summary	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total 16/17 - 25/26	Total 17/18 - 25/26
Business case	3.0	11.4	1.4	7.8	1.2	0.5	0.4	0.4	0.1	-	26.2	23.2
Double running	-	0.5	0.5	3.6	0.5	-	5.6	1.3	0.8	-	12.8	12.8
Estates costs	0.8	0.3	0.3	0.7	0.7	2.7	1.7	1.5	1.1	0.2	10.0	9.2
Service transition	8.0	6.8	7.6	8.4	9.3	12.7	15.2	6.4	1.3	0.2	75.7	67.7
Total	**11.8**	**18.9**	**9.6**	**20.5**	**11.7**	**15.9**	**22.9**	**9.6**	**3.3**	**0.3**	**124.7**	**112.9**

This compares with a total of £65m (£53m in 17/18-25/26) under the Comparator, as shown in Table 29.

Table 29: Transitional funding requirement under comparator option

Total Summary

Total Summary	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total 16/17 - 25/26	Total 17/18 - 25/26
Business case	3.0	-	-	-	-	-	-	-	-	-	3.0	-
Double running	-	-	-	-	-	-	-	-	-	-	-	-
Estates costs	0.8	-	-	-	-	-	-	-	-	-	0.8	-
Service transition	8.0	6.0	7.0	7.9	8.8	9.7	10.7	2.8	-	-	60.8	52.9
Total	**11.8**	**6.0**	**7.0**	**7.9**	**8.8**	**9.7**	**10.7**	**2.8**	**0.0**	**0.0**	**64.7**	**52.9**

3.6.6 The eight NW London CCGs have agreed a collaborative financial strategy to support the implementation of SaHF. The CCGs have assumed up to £25m per year to fund SaHF. This is shown in Table 30.

Table 30: CCG funding availability for SaHF and variance to requirements

	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total 17/18 - 25/26
Indicative funding	-	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	225.0
Transitional costs	11.8	18.9	9.6	20.5	11.7	15.9	22.9	9.6	3.3	0.3	112.9
OOH Hub transitional costs	0.3	1.3	1.5	2.5	0.5	-	0.1	-	-	-	5.9
Variance	**-**	**6.1**	**15.4**	**4.5**	**13.3**	**9.1**	**2.1**	**15.4**	**21.7**	**24.7**	**112.1**

The profile of annual costs versus annual funds available show that they are affordable in all years.

3.6.7 The table below outlines the total non-recurrent strategic funds held within CCG 5-10 year plans (which is within 'non-recurrent' spend within the CCG plans – see section 3.2.6), from which the £25m annual transitional costs will be made available to SOC1. This demonstrates that there is sufficient additional funding available to fund other strategic developments e.g. SOC2 and other strategic investments.

Table 31: CCG ring-fenced non-recurrent strategic funds

CCG Non-Recurrent Spend	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22, £m	2022-23, £m	2023-24, £m	2024-25, £m	2025-26, £m
Total	32.6	48.7	48.7	48.7	48.7	39.2	39.9	40.6	41.3	42.0

3.7 Financial Return on Investment (NPV)

The financial rate of return measures the overall value of the investment to the NHS over the period of the investment, which is calculated at £828m, with a payback period of eight years for hubs and nine years for the acute reconfiguration.

Approach

3.7.1 The financial NPV is intended to measure the overall value of proceeding with the business case to the NHS, in today's terms over a 25 year period from completion of construction (total of 32 years). The value to the NHS is measured by including cost only within the NPV.

3.7.2 An NPV that is positive after being discounted by inflation and the NHS Cost of Capital shows that a business case will add a definitive projected financial value over the cost of investment, over the assessment period. This section outlines:

- Overview of the NPV calculation (including a comparison with NPC GEM included within the Economic appraisal); and
- Summary of the NPV for the NHS for both the OOH and acute reconfiguration combined.

3.7.3 In addition, an NPV for the trusts has been calculated which takes account of the incremental income and expenditure to understand the underlying impact to the trusts from the reconfiguration (see section 3.7.10).

Overview of the NPV calculation

3.7.4 Table Table 3232 provides an overview of the key components of the NPV (as well as a comparison to the NPC GEM included within the Economic appraisal).

Table 32: Overview of NPV and NPC GEM (economic appraisal)

Description	NPV		NPC GEM	
Capital investment				
- NWL major hospitals	Includes VAT as cash flow effect on NHS	√	Excludes VAT as transfer in public sector	√
- NWL local hospital	Includes VAT as cash flow effect on NHS	√	Excludes VAT as transfer in public sector	√
- Outside NWL major hospitals	Includes VAT as cash flow effect on NHS	√	Excludes VAT as transfer in public sector	√
- Non-NHS spend	Focus on NHS	×	Extended focus on whole UK economy	√
Revenue impact of new build at Major and Local Hospitals				
- Operating costs		√		√
- Ongoing capex		√		√
- PDC	Avoid double counting capital charges and c	×	Avoid double counting capital charges and capital investment	×
Revenue impact of removing assets at Local Hospitals				
- Operating costs		√		√
- Ongoing Capex		√		√
- PDC	Cash flow impact on NHS providers	√	Transfer between NHS and HMT	×
Land receipts		√		√
Impairments	No Cash flow effect	×	No cash flow effect	×
Changes in pay costs				
- Consolidation savings		√		√
- Avoiding cost of new service standards	Does not distinguish reconfiguration options	×	Benefit compared to 'do nothing' situation	√
Income changes due to MFF or flows out of NWL	Transfers within public sector	×	Transfers within public sector	×
Period	25 years (2016/17 to 2041/42 inclusive)		Aligned to average useful economic life at each trust, using 60 years for new build, and 25 years refurbishment post build period.	
Discount rate	3.5% p.a. (discounted to 2016/17)		3.5% p.a. y1-30' 3.0% y31 to end of UEL	

3.7.5 An appraisal period of 32 years has been used as the costs and benefits considered should normally be extended to cover the period of the useful economic life ("UEL") of the assets encompassed by the options under consideration. 32 years has been deemed appropriate given that a significant proportion of the overall spend is attributable to refurbishment which typically has a UEL of c. 25 years (32 years including the 7 year build period).

Summary of the results

Out of hospital hubs and acute reconfiguration NPV

3.7.6 The NPV for the acute reconfiguration is positive overall, £305m in today's terms of added financial value over 32 years. This assessment includes the incremental impact/benefit of the reconfiguration only. This does not include any incremental CIP (as explained in 3.4.5). The NPV for the out of hospital hubs is a positive £523m, which includes only the hub-enabled benefits as part of the NPV analysis (as explained in section 2.3 of the economic case). This gives a total NPV of £828m.

3.7.7 Table 33 below provides a summary of the NPV for the trusts and OOH under the comparator and the SaHF option, with the incremental capital (£416m) to calculate the ratio of benefits to capital employed (2.0:1).

Table 33: NPV (ROI) over 32 years

£m	NPV (ROI) 0+32 years		
	Comparator NPV	SaHF NPV	Difference to Comparator NPV
CWWM	(10,186)	(10,619)	(433)
THH	(3,900)	(4,100)	(199)
LNWHT	(11,689)	(10,753)	937
Total Acute NPV*	**(25,776)**	**(25,471)**	**305**
Total NWL Hub NPV	-	**523**	**523**
Total NWL NPV	**(25,776)**	**(24,948)**	**828**
Total incremental Acute capital (Real)			(283)
Total incremental Hub capital (Real)			(132)
Total incremental capital (Real)			**(416)**
Ratio of financial benefits to capital employed (Note 3)			2.0:1

Note 1: The incremental capital reflects VAT inclusive Capital discounted to present value at a prevailing inflation rate of 2.5%.

Note 2: The above assessment includes the additional financing cost (£82m) to calculate the cost to the trusts, however this is excluded if assessing the cost to the overall public sector. If added back the NPV would be £910m.

Note 3: The 2.0:1 ratio of financial benefits to capital employed is calculated by dividing the NPV by the total incremental capital (real) of £416m.

3.7.8 The net position is made up of CW/WM and THH being a net receiver of activity/expenditure (negative NPV), whereas LNWH are transferring activity/expenditure (positive NPV).

3.7.9 The discounted payback period has been calculated to be nine years on the acute reconfiguration (after construction period of seven years), and eight years on the OOH hubs.

NPV (Income and Expenditure)

3.7.10 In addition to the above, a further NPV for the trusts has been calculated which takes account of the incremental income as well as the cost to understand the underlying I&E benefit impact to the trusts from the reconfiguration.

3.7.11 The NPV (Income and Expenditure) has been calculated for the trusts only as it is not applicable to the OOH hubs. The NPV for the acute reconfiguration is positive overall, £344m in today's terms of added financial value over 32 years.

3.7.12 The net position is made up of all trusts having a positive NPV as a result of CW/WM and THH being net receivers of activity/expenditure with an assumed margin, whereas LNWH are planning to take out more cost than the loss of income for the transferring activity.

3.7.13 Table 34 below provides a summary of the NPV for the trusts under the comparator and the SaHF option, with the incremental capital (£283m) to calculate the ratio of benefits to capital employed (1.21:1). The 1.21:1 ratio of financial benefits to capital employed is calculated by dividing the NPV by the total incremental capital (real) of £283m.

Table 34: NPV (ROI) over 32 years

£m	NPV (ROI) 0+32 years		
	Comparator NPV	SaHF NPV	Difference to Comparator NPV
CWWM	550	558	8
THH	126	129	4
LNWHT	(378)	(46)	332
Total Acute NPV (note 1)	**298**	**641**	**344**
Total incremental capital Acute (Real)			(283)
Ratio of financial benefits to capital employed			1.21:1

Note 1: The above assessment includes additional financing cost (£82m) to calculate the cost to the trusts. However this should be excluded if assessing the cost to the overall public sector. The NPV would be £426m.

3.7.14 The payback period has been calculated to be six years (after the construction period of seven years).

3.8 Confirming the preferred option

In order to have an affordable FSRR and optimise the benefits, the following are proposed- a) Public Dividend Capital (PDC) rather than loan funding for two trusts capital, and b) an accelerated approval and delivery timeline (as set out in the strategic case), which reduces capital by £16m, and accelerates the financial benefits.

Approach

3.8.1 The analysis to date is on the traditional timeline and assumed to be loan funded. This analysis demonstrates a sustainable I&E position for CCGs and trusts, and presents a positive Return on Investment. However as outlined in section 3.4, the capital required is not affordable (due to liquidity issues) if funded through loans for both THH and LNWH. Also, the programme are considering if the timeline can be accelerated to maximise the benefits of delivery. Further variant options have therefore been analysed below:

1. The PDC / loan funding mix has been presented in Section 3.8.3
2. The impact if the timeline could be accelerated presented in Section 3.8.10

3.8.2 In order to demonstrate the impact of these variant options, each has been run independently of each other on the traditional timeline option.

PDC vs Loan funding

3.8.3 As shown in section 3.4 based on loan the underlying surplus and FSRR of the trusts show the following:

- Underlying surplus of at least 2% of total revenue – all trusts are in a sustainable surplus position by end state under the SaHF scenario, however only THH and CWWM meet the 2% threshold with LNWH achieving just over 1%.
- FSRR of 3 or above – CWWM meets an FSRR of 4 by end state, however LNWH and THH are only able to achieve a 2 which is due to the loan funding requirements under the SaHF option.

3.8.4 Further analysis has been performed to assess whether a mix of both PDC and loan would be affordable (due to liquidity) to these entities.

3.8.5 Table 35 presents the mix of PDC to loan funding required to improve the FSRR to a 3 for THH and LNMWH.

Table 35: Variant options – loan and PDC mix

LNWH	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
100% loan - FSRR	2	2	2	2	2	2	2	2	2
100% pdc - FSRR	2	2	2	2	2	2	2	3	3

CW/WM	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
100% loan - FSRR	4	3	4	4	3	3	3	3	4
100% pdc - FSRR	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

THH	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
100% loan	2	2	2	2	2	2	2	2	2
8% loan, 92% pdc	2	2	2	2	2	2	2	2	3

3.8.6 The table shows the following:

- LNWHT can achieve an FSRR of 3 in year 24/25 with a loan to PDC mix of 2%:98%, however this would leave the Trust with a nil cash balance and would not provide the Trust any cash headroom to absorb any risks (or sensitivities), and thus the table reflects 100% PDC funding to show cash affordability.

- THH can achieve a FSRR of 3 through a loan to PDC mix of 8%:92%. Similarly to LNWHT this mix would not provide the trust with sufficient headroom to absorb any risk.
- CW/WM can achieve a FSRR of 3 through 100% loan funding; no switching analysis is therefore required.

Conclusion

3.8.7 The analysis performed above demonstrates that the capital required is only affordable if funded through PDC for both THH and LNWH (due to liquidity). This will have the following I&E implications for THH and LNWHT:

- LNWH - The trust's underlying position has a small I&E deterioration of £0.1m starting in FY22 increasing to £0.6m per year by FY26 under the PDC funded option than under loan funded (c£0.6m per annum). This is driven by the fact that PDC is charged at 3.5% whereas interest on the loan funded option is lower at c3%; and
- THH - The trust's underlying position each year is worse under the PDC funded option than under loan funded (c£0.2m per annum). This is driven by the fact that PDC is charged at 3.5% whereas interest on the loan funded option is lower at c3%.

3.8.8 The cash deterioration is primarily avoided as the PDC capital is not repaid, whereas under the loan scenario the principal is repaid in line with NLF guidance within 25 years.

3.8.9 Due to CWFTs recent (and ongoing) discussion with regulators concerning their 17/18-18/19 control total and (any resulting implications to receipt of STF funding), there is a risk that CWFT may not be able to afford loan funding (due to liquidity issues) which would result in the need for PDC funding. This will need to continue to be reviewed.

Accelerated vs traditional timeline

3.8.10 In order to perform a review of the impact of an accelerated timeline on the programme the position presented in the traditional timeline has been flexed to assess the impact of shifting the timeline forward. In order to isolate the impact of this variable the analysis performed by the trusts assumed that this option is still loan funded (as per the traditional timeline case comparison).

3.8.11 The alternative accelerated timeline (as set out in the strategic case) has been developed based on an assumption that business case development and approval can be achieved within three years. This would represent an acceleration on the start of the construction start date of one year and four months. The accelerated timelines are based on:

a. Parallel running of the business cases, including FBC development starting before the approval of the OBC; and
b. A faster approval and assurance route.

3.8.12 Based on the definition above, an accelerated timeline has been produced by the programme (see strategic case), and the implications/benefits of this option developed, based on an incremental approach built upon the detailed analysis performed on the traditional timeline. Analysis of the impact on the I&E, capital and cash position was requested from trusts (as these were considered the key areas for financial review).

3.8.13 Based on the submissions from trusts, under the traditional timeline, it was also possible for the Programme to estimate the impact under the accelerated timeline on transitional costs and deficit support.

3.8.14 The accelerated date of reconfiguration of 22/23 enables the earlier realisation of programme benefits. This section presents the key financial implications on:

a. Capital

3.8.15 The below table demonstrates, when compared to the traditional timeline, that the key driver of the £15.6m reduction in capital spend.

Table 36: Accelerated timeline acute trust capital requirement (acute trusts)

Capital	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Traditional Timeline										
LNWH	-	0.2	2.4	12.4	51.0	64.9	46.6	28.9	0.0	206.4
CW/WM	-	-	-	-	0.9	2.1	20.0	20.6		43.6
THH	-	-	-	-	-	-	39.1	39.1	-	78.2
Total	**0.0**	**0.2**	**2.4**	**12.4**	**51.9**	**66.9**	**105.7**	**88.6**	**0.0**	**328.2**
Accelerated timeline										
LNWH	-	0.5	2.9	17.0	95.2	57.7	27.8	0.0	0.0	201.1
CW/WM	-	-	0.7	1.4	19.0	19.7	-	-	-	40.8
THH	-	-	-	-	35.3	35.3	-	-	-	70.7
Total	**0.0**	**0.5**	**3.7**	**18.4**	**149.5**	**112.7**	**27.8**	**0.0**	**0.0**	**312.6**
Variance										
LNWH	0.0	0.3	0.5	4.6	44.3	(7.2)	(18.8)	(28.9)	0.0	(5.3)
CW/WM	0.0	0.0	0.7	1.4	18.1	17.6	(20.0)	(20.6)	0.0	(2.9)
THH	0.0	0.0	0.0	0.0	35.3	35.3	(39.1)	(39.1)	0.0	(7.5)
Variance total	**0.0**	**0.3**	**1.3**	**5.9**	**97.7**	**45.8**	**(77.9)**	**(88.6)**	**0.0**	**(15.6)**

b. I&E implications

3.8.16 The revised capital ask presented above has been profiled and modelled through the I&E of each trust. Table 37 below provides an overview of the impact that that the accelerated timeline has on I&E by trust in comparison to the traditional timeline.

3.8.17 The accelerated timeline shifts forward by one year the benefit of reconfiguration at LNWH (to 22/23) and for CW (WM) and THH by two years.

Table 37: Accelerated timeline I&E

I&E	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Traditional Timeline										
LNWH	(97)	(69)	(56)	(48)	(45)	(38)	(39)	4	5	(382)
CW/WM	(25)	(17)	(9)	4	4	5	5	8	17	(7)
THH	(8)	(8)	(6)	(5)	(3)	(1)	(1)	0	6	(25)
Total	**(130)**	**(94)**	**(70)**	**(49)**	**(43)**	**(33)**	**(35)**	**12**	**28**	**(415)**
Accelerated timeline										
LNWH	(97)	(69)	(56)	(48)	(45)	(39)	3	3	5	(343)
CW/WM	(25)	(17)	(9)	4	4	4	9	12	17	(1)
THH	(8)	(8)	(6)	(5)	(4)	(2)	5	6	7	(16)
Total	**(130)**	**(94)**	**(71)**	**(49)**	**(46)**	**(37)**	**17**	**20**	**29**	**(360)**
Variance										
LNWH	0	0	(0)	(0)	(1)	(1)	42	(2)	1	39
CW/WM	(0)	(0)	(0)	(0)	(1)	(1)	4	4	0	6
THH	(0)	(0)	(0)	(0)	(1)	(1)	6	6	0	10
Variance total	**(0)**	**(0)**	**(0)**	**(0)**	**(2)**	**(4)**	**52**	**9**	**1**	**55**

c. Deficit funding

3.8.18 Under the accelerated timeline the shift of the reconfiguration forward reduces the requirement for this deficit support as the I&E benefit is brought forward, for example, under the scenario above, LNWH obtains a surplus from 22/23, whereas under the traditional timeline it would still have a deficit of c. £39m. This reduces the requirement for deficit support loan funding by £41m. This is presented in Table 38 below.

Table 38: Deficit support under preferred accelerated timeline.

Loan type £'m	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total
Deficit Support - standard timeline	90	80	65	55	49	41	45	0	0	0	**424**
Deficit Support - accelerated timeline	90	80	65	55	50	44	0	0	0	0	**384**
Variance	0	0	0	(0)	(1)	(3)	45	**0**	**0**	**0**	**41**

d. Transitional costs

3.8.19 The table below provides a comparison of the requirement for transitional costs under the traditional timeline and the Programme estimate value under the accelerated timeline. This results in a £10m positive variance.

Table 39: Transitional costs under preferred accelerated timeline.

Total Summary	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Total 16/17 - 25/26	Total 17/18 - 25/26
Standard timeline - transitional costs	**12**	**19**	**10**	**21**	**12**	**16**	**23**	**10**	**3**	**0**	**125**	**113**
Accelerated timeline - transitional costs	**12**	**29**	**17**	**11**	**16**	**26**	**3**	**0**	**0**	**0**	**114**	**103**
Variance	**-**	**(10)**	**(8)**	**9**	**(4)**	**(10)**	**20**	**9**	**3**	**0**	**10**	**10**

e. Updated Financial NPV

3.8.20 The financial NPV of the acute reconfiguration is improved through the accelerated timeline and is estimated in Table 40 below, and shows an improvement of £46m, principally driven by the reconfiguration benefit brought forward.

Table 40: Impact on acute NPV – capital and reconfiguration benefit (Value to NHS, e.g. cost only)

£m	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	TOTAL
Capital									
Traditional	-	0	2	12	52	67	106	80	319
Accelerated	-	1	4	18	150	113	19	-	304
Net	**-**	**(0)**	**(1)**	**(6)**	**(98)**	**(46)**	**87**	**80**	**16**
Reconfiguration benefit									
Traditional	(130)	(94)	(71)	(49)	(43)	(33)	(35)	12	(443)
Accelerated	(130)	(94)	(71)	(49)	(46)	(37)	17	20	(388)
Net	**-**	**-**	**(0)**	**(0)**	**(2)**	**(4)**	**52**	**9**	**54**
Overall change	**-**	**(0)**	**(1)**	**(6)**	**(100)**	**(50)**	**139**	**88**	**70**
NPV @ 3.5%	**46**								

Conclusion

3.8.21 Based on the analysis performed above, the accelerated timeline provides the preferable option due to the fact that it reduces the capital ask by £16m, and more materially, shifts the benefit of reconfiguration forward. This not only benefits the trusts (particularly LNWH) but also reduces the pressure on the wider health economy by reducing the level of deficit support required by c£41m and reducing the level of transitional support by c£10m.

Overall Conclusion of Using PDC and Accelerated Timeline

3.8.22 Further to the above, although the accelerated timeline analysis was performed on a loan funded basis the analysis on PDC / loan funding would still hold true for both THH and LNWH under the accelerated timeline (this is due to the fact that though the accelerated timeline does reduce the level of capital ask it is not material enough to affect the overall affordability under a loan funded scenario; the main benefit of the accelerated timeline comes from bringing the reconfiguration benefit forward). As such the preferred option is:

1. PDC funding for THH and LNWH (and loan funding for CW/WM); and
2. The case to be developed under the accelerated timeline.

Due to CWWMs recent (and ongoing) discussion with regulators concerning their 17/18-18/19 control total and (any resulting implications to receipt of STF funding), there is a risk that CWWM may not be able to afford loan funding (due to liquidity issues) which would result in the need for PDC funding. This will need to continue to be reviewed.

3.8.23 Total capital of £513m, comprising acute capital ask of £303m, £140m capital for the hubs and £69m funding for primary care.

Table 41: Public sector and private sector capital sources and phasing

/ACCELERATED TIMELINE	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m	CSR1 £m	21/22 £m	22/23 £m	23/24 £m	24/25 £m	25/26 £m	CSR2 £m	TOTAL £m
DH													
PDC		1	3	17	130	**151**	93	28				**121**	**272**
Loan			1	1	19	**21**	20					**20**	**41**
Hubs	2	4	2	26	12	**46**		4				**4**	**50**
NHSE	1	4	4	7	2	**19**		1				**1**	**19**
ETTF													
Hubs	2	8	19			**29**						**-**	**29**
Primary care		12	57			**69**						**-**	**69**
Capital receipts retained					(7)	**(7)**		(9)				**(9)**	**(16)**
Public Sector Capital	**6**	**29**	**85**	**51**	**156**	**327**	**113**	**23**	**-**			**136**	**463**
LIFTCO			13	32		**46**						**-**	**46**
LA developer				1		**1**						**-**	**1**
GP's		1	1	2	0	**4**		0				**0**	**4**
Private sector capital	**-**	**1**	**15**	**35**	**0**	**50**	**-**	**0**	**-**			**0**	**50**
TOTAL EXPENDITURE	**6**	**29**	**100**	**86**	**156**	**377**	**113**	**23**	**-**			**136**	**513**

3.9 Sensitivity analysis

We have demonstrated that the case remains affordable under a range of scenarios by conducting sensitivity analyses.

Approach

3.9.1 A number of sensitivities have been run to test the robustness of the affordability conclusions. There are a number of consistent sensitivities (e.g. capital 30% and savings reduced by 20%), alongside some specific risks for the hub developments and the acute reconfiguration. These have been run against the analysis presented in sections 3.1 to 3.7 on the traditional timeline and loan funding scenario, and would not be materially different under the preferred option set out in section 3.8.

I&E sensitivities

a. Hub I&E sensitivities

3.9.2 The out of hospital hubs sensitivity analysis considers risks that would pertain to the out of hospital hubs.

The I&E impact of the hub has been tested by modelling changes to the key drivers of the I&E improvement,

- **Capital costs increase by 30%**
  This could reflect higher material costs, higher capital inflation, the impact of a delay in the construction timetable resulting in higher capital charges.
- **Premises costs increase by 20%**
  Higher rent charged by landlords, including unitary payments for LIFT scheme, to reflect investment in the facilities and the NHS taking greater capacity
- **Outpatients savings attributable to OOH hubs reduce by 10%**
  This would be caused by not being able to reduce the tariff by 20%.
- **Non elective savings attributable to OOH hubs reduce by 20%**
  This would be caused by the hub having less of an impact on non elective admissions avoided.

Table 42: I&E sensitivities (annual)

Change in I&E (£m)		Total
SaHF I&E benefit (see table 15)		38.1
Capital costs	30%	(3.0)
Premises costs	20%	(1.5)
Outpatient savings attributable to OOH hubs	10%	(0.5)
Non-elective savings attributable to OOH hubs	20%	(8.9)
SaHF I&E benefit post sensitivities		24.2

3.9.3 **Conclusion:**

The I&E is shown to be robust in the face of the combined change in cost assumptions tested above. The I&E improvement is most sensitive to the non-elective savings.

Non-elective savings would need to be 86% lower than the current planned levels for the hub benefit of £38m to be negative.

b. Acute sensitivity analysis

3.9.4 The acute sensitivity testing considers key risks and how they would impact both the SaHF reconfiguration as well as the comparator. These are risks to the delivery of the CIP, the capital costs of the programme, transitional costs becoming recurrent, reconfiguration benefit (e.g. the recurrent revenue cost associated with the reconfigured activity at the trusts) and specialist commissioning due to increased risk highlighted by NHSE. The sensitivity analysis then considers the impact of a combination of the above.

3.9.5 The sensitivity of trust I&E's to changes in the following cost drivers has been tested:

- 25% reduction in specialist commissioning contribution (excluding high cost drugs which are pass through);
- Only 90% of BAU CIP delivered in the comparator scenario;
- Only 90% of additional CIP delivered in the SaHF scenario;
- Only 90% of BAU and additional CIP delivered;
- Increase in capital costs of 30%;
- 5% of transitional costs become recurrent; and
- Reduction in the assumed reconfiguration cost savings of 20%.

3.9.6 Two combined scenarios were run, combining:

- Only 90% of BAU and additional CIP delivered, an increase in capital costs of 30%, 5% of transitional costs become recurrent and reduction in reconfiguration savings of 20%; and
- Only 90% of additional CIP delivered, an increase in capital costs of 30%, 5% of transitional costs become recurrent and reduction in reconfiguration savings of 20%.

Table 43 shows the impact on both individual trust's and the total I&E of applying these sensitivities.

Table 43: Trust sensitivity analysis

Sensitivity impact on trust I&E		I&E							
		Comparator				SaHF			
Base case end state		CW	LNWH	THH	Total	CW	LNWH	THH	Total
Specialised commisioning (25% reduction)	1	CW	LNWH	THH	Total	CW	LNWH	THH	Total
CIP - 10% failure of BAU	2	CW	LNWH	THH	Total	CW	LNWH	THH	Total
CIP - 10% failure of additional CIP	3					CW	LNWH	THH	Total
CIP - 10% failure of BAU and additional CIP	2+3	CW	LNWH	THH	Total	CW	LNWH	THH	Total
Capital cost - 30% increase	4					CW	LNWH	THH	Total
Transitional costs - 5% become recurrent	5					CW	LNWH	THH	Total
Reconfiguration costs - 20% adverse	6					CW	LNWH	THH	Total
Combined Sensitivities impact on end state (ref. above)									
1+2+3+4+5+6		CW	LNWH	THH	Total	CW	LNWH	THH	Total
3+4+5+6		CW	LNWH	THH	Total	CW	LNWH	THH	Total

End state deficit
End state surplus less than 1% (i.e. not meeting business rules)
End state surplus more than or equal to 1%

Conclusion

3.9.7 The sensitivities performed show that BAU CIP has the most material impact on all trusts sustainability, however this is also a risk under the comparator. In addition the risk of delivery of the cost savings relating to the SaHF reconfiguration sensitivity would also have a material adverse impact on LNWH.

3.9.8 As the SOC is anchored on CCG and trust plans for 16/17, in addition to the above, the following sensitivities were also considered:

- Trusts: The largest threat to the achievability of trusts normalised 16/17 plans is CIP failure. This has already been tested as a sensitivity above. It is assumed that any other normalised variances would be recovered recurrently by the implementation of mitigations by the trusts.
- CCGs: CCGs, as shown in Table 10, are forecasting strong underlying positions (from £69m in 16/17 to £87m in 20/21) which provides resilience to any downside risks. The impact of a material reduction in the underlying position would be to put at risk the ability to fund non-recurrent spend and therefore potentially impacting on the transitional funding available to trusts. Mitigations would be (i) other mechanisms of

funding could be considered, such as STF funding, in the interim years whilst the CCGs recover their positions or ii) the transitional cost projections could be reviewed further in conjunction with Trusts to potentially reduce these costs.

- 16/17 financial risk - All CCGs and trusts as at M6 are forecasting to meet their control totals. However there is also an inherent risk about their respective underlying positions which needs to be tested
- 16/17 activity risk – In the period leading up to 22/23 there is a risk that activity could exceed 16/17 plans, and if not recovered in future years could therefore exceed the projections underpinning the SOC. CCGs and trusts will need to collectively monitor any unplanned activity growth and implement mitigation plans.

Financial NPV sensitivities

a. OOH hubs

3.9.9 The I&E sensitivity scenarios have been applied to the financial NPV calculation. This has been summarised in Table 44 below.

Table 44: Hub NPV sensitivities

Change in NPV (£m)		Total
SaHF NPV - hubs		523.4
Capital costs	30%	(34.9)
Premises costs	20%	(26.7)
Outpatient savings attributable to OOH hubs	10%	(8.2)
Non-elective savings attributable to OOH hubs	20%	(155.5)
SaHF NPV post sensitivities		298.1

3.9.10 The NPV of the investment in the hub has been tested by modelling changes to the key drivers of the Return on Investment.

- **Capital costs increase by 30%**
  This could reflect higher material costs, higher capital inflation, the impact of a delay in the construction timetable resulting in higher capital charges.
- **Premises costs increase by 20%**
  Higher rent charged by landlords, including unitary payments for LIFT scheme, to reflect investment in the facilities and the NHS taking greater capacity
- **Outpatients savings attributable to OOH hubs reduce by 10%**
  This would be caused by not being able to reduce the tariff by 20%.
- **Non-elective savings attributable to OOH hubs reduce by 20%**
  This would be caused by the hub having less of an impact on the NEL admissions avoided than planned.

3.9.11 **Conclusion**: The ROI is most sensitive to the non-elective savings as these are the largest driver of the NPV over the expected lives of the hubs, however the business case is shown to be robust in the face of the above combined set of unmitigated sensitivities.

b. Acute NPV

3.9.12 The capital, transitional costs and reconfiguration I&E sensitivity scenarios have been applied to the financial NPV calculation. CIPs have been excluded as these are also in the comparator. This has been summarised in the table below.

Table 45: Programme-wide sensitivity analysis – NPV for acute reconfiguration

£'m	Ref	ChelWest		LNWH		THH		Total Sensitised NPV	Sensitivity impact on NPV
		Sensitivity value	NPV Surplus/(Deficit)	Sensitivity value	NPV Surplus/(Deficit)	Sensitivity value	NPV Surplus/(Deficit)		
SaHF 32 year NPV			(433)		937		(199)	305	
Capital Investment - 30% increase	1	(10)	(443)	(49)	887	(19)	(218)	226	
Transitional costs - 5% become recurrent	2	(3)	(436)	(13)	924	(1)	(201)	287	
Reconfiguration costs savings - 20% adverse	3	-	(433)	(257)	680	-	(199)	48	
									Combined Senstivities
Combined sensitivites	1+2+3	(14)	(446)	(319)	618	(20)	(219)	(48)	

3.9.13 The reconfiguration cost saving sensitivity (20%) also covers the sensitivity for different levels of activity transferring to other organisations.

3.9.14 Table 45 shows that when each individual sensitivity is applied the NPV remains positive.

3.9.15 When all sensitivities are applied to the NPV, the NPV moves to a negative £48m.

Conclusions of the sensitivity analysis

3.9.16 The OOH I&E is shown to be robust in the face of the combined change in cost assumptions. The OOH I&E is most sensitive to the non-elective savings and would need to be 86% lower than the current planned levels for the hub I&E benefit of £38m to reduce to zero.

3.9.17 The acute I&E sensitivities performed show that BAU CIP has the most material impact on all trusts, however this is also a risk under the comparator. In addition the risk delivery of the cost savings relating to the SaHF reconfiguration sensitivity would also have a material adverse impact on LNWH.

3.9.18 The OOH NPV ROI is most sensitive to the non-elective savings as these are the largest driver of the NPV over the expected lives of the hubs, however the business case is shown to be robust in the face of a combined set of unmitigated sensitivities.

3.9.19 The acute NPV ROI shows that when each individual sensitivity is applied the NPV remains positive, however when all sensitivities are applied to the NPV, the NPV moves to a negative £48m and is therefore less able to absorb all risks if these were to occur collectively.

3.10 Conclusion

3.10.1 We have demonstrated that the case is affordable under a range of scenarios by conducting sensitivity analyses.

3.10.2 We have analysed the capital investment requirement by year and by assumed funding source (on the basis of loan funding and on the traditional timetable) showing the required funding by CSR period and by source, and later (see point 8 below) explored an alternative affordable funding option and an accelerated timetable.

3.10.3 A sustainable financial position for North West London CCGs is demonstrated through 10 year financial projections.

3.10.4 Within the CCG projections the affordability of the hub capital investment to the CCGs is demonstrated.

3.10.5 Under the 'comparator' all trusts will be in financial deficit, with a combined deficit of £114m at 24/25, which would improve to £18.4m deficit under the SaHF scenario before the reconfiguration (with the hub investment). After reconfiguration the Trust financial projections demonstrate that trusts have an I&E surplus position of £27.6m at 24/25, with the reconfiguration contributing a c.£50m benefit. However if the capital investment was funded by loans, two of the trusts would have a below target Financial Sustainability Risk Rating (FSRR) and be unable to meet loan repayments.

3.10.6 Currently the trusts are running in-year deficits which would require an estimated cash support of £1.1bn over the next 10 years (and continue thereafter), which would reduce to £0.5bn under the SaHF scenario before the acute reconfiguration (where additional CIPs are delivered, partly due to hub investment to enable QIPP delivery). Under the SOC part 1 option ('SaHF scenario after reconfiguration'), the cash deficit support in the 10-year period would reduce further to £0.4bn and is eliminated post reconfiguration.

3.10.7 The transitional cost projections are set out, together with confirmation of affordability to NWL.

3.10.8 The financial rate of return measures the overall value of the investment to the NHS over the period of the investment, which is calculated at £828m, with a payback period of eight years for hubs and nine years for acute reconfiguration.

3.10.9 The loan funding scenario is unaffordable (from a liquidity perspective), so we have explored two scenarios:

a) In order to have an affordable FSRR and optimise the benefits, Public Dividend Capital (PDC) rather than loan funding for two trusts capital is proposed to ensure the FSRR remains at a 3 or above; and

b) An accelerated approval and delivery timeline (as set out in the strategic case), which reduces capital by £16m, and accelerates the financial benefits.

The PDC funded scenario under an accelerated timeline is our preferred option.

Chapter 4

Commercial Case

The Commercial Case demonstrates that the preferred option will result in a viable procurement and well-structured deal

1. Current provider arrangements will be utilised to identify the procurement implications of the proposals, supported by a central programme function to realise the benefits of economies of scale.
2. The procurement implications of the proposals have been identified and worked through:
    - Commercial arrangements have been identified for each of the 27 hubs
    - The hospital reconfiguration element involves five projects across three trusts. While assumptions have been drawn up for each of those projects, those assumptions will be developed in Outline Business Cases
3. Where staff are affected by changes, we will seek to retain them in the NHS in NW London.

4.1 Introduction

4.1.1 This section provides an overview of the current commercial landscape for the provider and commissioner estate within NW London, outlining contractual arrangements currently in place and procurement options available in order for providers and commissioners to deliver the proposed changes.

4.1.2 A number of providers must work within existing contractual arrangements, such as Private Finance Initiative (PFI) contracts, to deliver the proposed changes. For others, procurement options include the ProCure21+ framework or the Local Improvement Finance Trust (LIFT) initiative. These options are discussed in more detail in the sections below.

PFI

4.1.3 West Middlesex University Hospital, Central Middlesex Hospital and Willesden Centre for Health and Social Care are all the subject of Private Finance Initiative (PFI) contracts. The terms of contract generally will require works for remodelling and/or refurbishment to be managed through a variation process, whereby the PFI company will be asked to respond to a request with an estimate of cost, timing and any contractual implications, for negotiation prior to agreement and implementation. There may be circumstances in which a PFI company will be entitled to refuse to implement a requested variation. Experience in some cases suggests that this variation process can be time-consuming and expensive, though the contract terms do generally impose obligations to evidence Value for Money and the outcome varies greatly from one PFI to another.

ProCure21+/Procure 22

4.1.4 The ProCure21+/Procure 22 National Framework is a framework agreement with six Principal Supply Chain Partners (PSCPs), selected via an Official Journal of the European Union (OJEU) Tender process, for capital investment construction schemes across England up to 2016. The PSCPs have dedicated supply chains of over 1,200 small-to-medium-size enterprises (SMEs) that can be mobilised very quickly to offer expert advice, design and construction services. An NHS Client or joint-venture may select a PSCP for a project they wish to undertake without having to go through an OJEU procurement themselves.

4.1.5 ProCure21+ is a suitable procurement route for the following types of work:

- Service planning or reconfiguration reviews
- Major Works Schemes (or refurbishments)
- Minor Works programmes, in which each task value does not exceed £1m
- Refurbishments
- Infrastructure upgrades (roads, plant, etc.) and non-health buildings (car parks, etc.)
- Feasibility studies.

4.1.6 One of the advantages of the ProCure21+ method of procurement is that design risk can be transferred if desired, as the PSCP is contracted to provide a suitable design and build solution at an agreed Guaranteed Maximum Price (GMP).

LIFT

4.1.7 The Local Improvement Finance Trust (LIFT) initiative was founded in 2000 as a vehicle for partnership between the public and private sectors for regeneration and the development of facilities for primary care and community services. Under the LIFT structure, facilities are refurbished or built and maintained by a local LIFT company (LIFTCo), which has the responsibility for leasing facilities back to the NHS and maintaining the premises over the long-term.

4.1.8 Following the abolition of PCTs in the Health and Social Care Act (2012), the arrangements for the LIFT programme have changed; commissioners of primary and community health care are now required to work with two DH-owned property companies, NHS Property Services (NHS PS) and Community Health Partnerships (CHP) to identify and agree their requirements for any new estate. If a building is required in an NHS LIFT area, then CHP will

normally take the head lease from the LIFTCo and then put in place sub-leases with the providers of services commissioned by the CCG and NHS England for the parts of the building that their services occupy.

4.1.9 LIFT procurement arrangements are currently being reviewed nationally and so this option may change in the future. It should also be noted that Central London and West London CCGs are not covered by a LIFT company.

NHS Property Services

4.1.10 NHS Property Services (PS) was created by the Health and Social Care Act 2012. It provides strategic estates management for the NHS (acting as a landlord, modernising facilities, buying new facilities and selling facilities the NHS no longer needs) and is also a provider of support services.

4.1.11 NHS PS owns a large number of health centres and GP practices in NW London, for which it is landlord and provides hard and soft facilities management (FM) services. For properties not owned by NHS PS, it is likely to be the head-leasee and provide a soft FM service to health providers.

4.1.12 If the site is owned by NHS PS and we are refurbishing or extending the building we may ask NHS PS to raise the capital for the work.

4.1.13 Where it is a new build we will follow the NHSE capital investment process. DH/NHSE will normally jointly confirm the delivery route. If an NHS PS site is to be redeveloped by LIFT, then it will lease the site to the Community Health Partnership (CHP) so the CHP can enter into contract with LIFT Co.

Standard building contracts

4.1.14 Providers may choose to adopt a traditional competitive tendering process with standard form of building contracts (such as the New Engineering Contract (NEC) or Joint Contracts Tribunal (JCT) forms). Under this arrangement, the Provider is able to appoint a design team before tendering the fully developed scheme to a number of contractors. This means that the Provider would retain the design risk in the scheme but is able to include time and cost overrun protection in the contracts.

4.1.15 Current provider arrangements will be utilised to identify the procurement implications of the proposals. Commissioners are responsible for developing OBCs for out of hospital hubs and the primary care estate and taking through the NHSE capital investment process. Trusts are responsible for developing OBCs in respect of acute sites that they own and taking this through a process defined by NHSI. All trust OBCs have to be supported by commissioners. The local hospital OBCs are being led by the trust with significant CCG involvement.

4.1.16 The SaHF central programme team will provide a central liaison function to ensure:

- Timelines for procurements remain aligned across providers, for example managing risks of late delivery across different providers
- Coordination of activity and opportunity for joint procurements where possible, which would take place at the outset and during the process as required, for example working across trusts to develop contract packaging strategies which will deliver enhanced value for money.

4.2 The procurement implications of the proposals have been identified and worked through

4.2.1 This section sets out the services required to implement the proposed changes at each site affected by the SaHF programme and describes the proposed commercial approach to deliver them.

4.2.2 There are three elements of SaHF which require capital investment:

- Primary care estate
- Out of hospital hubs
- Hospital reconfiguration

4.2.3 The following sections outline the commercial strategy for each element of the programme.

Primary care estate

4.2.4 The primary care estate element of the programme is in the early planning stages and will involve a programme of work across all CCGs, working closely with NHS England and NHS Property Services, through which commercial arrangements will be defined.

4.2.5 There are four ETTF estate schemes in NWL that have been approved. Chiswick is one of these with a hub. We have also been successful in securing funding to create the primary care facility at CMH which is part of our hub proposal. Whilst the total capital requirement will remain the same, the source of funding source may change dependent on the outcome of capital bids.

Out of hospital hubs

4.2.6 The out of hospital hubs element of the programme involves 18 projects across eight CCGs. Services to be provided for the hub sites include clinical services and estates services. Out of hospital hub locations are shown in Table 1.

4.2.7 Clinical services include GP and community services. GP services will be delivered in line with the relevant GP contract. NHS England and the CCG will work together to ensure that GP services meet the requirements of the required service model. CCGs will commission community hub services in accordance with EU regulations. Individual service business cases relating to in-scope services to be housed in the hub will also reference how nationally recognised standards have informed the development of the service and clinical coding for health outcomes.

4.2.8 At the DMBC stage, it was estimated that 29 hubs were required, four of which are no longer proposed as part of Out of Hospital Hub plans. Further detailed analysis completed as part of SSDPs suggests that 27 hubs were required, which includes two hubs not listed in the DMBC. Further engagement on these changes, and their associated impact on equalities, will take place at the options appraisal and OBC stages of the hubs business case process.

4.2.9 We are making the best use of the existing public sector estate and are proposing enhancements at 11 partially or fully operational hubs. We have proposed seven new out of hospital hubs in key localities to enable us to most effectively use the available public estate and acute reconfiguration at two existing hospital sites at Ealing and Central Middlesex Hospital.

4.2.10 The table below includes the proposed 18 hubs for which there is capital investment required. In addition there are four hubs already in existence which do not require capital. There are also two included within the outer NW London hospitals (Ealing and CMH), two within inner NWL hospitals at St Mary's and Charing Cross and there is a further hub under review (West Middlesex) making 27 in total.

Table 1: Hub locations

CCG	Hub
NHS PS hubs	
Brent	Wembley, Centre for Health and Care
Brent	Willesden, Centre for Health and Care
Central London	Church street
Central London	Central Westminster
Hammersmith and Fulham	Parson's Green Health Centre
Harrow	NE locality Belmont/Kenmore
Harrow	The Pinn
Hillingdon	North Hillingdon
Hillingdon	Uxbridge and West Drayton
Hounslow	Chiswick
Hounslow	Brentford/West Middlesex
West London	Violet Melchett
West London	St Charles
NHS LIFT hubs	
Ealing	Ealing East
Ealing	Ealing North
Harrow	Alexandra Avenue
Hounslow	Heart of Hounslow
Hounslow	Heston

4.2.11 The out of hospital hub schemes in scope are at various stages of planning, some of them at a very early stage, and therefore the commercial arrangements for each scheme are not yet known. It is possible, however, to set out the various approaches to delivering works and facilities management services which might apply, dependent on the outcome of further work and the business case process. These are shown below in Table 2.

Table 2: Commercial arrangements for each hub type

Works	Facilities Management services	Types of scheme
NHS PS-led contract for refurbishment or extension	NHS PS-led contract for FM and lifecycle	New build or refurbishment on NHS PS-owned site
New LIFT contract for new build for refurbishment or extension	New LIFT contract for FM and lifecycle	New build or refurbishment on NHS PS-own site or newly acquired site
Existing PFI or LIFT contract for refurbishment or extension	Existing PFI or LIFT contract for any variation to FM and lifecycle	Site subject to an existing PFI or LIFT contract
Private developer for new build	Private company or NHS PS for FM and/or lifecycle	New build on privately owned site, possible subject to a s106 or similar planning arrangement with a Local Authority

4.2.12 Though arrangements other than those set out above are possible – these are the types of arrangements indicated by the intelligence gathering carried out to date and contemplated in the financial modelling for the Economic Case. Whether a particular scheme will be NHS PS-led or LIFT will generally be determined by the terms of the Strategic Partnering Agreement and Value for Money tests.

4.2.13 Further work will also be required to determine where it may be appropriate to work with Local Authorities to identify where there may be options to collaborate in ways that make best use of the public estate.

4.2.14 As stated above, the various hub schemes are at different stages of planning, with some of them at a very early stage, so it is not possible to state with any certainty what procurements for works and estates services would apply in each case. These will be determined during the development of each business case, dependent on the nature, scope and value of the scheme and the commercial arrangements, as well as procurement law and best practice.

4.2.15 The table below indicates the procurement implications for the various types of scheme.

Table 3: Out of hospital hub procurements

Works	Procurement route	Types of procurement
New build or refurbishment on NHS PS-owned site	Open-market or framework procurement of contract for works	Open-market or framework procurement of contracts for FM and lifecycle
New build or refurbishment on NHS PS-own site or newly acquired site	LIFT procurement	LIFT procurement
Site subject to an existing PFI or LIFT contract	PFI or LIFT contract variation: no procurement	PFI or LIFT contract variation: no procurement
New build on privately owned site, possible subject to a s106 or similar planning arrangement with a Local Authority	Not procured by the NHS	May or may not be procured by NHS depending on precise arrangement entered into

Hospital reconfiguration

4.2.16 The hospital reconfiguration element of the SaHF programme involves five projects across three trusts in SOC part 1 (with an additional four projects in two trusts in SOC part 2). Each project will require a number of services, including programme management, capital works and ongoing facilities management.

4.2.17 The analysis to determine the commercial approach for each service required across all the projects is currently being developed by trusts within the relevant draft OBC. This work will review the strengths and weaknesses of different approaches and provide a clear rationale for the choices made. For proposed contracts, OBCs will also provide details including:

- Key contractual clauses
- Contract lengths
- Charging mechanisms
- Potential for risk transfer

4.2.18 The table shows the current assumptions as to the expected commercial approach for each project, outlines the procurements which are currently thought to be required, and the likely procurement route. These may change further as trust plans are developed.

Table 4: Hospital reconfiguration commercial approach and procurement route for SOC part 1

Trust	Project	Services required	Commercial approach	Procurement route
Chelsea and Westminster Hospital NHS Foundation Trust	Capacity increase at West Middlesex Hospital	Programme management	New contract	Outsourced programme management office (O-PMO), provided that it demonstrates value for money
		Capital works for reconfiguration and expansion of emergency department	Variation to the existing PFI agreement	Contract variation
		Capital works for refurbishment of adults and inpatients accommodation	Operated under Concessionary PFI contracts	Competitive tender operated by PFI Contractor
		Facilities management	Amendments to current contracts	Contract variation
The Hillingdon Hospitals NHS Foundation Trust	Capacity increase at Hillingdon Hospital	Capital works	New contract	ProCure21+/Procure 22 framework
London North West Healthcare NHS Trust	Capacity increase at Northwick Park Hospital	Capital works for expansion to acute services	New contracts	ProCure21+/Procure 22 framework
	Transition of Central Middlesex Hospital to a local and elective hospital	Capital works for development of Brent hub, relocation of genetics service from Northwick Park and relocation of Ealing DGH elective activity	Variation to the existing PFI agreement	Competitive tender operated by PFI Contractor
	Transition work on Ealing Hospital	Capital works for design and build of refurbished facilities	New contract	ProCure21+/Procure 22 framework

4.2.19 We have described the proposed commercial approach for each of the services which will be required across the five hospital reconfiguration projects in SOC part 1 (with an additional four contained in SOC part 2). For a number of those services a new contract will be required and therefore the trust involved will run a procurement process in order to choose a preferred supplier.

4.2.20 The analysis to determine the appropriate procurement route for each new contract is currently being developed by trusts within the relevant draft OBC. This work will review the strengths and weaknesses of different approaches and provide a clear rationale for the choices made. For proposed procurements, OBCs will also provide details including:

- The procurement timetable
- Procurement costs
- Internal and external skills and resources required

4.3 Where staff are affected by changes, we will seek to retain them in the NHS in NW London

4.3.1 The STP identified a number of workforce challenges, including: workforce shortages; improving recruitment and retention; workforce transformation to support new ways of working and leadership and organisational development to support services.

Key principles

4.3.2 For staff changes which fall under SaHF, the following principles will apply to all staff groups and employers. These staff will include students and trainees affected by the changes.

- Patients First: SaHF is a clinically driven programme and in managing workforce changes we will continue to put patients (and the public) first in the delivery of its objectives and in implementing changes to service delivery ensuring that clinical safety is not compromised.
- Continued employment with no redundancies where practicably possible**:** Every effort will be made to ensure that staff affected by the implementation of SaHF continue to remain employed within the NW London NHS sector wherever possible and, if this is not possible, within the wider NHS or associated bodies. All reasonable steps will be taken to avoid redundancies.
- Equality of opportunity**:** No employee will receive less favourable treatment on the grounds of age, disability, gender, gender reassignment, pregnancy/maternity, marriage or civil partnership, race, religion or belief, sexual orientation.
- Transparency: Staff should be involved in consultation on changes which affect them and before final decisions are made.
- Partnership working: Trade union and staff association colleagues will be involved throughout the management of change and the approach and implementation of change will be managed in partnership with them.
- Treating people as individuals: Employees will be treated as individuals with due regard to their personal and employment circumstances and their needs understood and addressed as far as possible. They will be entitled to be accompanied to meetings by a trade union and staff association representative or colleague and will receive training, development and induction and other support commensurate with their new role and individual needs.
- Individual responsibility: Individuals have a responsibility to engage positively with the process of change, to remain open to new ways of working and to take ownership of their own individual training and development needs.
- Common approach: There will be a common and simple approach to managing organisational change, including common processes where practicable, compliant with employment law and NHS terms and conditions of service. NW London CCGs recognise that individual NHS organisations will continue to manage and take responsibility for their own employment issues, however, where it makes sense for individual employees, NHS trusts and NW London CCGs to pursue common processes and approaches to managing change these will be agreed and implemented.
- Working in partnership: The trusts will work constructively and in partnership to manage changes in the overall workforce, ensuring that these changes are undertaken in the best interests of health care in NW London.

4.3.3 In supporting the above principles, TUPE and Cabinet Office Statement of Practice (COSOP) employment legislation and practice will be applied wherever possible. This will help to ensure continued employment of valuable staff within the sector and a smooth transition of management of staff between organisations.

4.3.4 The Management Case provides more detail on the change management aspect of the programme.

4.4 Conclusion

4.4.1 This section has set out the procurement approach. Procurement will be conducted through the current provider arrangements, supported by a central NW London wide programme to realise the benefits of procuring at scale and ensuring consistency. This will also facilitate the retention within NW London of any staff affected by the changes.

Chapter 5

Management Case

The Management Case demonstrates that the preferred option is capable of being delivered successfully, in accordance with recognised best practice

1. NW London has well established collaborative working arrangements, including a CCG Collaboration Board and an Implementation Programme Board as a result of our longstanding clinical strategy *Shaping a Healthier Future* (SaHF). The SaHF programme is clinically led. There are three medical directors who provide general clinical oversight of the programme and ensures that all decisions are clinically led and focused. A Clinical Board provides clinical input to the programmes of work
2. We have a strong and effective Programme Management Office (PMO) with a Programme Executive in place.
3. We have built strong relationships with stakeholders and engaged widely on our proposals with patients and the broader community.
4. We have already made significant progress, with a proven track record of successful and safe transformation.
5. We have built on our existing arrangements and are updating our governance to ensure it is fit for purpose to deliver the Sustainability and Transformation Plan (STP) and the next phase of SaHF. We have set out the lessons learnt and key changes.
6. For the next phase of business case development we have prepared clear project plans, established programme assurance and identified key risks.
7. We have drawn up a benefits framework which we will use to track benefits realisation.

5.1 NW London has well established collaborative working arrangements and these are confirmed in the STP

5.1.1 Since our Shaping a Healthier Future (SaHF) proposals were approved by the Secretary of State in 2013 we have established robust governance arrangements to deliver the SaHF programme.

5.1.2 The nature of the programme has fundamentally changed from being a commissioner-led strategy programme to a partnership approach to implementation involving commissioners and providers.

5.1.3 This governance structure has been effective in helping us to manage input from multiple stakeholders, including providers, clinicians, strategic finance, our operational delivery boards and collaboration with the CCGs.

5.1.4 Since approval, the governance arrangements have supported a range of transformational changes. The structures are described in more detail in the rest of this section, starting with the original design principles.

Principles for governance design

5.1.5 The governance arrangements do not replace the current responsibilities that trust boards and CCG governing bodies have for the safe delivery of services.

5.1.6 The governance arrangements for the programme were designed based on a number of key principles:

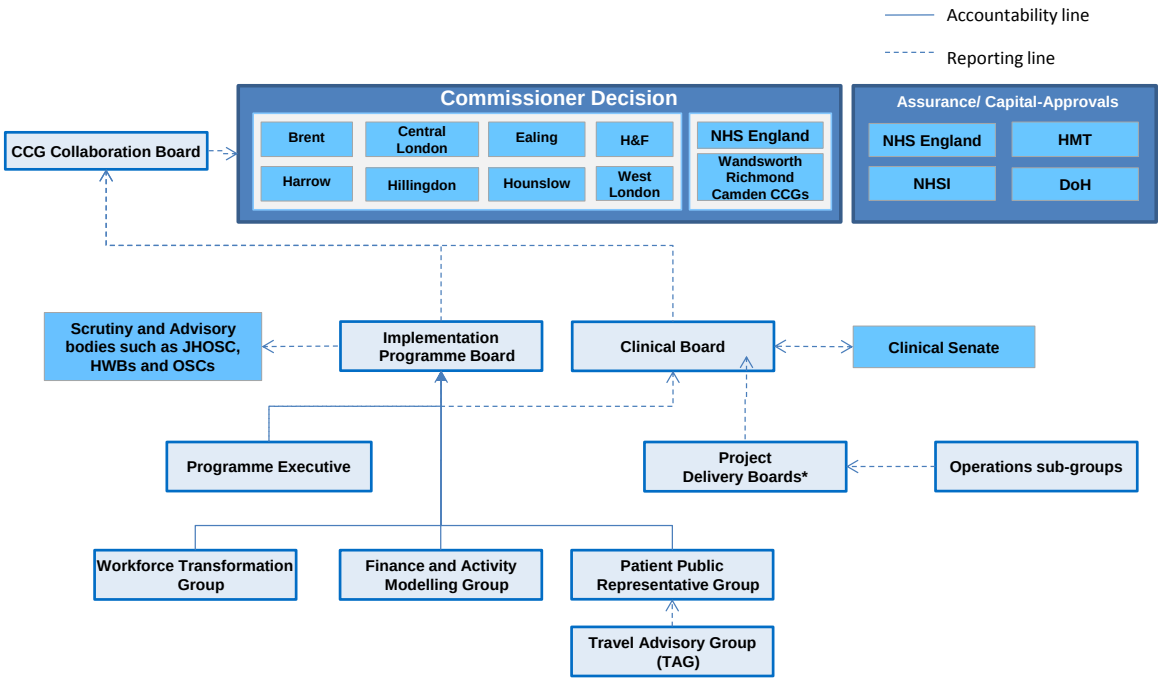
- Maintaining strong clinical leadership through a clinically led process, to ensure that clinicians and decision makers can be confident that changes can be made safely and sustainably
- Maintaining safety through transition remains paramount
- Having clear points of accountability for all key deliverables
- Driving change through locally managed activity where possible, with central intervention only where necessary
- Be integrated with the work of local strategic partnerships, social care services and mental health services
- Be transparent and open to scrutiny from local authorities, patients and the public
- Be aware of the patient, carer and community voice on all decisions that impact on their experience, taking into account protected groups, disadvantaged groups and carers.
- Enabling providers to take responsibility for their own changes, but within a system wide approach, to ensure key dependencies are identified and managed
- Providing assurance that the anticipated benefits of the programme will be delivered

Governance structures

5.1.7 The eight CCGs oversee the implementation of SaHF to make sure it is consistent with the decisions made by the JCPCT. They take decisions on how to implement the delivery of the proposed changes, and who to involve at each stage. NHS England and Camden, Richmond and Wandsworth CCGs are also involved where there may be a material impact on them. Materiality is defined through agreed thresholds of activity movements, and in consultation with these CCGs.

5.1.8 To implement SaHF, the eight CCGs established the SaHF Implementation Programme Board, and a Clinical Board with supporting workforce, finance and activity and patient representative groups. The overarching governance structure for SaHF is shown in Figure 1.

Figure 1: SaHF programme governance structure



- ***Project Delivery Board running from November 2016.***

CCG Collaboration Board

5.1.9 At their inception the eight CCGs created a Collaboration Board of the commissioners to support alignment, shared problem solving, and to hold each other to account for delivery of joint strategies. The Collaboration Board has no statutory responsibility, but does report into and make recommendations to the eight statutory Governing Bodies of the eight CCGs. The Collaboration Board:

- Takes responsibility for leading the SaHF Reconfiguration Programme Implementation, including receiving regular reports from the SaHF Implementation Board and establishing decision-making governance structures as required during the implementation process.
- Oversees implementation of the strategy for transforming primary care and out of hospital services, working collaboratively where agreed by members in relation to major out of hospital transformation programmes and evaluation of benefits.
- Takes responsibility for ensuring delivery of major transformation programmes established across the CCGs including decisions regarding programme design, resource allocation (including recommendations regarding shared procurements), overseeing progress and benefits realisation.
- Manages the financial risk across the eight NW London CCGs through a shared financial strategy.

The Implementation Programme Board

5.1.10 To implement SaHF the eight CCGs then established the SaHF Implementation Programme Board which is accountable to the CCG Collaboration Board. The Implementation Programme Board:

- Oversees the implementation of the programme in line with decisions taken by the NW London JCPCT in February 2013 and direction from the NW London CCG Collaboration Board.
- Acts as a forum to jointly manage progress, resolve issues and manage programme level risks and interdependencies.

- Monitors progress of the transformation of services, keeping oversight of all multi-organisational change and ensuring quality, equalities and patient needs are suitably considered at all times.
- Brings together local commissioners and providers to jointly manage implementation and ensure decisions on changes to service provision are being made and delivered consistently across NWL.
- Acts as a forum to jointly report on and manage progress, resolve issues and manage programme level risks and interdependencies between other provider / CCG projects and related programmes within the Strategy & Transformation Directorate (NWL CCGs).

The SaHF programme is clinically led and there is clinical oversight of the programme

5.1.11 Clinical leadership is core to SaHF and the way that we operate. There are three medical directors, who provide general clinical oversight of the programme and ensure that all decisions are clinically-led and focused. A Clinical Board provides clinical input to the programmes of work. Our medical directors are:

5.1.12 Dr Mark Spencer chairs the Clinical Board, the membership of which comprises all NW London trust Medical Directors and all NW London CCG Chairs, ensuring full clinical engagement of every NHS organisation in the planning and implementation of the strategy. They ensure that the programme disseminates clinical best practice.

5.1.13 Dr Tim Spicer has contributed to a wide range of projects including the North West London Integrated Care Pilot. Tim is Chair of Hammersmith & Fulham CCG as well as being a Medical Director for the *Shaping a Healthier Future* programme.

5.1.14 Dr Susan LaBrooy was Medical Director at The Hillingdon Hospitals Foundation Trust. She has clinically lead the merger of Mount Vernon and Hillingdon Hospitals, and most recently as clinical quality lead achieving Foundation Trust status for Hillingdon Hospitals Foundation Trust. Susan also led a team responsible for improving A&E targets for the Modernisation Agency, and contributed to the London and National Implementation for Older People.

5.1.15 The Clinical Board:

- Provides clinical leadership and input to the programmes of work
- Monitors and manages clinical risk across NW London during implementation, agreeing collective action to address any issues (including making recommendations to individual CCGs, providers, the Implementation Programme Board and the NW London CCG Collaboration Board)
- Ensures safe transition of services from sending to receiving units, by identifying the clinical risks and planning appropriate mitigating actions during transition
- Leads clinical implementation planning, in particular advising on safe sequencing of change
- Advises the programme on clinical readiness for the implementation of major service change
- Oversees the development of clinical pathways
- Monitors clinical benefits realisation
- Ensures the needs of patients, carers and the wider community are considered at all times.

5.1.16 The Clinical Board is supported by clinical networks and project delivery boards, which:

- Advise the Clinical Board on clinical implementation planning for specific services to ensure safe sequencing of change
- Support the Clinical Board in further developing the pathways and protocols for urgent care, maternity and paediatrics where necessary.

5.1.17 The programme leadership and clinical leadership ensure that decisions take into account and respond to the needs of ‘protected groups’, economically disadvantaged groups and carers.

5.1.18 Each of the SaHF portfolio of programmes has a Clinical Responsible Officer working alongside a Senior Responsible Officer. They have oversight for the safe and effective transition, as well as provide expert advice on plans. As with the SaHF programme, they act as the clinical champion for the changes being made, and as key clinical liaison with the wider clinical community.

5.2 We have a strong and effective PMO with a Programme Executive in place

Delivery structures: SaHF delivery through a unified Strategy and Transformation Directorate

5.2.1 The eight CCGs in NW London are working collaboratively through a unified Strategy and Transformation directorate, to deliver a portfolio of programmes to achieve their joint vision for a transformed health and social care economy in North West London. The eight CCGs have a Memorandum of Understanding (MOU) in place setting out how they work together to successfully implement their strategic plans, whilst recognising each CCG's individual sovereignty and the need for local decision-making. The NW London CCGs Collaboration Board, accountable to the respective CCG governing bodies, is responsible for overseeing the coordination set out in the MOU, providing the infrastructure to support co-operation and collective working across the collaboration of CCGs.

The Programme Executive

5.2.2 To implement SaHF the eight CCGs established a Programme Executive which is accountable to the Implementation Programme Board and the Clinical Board. The Programme Executive:

- Steer, inform and approve day to day programme activities, and provides leadership, coordination and strategic direction of the programme and relevant work stream deliverables
- Ensure transparency and patient engagement in all stages of the reconfiguration programme design and implementation
- Manage programme delivery in line with the scope, aims and timescales set out by the NW London CCG Collaboration Board
- Jointly resolve issues and engage other stakeholders such as CCGs, providers and NHS England to escalate issues or implement joint action as required.

A fully resourced PMO

5.2.3 The Strategy and Transformation directorate contains specific resources that are primarily focused on the timely delivery of the preferred option described in the Decision Making Business Case (DMBC), and summarised in the Strategic Case. This team provides oversight of all the work programmes, ensuring that risks and issues are reported and managed appropriately. The PMO is also responsible for overseeing the development of the Strategic Outline Case (SOC) part 1 and part 2. The team will also report of the progress of the subsequent Outline and Full Business Cases.

5.3 We have built strong relationships with stakeholders and engaged widely on our proposals with patients and the broader community

SaHF's inclusive approach to engaging with stakeholders has been a priority

5.3.1 Developing an inclusive approach to engaging with stakeholders has been a priority of SaHF. We understand that patients, staff and the wider public care deeply about what happens to their local NHS services and it is critical that they are part of the journey we undertake. We are working to the following engagement principles:

- Plan and undertake appropriate engagement with relevant stakeholders at each stage of the programme
- Deliver sufficient levels of awareness and understanding about proposed service changes across NW London among key identified stakeholder groups
- Provide regular opportunities for stakeholders to engage with us before, during and post formal consultation to facilitate engagement and consultation through high quality, credible communications channels and messages
- Baseline and monitor support among key stakeholder groups, before, during and after engagement
- Meet statutory requirements to engage stakeholders
- Ensure consistency of communications between commissioners and providers, as part of managing internal communications
- Ensure consistent clinical engagement through regular dialogue between programme Medical Directors and provider/borough clinicians
- Be proactive in identifying existing stakeholder events and meetings to tap into to increase programme awareness and relationship with stakeholders
- Work collaboratively with the media to ensure access to accurate information for the public
- Use social and online engagement to reach newer audiences.

SaHF programme's approach to stakeholder engagement and communications

Figure 2 outlines SaHF stakeholder engagement approach, which is based on an analysis of stakeholder position, programme involvement and the desired outcomes.

Figure 2: SaHF stakeholder engagement approach

	Role	Programme Involvement	Where do they need to get to as change is implemented?
Patients & public (including Healthwatch)	Most affected by changes	• Patient rep on Implementation Programme Board • Consult & inform Patient and Public Oversight Group • Involve in relevant local steering groups • Maintain programme website • Targeted public communications as changes are made	*"I know where to go when and have confidence I will receive a good service"*
Providers	Deliver the changes in primary and secondary healthcare services/service models	• Members of Implementation Programme Board / CIGs / Clinical Networks • Part of acute transition, CCG and local workstreams and steering groups where necessary • Programme support to business case development	*"I am clear what to do when, am working collaboratively with other providers and can make change safely "*
Commissioners	Support delivery of the changes and ensure commissioning plans align with transition plan	• Members of Implementation Programme Board and Clinical Board (through CCG Collaboration Members) • Members of local steering groups	*"I am clear what the system needs to do, and when, and am leading delivery with providers and local partners "*
Staff	Will help implement changes Job may be impacted (e.g. change of role or working location)	• Involve in relevant local steering groups / workstreams • Communications by relevant employer (supported by standard materials from central team)	*"I understand and feel enthused about my future role"*
Assurance Bodies (JHOSC, OSCs, DoH, Monitor, NTDA, NHS England)	Review planned changes to health economy, ensure alignment with wider health economy and provide QA support	• Attend Implementation Programme Board, Clinical Board and local steering groups as and when required to provide assurance • Quality, safety and risk reviews • Ad hoc engagement (including 121s) as required	*"I believe changes are being implemented safely" "My local services are prepared for change and will be better integrated in the future"*
Local government	Changes may impact local services (e.g. community services) and constituents	• Include in relevant local steering groups / workstreams • Update via programme newsletter and website • Ad hoc engagement as required	*"I believe changes are being implemented safely" "My local services are prepared for change and will be better integrated in the future"*
Regional and National Government	Influence beliefs and attitudes of patients and the public	• Manage relationships through Department of Health • Update via regular briefings and structured engagement	*"I believe changes are being implemented safely. Services are prepared for change and ready for future challenge"*
Media	Influence beliefs and attitudes of patients and the public	• Manage relationships through regular media releases • Update via regular briefings, meetings and ad hoc engagement as required	*"I have confidence in the NHS to safely deliver the improvements"*

Patient and Public Representative Group (PPRG)

5.3.2 There are various advisory and scrutiny committees and bodies, many of which are statutory and have specific terms of reference that define their functions, roles and responsibility independent of SaHF. However a PPRG has been convened specifically to advise and steer SaHF. The PPRG:

- Brings together patient and carer representatives from across NW London to monitor and support the Strategy and Transformation directorate in ensuring it considers and responds to the needs of patients, carers and the public during the planning and implementation of changes
- Is the voice of the public throughout the planning and implementation processes of Shaping a Healthier Future

- Challenges the programme to ensure the local population is taken into account at all stages and to ensure there is a robust process for regular engagement more widely across NW London
- Monitors patients and wider local public and that their views are reflected in the implementation of service changes
- Acts as a voice for representatives of patients, voluntary sector organisations and relevant interest groups and share their knowledge and local insight with the programme
- Advises on effective communication between patients, the wider public and commissioners:
    - Reviews and advises on communications materials
    - Advises on local channels for communications activity
    - Supports the dissemination of relevant programme information to any the community groups, organisations and stakeholder networks with which they are involved
    - Advises on the robustness of local engagement activities and on which groups or individuals they should engage with locally.

Patient and public engagement and consultation

5.3.3 Any programme of the size of SaHF that is proposing significant changes to the way that services are provided has a duty to formally consult and engage the public on these changes. This formal requirement is in addition to significant informal and non-statutory engagement and pre-engagement activities that have been undertaken and are ongoing.

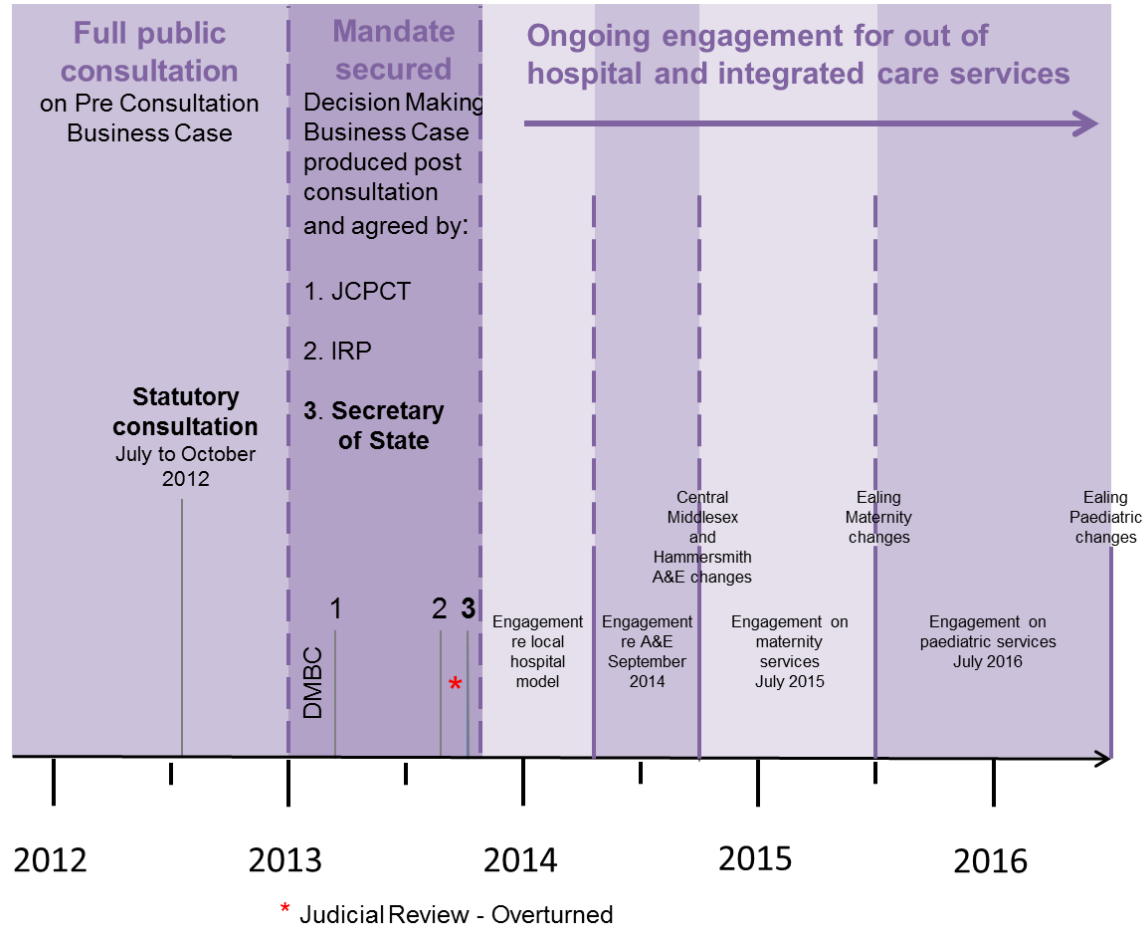
5.3.4 Significant and sustained public and stakeholder engagement was undertaken ahead of publication of the SaHF Decision Making Business Case (DMBC), through which we consulted on our proposals. Further engagement has taken place, following the Joint Committee of Primary Care Trust (JCPCT)'s approval of SaHF proposals, and the subsequent review and acceptance of recommendations by the Secretary of State for Health, through the Independent Review Panel (IRP). Our engagement process is ongoing, and has included:

- Full public consultation on the Pre-Consultation Business Case (PCBC) - statutory consultation on the pre consultation business case from July to October 2012
- The consultation informed the subsequent Decision Making Business Case and two alternative proposals relating to Ealing and Charing Cross local hospitals, which were approved by the JCPCT in February 2013.
- Decision reviewed by the Independent Reconfiguration Panel (IRP) in September 2013
- Final approval from the Secretary of State for Health in October 2013
- Clinical design and public engagement on local hospital proposals from October 2013 to April 2014
- Public engagement on specific service changes.

5.3.5 Our engagement activities vary according to the focus of the programme at different points in time. We have undertaken a significant amount of engagement on the specific changes to A&E at Hammersmith Hospital and Central Middlesex Hospital, and to the maternity and paediatric services at Ealing.

5.3.6 We have also undertaken an extensive co-production of our work on integrated care models with our lay partner advisory group, who were fully embedded throughout the work and who won an award for the NHS Patient Champion of the Year 2015.

Figure 3: ImBC timeline of public consultation and ongoing engagement



5.3.7 The SaHF programme, led by local clinicians, proposed changes to services in NWL that would safeguard high quality care and services for the local population. This included:

- Consolidation of maternity and neonatal services from seven to six sites to provide comprehensive obstetric and midwife-led delivery care and neonatal care.
- Consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay and ambulatory facilities.
- Consolidation of A&E departments from nine to five sites with units at four hospitals Charing Cross, Central Middlesex, Hammersmith and Ealing hospitals being revised. Serious emergencies are referred to A&Es at Hillingdon, Northwick Park, West Middlesex, Chelsea and Westminster or St Mary's hospitals.

5.3.8 The key trusts for these services are Chelsea and Westminster, Hillingdon, London North West Healthcare Trust and Imperial

5.3.9 We undertook increased engagement after the JCPCT decision was reviewed by the IRP in September 2013. This included early engagement on the local hospitals at Ealing and Charing Cross in 2013 and 2014. This included:

- Large public engagement and co-design events in October and November 2013, discussing future options for the hospital with patient groups and local clinicians
- Going out to meet local communities and the voluntary sector in Ealing and Hammersmith and Fulham to discuss future options for the hospital and the needs of different patient groups
- Meeting with acute clinicians from both Ealing Hospital and Imperial College Hospital to discuss the new models of care and strengthen our plans using their experience and intelligence of delivering local services

- Working with CCG Governing Body Clinical Leads and Lay Members to ensure that services are properly planned for local residents which meet their specific needs
- Meetings with local Councils through attendance and presentations to Scrutiny Committees and Health & Wellbeing Boards

5.3.10 In addition, between the 6th February and 21st February 2014, we conducted a series of focus groups in the London boroughs of Ealing and Hammersmith & Fulham. The objectives of these focus groups were to explore what the local population knew about the proposed changes to healthcare in the two boroughs and identify their key information and communication needs going forward.

5.3.11 We have also undertaken specific engagement with the vulnerable and frail elderly and with carers or representatives of these patients. At a high level, this has included:

- Meetings with Age UK. We met 6 elderly groups in Ealing (four facilitated by Age UK and two Asian Elderly groups both in Southall) and saw approximately 300 people in total
- Meeting with the Hammersmith & Fulham Older Peoples Forum and Hammersmith Disability Forum
- Meetings with groups representing patients with Long Term Conditions e.g. Hammersmith & Fulham stroke association, Hammersmith & Fulham MENCAP, Ealing Carers Forum, and the Get the Right Treatment Learning Disability Project.

5.3.12 Our engagement is ongoing, and we plan to work with the local population and clinicians from a range of organisations and specialties to define the detailed clinical model for Ealing, and the future configuration of services at the site. We are planning further co-design and engagement on the local hospital at Ealing in 2017 as we develop clinical models for the OBC, and will update our equalities assessments in line with this process.

5.4 We have already made significant progress, with a proven track record of successful and safe transformation

5.4.1 Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions.

5.4.2 We have a proven track record of progress and have had successes in improving patient care and clinical outcomes so far but need to increase the pace and scale of what we do if we are going to achieve the full benefits of SaHF. We also need capital to affect further changes.

5.4.3 Since the decision in October 2013 by the Secretary of State for Health which gave us a mandate to continue with the proposed reconfiguration, we have made the following progress against key elements of our strategy:

- Provide out of hospital services and move delivery closer to people's homes through:
  - Improved access to GPs through the transformation of primary care
  - Improved care processes and patient pathways on non-elective activity in secondary care
  - Reduced variation in diabetes by CCG and by GP federation and network
  - Better coordinated and more integrated care across providers in practice collaborating with GP surgeries, local NHS hospitals and community and social care services, an example being the St Charles Hub in West London
  - Significant investment in out of hospital services and the primary care estate
- Reconfigure and transform our acute services and implement new models of delivery through:
  - Implementation of new 24/7 urgent care centres and closure of two A&E departments
  - Transformed maternity services and closed the Ealing maternity unit
  - Transformed paediatric services and closed the Ealing paediatrics inpatient ward
  - Piloted seven day services

5.4.4 These achievements in implementing the SaHF proposals are the foundation for future progress. Further detail on each of these areas is provided in the following sections.

Improved access to GPs through the transformation of primary care

5.4.5 Significant investment has been made in primary care as part of the SaHF proposals. These are crucial to the out of hospital strategy and are the foundation for future changes. Current progress includes:

- GP practices in North West London offering extended hours have been increasing, which includes 56 GP practices in Brent, 22 in Central London, 69 in Ealing, 33 in Harrow, 24 in Hammersmith & Fulham, 43 in Hillingdon, 43 in Hounslow and 32 in West London in NW London - this has enabled around 1.9m NW London residents to access GP services at weekends
- Investment in new technology at 80 GP practices means half a million patients can useonline, email, video or telephone consultations
- Single GP IT system with each borough, enabling GPs to see and treat patients from other practices while viewing the care record
- 14 of the 15 operational out of hospital hubs offering primary care services

- Nearly two-thirds (250 of 389) of NW London GP practices have signed up to an information sharing agreement, allowing them, with consent, to access patients' records across different practices and between practices and hospitals to join up care.

Improved care processes and patient pathways on non-elective activity in secondary care

5.4.6 We are enhancing our care processes in secondary care through our approach to implementing 7 day services. Multi-disciplinary team (MDT) working involves doctors, nurses, therapists and pharmacists to facilitate the patients' pathway through their hospital stay and transfer of care back to their usual place of residence. A further example is our rapid response services, including the short-term assessment, rehabilitation and reablement service (STARRS) which is triggered by arrival in A&E of patients meeting certain criteria and involves an MDT of therapists, nurses and doctors to rapidly implement a range of tailored community support to avoid the need for admission.

5.4.7 As shown in section 1.4.37 in the Strategic Case, in NW London our non-elective admission figures have shown low growth and been on a downward trend in admission rates per 100,000 at most CCGs since 2012/13. In contrast, the non-elective admission rate in London as a whole has increased slightly, and nationally it shows a clear upward trend. The three-year rolling average shows this more clearly, with five of our CCGs showing an obvious downward trend, two holding steady and only one with an upward trend. This provides compelling emerging evidence that our end-to-end model of patient care is appropriate and effective, and that we have already taken many of the right steps towards implementing it.

5.4.8 All our CCGs have seen a reduction in the number of non-elective bed days per 100,000 over the last five years, even those that have not seen a fall in admission rates. This means that in NW London, we have already made notable improvements to the way that we support our patients' transfer of care from hospital back into the community.

Reduced variation in diabetes by CCG and by GP federation and network

5.4.9 Much has already been achieved in the management of nearly 70,000 people with diabetes among the five CCGs in inner NW London. It was recognised that there was considerable variation in clinical practice between, and even within, different GP practices, and that unacceptably poor outcomes needed to be addressed using a proactive population-based approach. The initiative has identified the people at highest risk of complications, such as those with mental health problems, a history of poor compliance, poor motivation or poorly controlled diabetes, and then offers appropriate direct support from a multidisciplinary team (MDT). Currently most care is provided by GPs and practice nurses, but the intention is to change this to community workers, health coaches, physicians' assistants and other 'non-traditional' roles. The infrastructure to support this will be housed in our hubs, from which care can be delivered in person or virtually by members of the MDT.

5.4.10 As shown in the Strategic Case, the diabetes dashboards along with other dashboards for asthma, have demonstrated how increasing visibility of practice performance across specific domains will have a significant impact on improving delivery of outcomes.

5.4.11 A three tier approach is proposed to improve performance and drive down variation:

- Set practice-specific relative targets, e.g. any practice within a certain range to improve performance by 5/10/20% over agreed time-period
- Target practices below the CCG or NWL average (mean or median) to bring them up to the current average
- Focus on poor performing practices by setting minimum acceptable standards for NWL

5.4.12 Specific clinically-meaningful outcome measures will be developed to ensure progress with reduction of key events e.g. for diabetes: amputation, blindness, development of chronic renal failure; and improvement in oral anticoagulant prescribing for defined patient-cohorts.

Better coordinated and more integrated care across providers in practice collaborating with GP surgeries, local NHS hospitals and community and social care services, an example being the St Charles Hub in West London

5.4.13 Our work on integrated care relates to the need for care to be integrated and personalised. This means that the system will look and feel from a patient's perspective that it is personalised, and that individuals will be enabled and supported to be well and live well.

5.4.14 The intention through co-location is to enable the local population to access more services, more easily in one location, to share more of the space to integrate services and people, as well as to release savings and improve utilisation levels.

5.4.15 Significant progress has been made in delivering whole systems integrated care at scale and pace:

- A single discharge agreement has been agreed across NW London with all boroughs committed to get patients home quickly and safely when they are fit to leave which can reduce stays by up to three days.
- Early adopters include our health and social care partners in each of the eight boroughs of NW London who are collaborating with people who use services to co-design and implement new models of person-centered care**.** For example**:**
  - Brent: Wembley and Willesden Centres for Health and Care are already operational hubs delivering enhanced primary care services and a pilot for self-care support.
  - Harrow: Alexandra Avenue and The Pinn Medical Centre are already operational hubs delivering enhanced primary care services amongst other services.
  - Hillingdon: Care Connection Team in place in four GP practices with a view to scale up delivery of services.
  - West London: St Charles has already established elements of an operational Hub delivering enhanced primary care services amongst other services which is included as a case study in the Strategic Case.
- Rapid access services in all North West London boroughs to help keep patients with long term conditions out of hospital where possible, and discharged quickly from hospital when they have needed to be admitted. This has helped more than 3,000 people in Harrow and prevented 2,700 hospital admissions in Brent.
- Self-care directory of programmes and their enablers has been launched. In addition self-care leads from each of the CCGs meet every two months to share best practice and prioritise interventions in their local area. Plans for this to be piloted across NW London in approximately 200 GP practices, and licences are being applied for to cover all patients with long term conditions. Third sector service to help patients' self-care "Hillingdon4All" has been rolled out in Hillingdon.
- Metrics and intelligence supported by three years of data loading and linkage completed for acute, community and mental health data. Primary care data has started to be loaded, and social care data will be loaded into the system in the coming months. Dashboards have been successfully piloted in eight practices.

5.4.16 In West London the CCG has developed two hubs: the St Charles integrated care centre, W10 and the Violet Melchett Integrated Care Centre, SW3.

5.4.17 My Care, My Way is an integrated care service for people aged 65 and older. This service has been rolled out to 24 of our 45 practices, covering 73% of the registered population, the plan is to roll out to the other practices as part of stage 3.. The Hub at St Charles went live in September 2015. The focus of this exciting service is planned care that anticipates and prepares for any changes in a patient's health and social care needs. It empowers patients to manage every aspect of their care in partnership with their GP.

5.4.18 With longer appointments with their GPs and a wide range of health and social care professionals on hand to provide support, the centres provide patients with a wide range of services conveniently under one roof. Examples services include basic foot care, diabetes clinics and social care. It means patients can access all the service they need in one place at one time.

Significant investment in out of hospital services and the primary care estate

5.4.19 The eight NW London CCGs have made significant investment in out of hospital services. This includes service and infrastructure investments on:

- Primary care including urgent care centres and IT services for GPs.
- Integrated care including case management, rapid response, and non-acute winter pressure spending.
- Community out of hospital including new re-provisioned outpatient services and out of hospital services provided by GPs (old LES/DES).

5.4.20 More than 75,000 outpatient appointments have been re-provisioned in a community setting, with pathways redesigned.

Implementation of new 24/7 urgent care centres and closure of two A&E departments

5.4.21 During 2014/15, major changes to the urgent and emergency care system were carried out in order to improve the quality of care in NW London. Changes included establishing 24/7 urgent care centres at all hospitals in NW London, and the cessation of A&E at Hammersmith and Central Middlesex hospitals where activity levels were low and where in one case there were shortages, and in the other there were no, emergency medicine consultants staffing the A&Es. The noted benefits included:

- Increased consultant cover to comply with London Quality Standards at two receiving hospital sites
- Improved resilience within the system through reduced reliance on temporary staff.

Transformed maternity and paediatric services, and closed the Ealing maternity unit and the Ealing paediatrics inpatient ward

5.4.22 We have transformed maternity services and closed the Ealing inpatient maternity unit. In 2015, the programme delivered significant clinical improvements for women and new-born services via consistent and networked model of care for maternity services. This model has meant:

- Women have increased choices of where they receive their antenatal and postnatal care as well as birth setting
- A range of coordinated community and hospital based services for mothers and babies;
- A consolidation of acute specialist expertise in NW London (from seven inpatient units to six inpatient units) leading to increased senior consultant cover on the labour wards, from an average of 101 hours before the changes to 122 hours per week after the changes
- Women can receive improved continuity of care under new pan NW London network of maternity services, with an increase from 58% to 79% of women
- Presence of 100 more midwives across NW London

5.4.23 The changes were endorsed by the Royal College of Midwives and an evaluation after six months showed that all of the short term, and many of the longer term, benefits of the changes had been achieved.

5.4.24 In 2016 NHS England has conferred us with early adopter status for maternity because of the programme we've already put in place on the continuity of care.

5.4.25 We have transformed paediatric services and closed the Ealing paediatrics inpatient ward. In 2016, the Acute Care Transformation programme, working with our providers, has delivered a major change to services for children and young people in need of acute care. Our new model of care has involved:

- Better access to urgent and emergency care
- Provision of Paediatric Assessment Units staffed by consultant paediatricians
- Provision of purpose built units, staffed by consultants, to provide care for children who need observation and clinical intervention
- Provision of 60 additional paediatric nurses recruited to the NW London workforce
- A large refurbishment and expansion programme has also taken place in our hospitals over the last few months
- A new children's A&E at Hillingdon Hospital and the children's ward and A&E at West Middlesex Hospital have expanded

5.4.26 The impact of these changes is scrutinised using data submitted for our weekly dashboard.

5.4.27 The main public concern prior to the transition was that many children would need to be transferred out of Ealing Hospital's urgent care centre or adult A&E to receive care. So far the number of children transferred using non-emergency patient transport has been substantially lower than we had planned for, on average just three children a week.

Improved seven-day access

5.4.28 In 2015, NHS England appointed NW London as a first wave delivery site for seven-day services, to pioneer new models of care across NW London to improve weekend acute care in hospitals. This is an NHSE priority.

5.4.29 Our achievements to date include:

- Developed and piloted an evidence-based clinical model of care to ensure:
  - All emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital
  - Ongoing review by consultant every 24 hours of patients on general wards
- Workforce capacity including a discharge to assess process for patients transferring from acute to community care
- Reporting regime and network to manage demand and capacity across the whole of NW London
- Clinical decision support through electronic vetting of reports built into the system
- Launched a first of its kind NWL Career Framework for Radiographers in order to address current vacancy rates and time lost waiting for access to diagnostics.

5.5 We have built on our existing arrangements and are updating our governance to ensure it is fit for purpose to deliver the STP and the next phase of SaHF

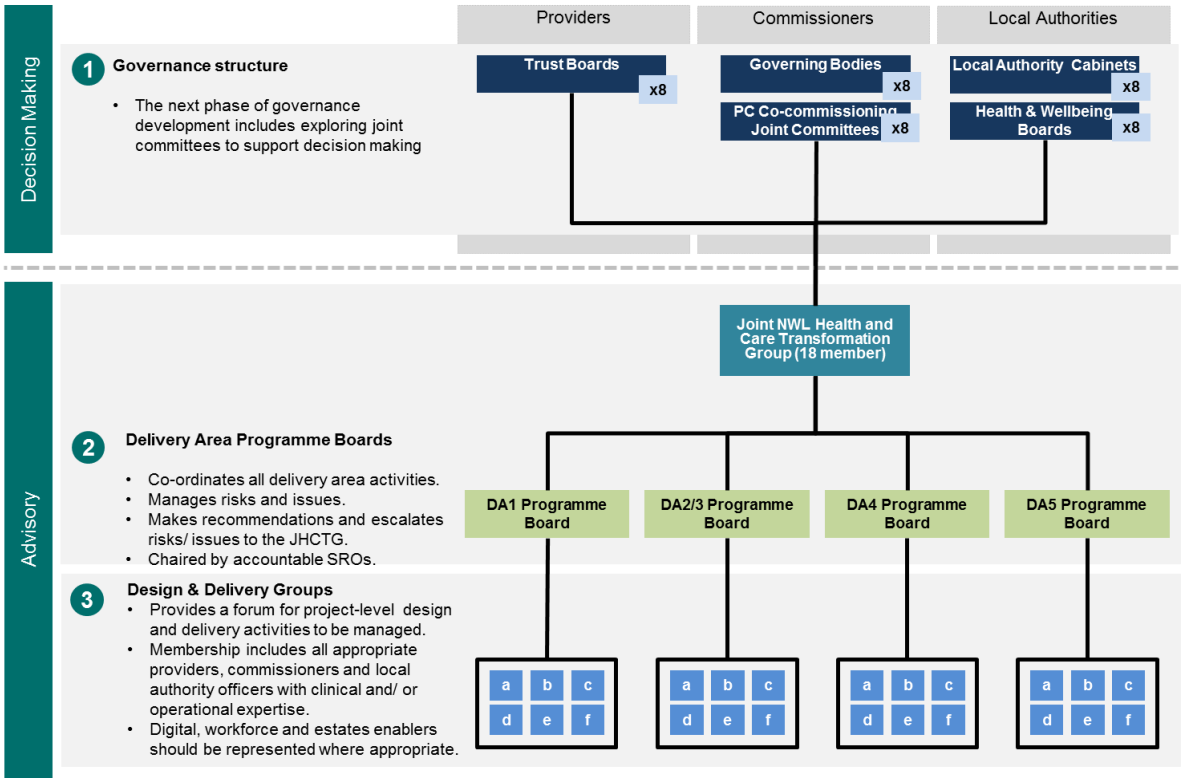
STP Delivery Area governance structure

5.5.1 Governance arrangements were in place ahead of the Sustainability and Transformation Plan (STP) but we are now developing a plan to implement a new decision making structure and full governance arrangements.

5.5.2 The programme governance will evolve to complement the broader governance around the delivery of the STP. The STP focuses on five Delivery Areas, whose remit includes the proposals set out in this business case but also extends beyond them covering public health and mental health.

5.5.3 The STP decision making structure sets out the roles of the Delivery Area Programme Boards and the Design and Delivery Groups. These plans are still being put in place.

Figure 4: STP Decision making structure



5.5.4 Our NW London workforce strategy builds on our successes in acute service reconfiguration, addressing local workforce challenges and supporting the out of hospital agenda. It is aligned to the NHS Operational Planning and Contracting Guidance and is being delivered through a newly established governance structure and strategic framework.

5.5.5 We will achieve transformation through the strengthened collaboration between Health Education England (HEE), NW London providers, commissioners and local authorities. This approach ensures delivery will combine expertise and experience of investing in education and workforce initiatives with that of service planning, commissioning and care delivery.

5.5.6 To improve governance, we have established an STP joint workforce team bringing together HEE NW London and NW London CCGs. This will operate through a newly established Board that is co-chaired by the CCG, Social Care and HEE.

NW London Provider Board

5.5.7 The NW London Provider Board is a joint forum that is attended by all of the provider Chief Executives in NW London. The Provider Board oversees a number of work streams which seek to address the productivity challenges facing the wider NHS in a collaborative way. It enables trusts to look beyond organisational boundaries, and in doing so meets the ambitions set out in the Five Year Forward View (FYFV). It also increases the ownership of the productivity agenda by acute trusts.

5.5.8 Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review[1]. These opportunities are detailed in the STP. Three of the four acute trusts have recently signed off a joint venture for pathology to deliver £96m of savings over 10 years, and other providers are looking to join this in the future. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery of the priority projects for:

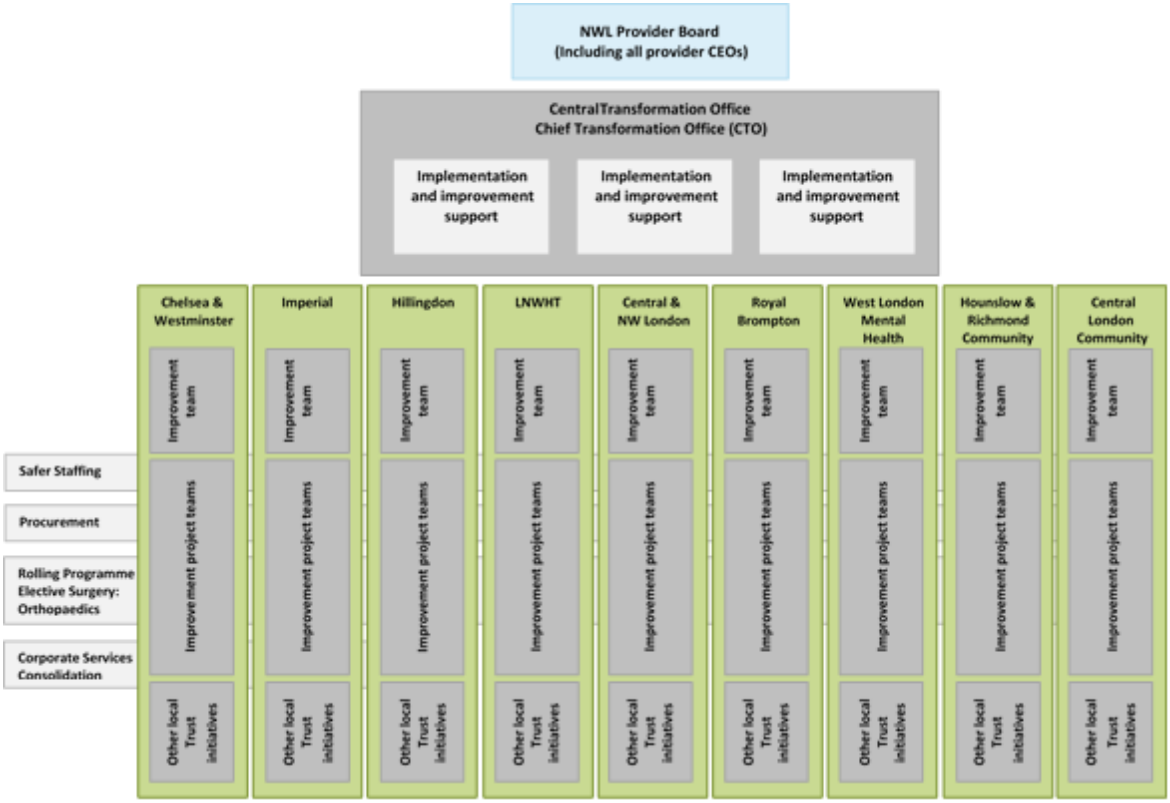
- Safer Staffing
- Procurement
- Consolidation of Corporate Services
- Rolling programme of elective surgery (GiRFT) started with orthopaedics.

5.5.9 The programme structure is shown in the figure below. The programme started with the acute trusts but all community and mental health providers are also now participating. To achieve this providers have:

- Recruited a sector transformation director (Chief Transformation Officer) to lead the programme, with analytics funded by CCGs and PMO provided by Imperial College Health Partners.
- Recruited programme directors and supporting project managers for all programmes, funded by the trusts to whom savings accrue. Savings are expected in-year from procurement, and all trusts are expecting to deliver their bank and agency targets, with plans for a pan NW London bank by the end of the year.

[1] Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, Coles, Lord P. (2016)

Figure 5: NW London Productivity Programme



5.6 For the next phase of business case development we have prepared clear project plans, established programme assurance and identified key risks

5.6.1 This section describes the programme delivery approach for SaHF currently and for the delivery of SOC part1 and SOC part 2.

5.6.2 This section outlines:

- Programme milestones under a traditional and an accelerated timeline
- Implementation planning and business case process
- Implementation plan and build start for hospital reconfiguration and out of hospital
- Plan to work with the trusts during transition
- Engagement with staff and unions.

Programme milestones under a traditional and accelerated timeline

5.6.3 Two sets of programme milestones have been developed based on a 'traditional' and 'accelerated' timeline. The former is the original set of timelines that had been developed for the programme, and assumes sequential development and approval of business cases before capital funding is released.

5.6.4 The accelerated process is described in more detail in the following section. The accelerated timeline refers only to acute hospital business cases, and does not include those for out of hospital hubs, where individual approvals are below DH and Treasury limits. The key high level programme milestones are shown in Table 1 and shows a comparison between the two timelines.

Table 1: Programme milestones with a comparison of traditional and accelerated timelines for SOC part 1

	Traditional Timeline	Accelerated Timeline
Overall programme milestones	Estimated Date	Estimated Date
SOC part 1 approved – NHS England Investment Committee	January 2017	January 2017
Out of hospital hubs milestones	Estimated Date	Estimated Date
Business case phase for first wave of schemes (PID and OBC)	FY 16/17	FY 16/17
Business case phase for majority of schemes (OBC and FBC)	FY 17/18	FY 17/18
First hub sites open (those that require minor works)	FY 17/18	FY 17/18
Construction phase for first wave of schemes	FY 17/18	FY 17/18
Construction phase for second wave of schemes	FY 18/19	FY 18/19
All out of hospital hubs complete	FY 23/24	FY 23/24
Hospital reconfiguration milestones	Estimated Date	Estimated Date
All hospital OBCs approved by	February 2019	February 2018
All hospital FBCs approved by	March 2022	March 2019
All implementation begun by	July 2022	June 2019
All implementation complete by	December 2023	November 2022

*To be confirmed when Central Middlesex Hospital and Willesden timeline is finalised

Accelerated timeline for hospital reconfiguration

5.6.5 Typically significant acute hospital transformation schemes require a five year period to develop and refine business cases, and ensure that these pass through the relevant approval mechanisms. This assurance must happen before any change may occur. This assumes the development and approval of the Outline Business Cases (OBC) and Full Business Case (FBC) happens in sequential stages. If this timeline were followed in NW London then the proposed transformational changes would not be realised within the time scope of the STP. The challenges described in the STP and strategic case would not be addressed, patients would continue to receive care below the standards they should expect and the system would become financially unsustainable.

5.6.6 Therefore an alternative accelerated timeline has been developed based on the assumption that business case development and approval can be achieved within three years whilst still achieving the same level of required assurance. The accelerated timelines are based on:

- Parallel running of the business cases, including FBC development starting before the approval of the OBC
- A faster approval and assurance route.

5.6.7 The obvious benefit of an accelerated timeline is that the benefits described in this business case can be delivered sooner. The issues of resilience and sustainability within our providers can also be addressed more quickly.

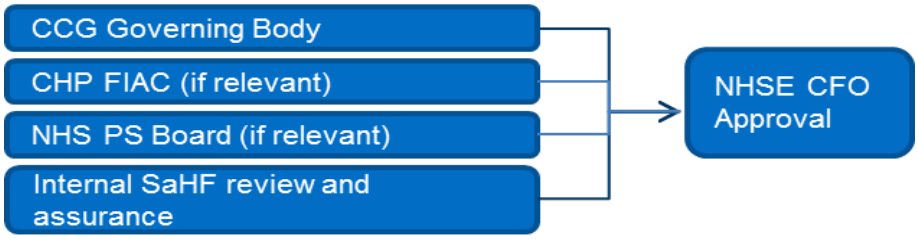
Implementation planning and business case process

5.6.8 Following approval of SOC part 1, each hospital reconfiguration project and out of hospital scheme within the SaHF portfolio which requires capital investment will be required to complete an Outline Business Case (OBC) and a Full Business Case (FBC) before implementation can begin. The detailed implementation plans for the hospital reconfiguration and out of hospital capital programmes will be outlined in the relevant business cases. There will however be interdependencies between hospital schemes, and across the hospital and out of hospital programmes which are being managed centrally by the SaHF programme. The accelerated assumption assumes SOC part 1 does not need DH approval before commencing OBCs.

Out of hospital business cases

5.6.9 CCGs are developing PIDs, OBCs and FBCs for each of the proposed out of hospital hub schemes. Governance routes vary according to stakeholders involved in each scheme, but the NHSE CFO has the final approval. Procurement and Audit Committee (FIPA) has the ultimate approval responsibility. Figure 6 shows the assumed approvals route for the hub PIDs, OBCs and FBCs.

Figure 6: Out of hospital hub OBC and FBC approvals



Timescales for the completion of the out of hospital business cases

5.6.10 Following approval of each OBC, the required procurements and commercial negotiations will commence as outlined in the Commercial Case, and the development of the FBCs will begin. The expected dates by which approvals for both the OBC and FBCs under both timelines are shown in Table 2. Dates shown refer only to the business cases, and developments that the capital accessed through business cases enable will then begin.

Table 2: Out of hospital hub business case timetable

CCG	Hub	OBC approval	FBC approval
Brent	Wembley Centre for Health and Care*	TBC	TBC
Brent	Willesden Centre for Health and Care*	TBC	TBC
Central London	Church Street	TBC	TBC
Central London	Central Westminster	July 2017	Jan 2018
Ealing	Ealing East	July 2017	Jan 2018
Ealing	Ealing North	July 2017	Jan 2018
Hammersmith and Fulham	Parson's Green Health Centre	Feb 2017	June 2017
Harrow	Alexandra Avenue	TBC	TBC
Harrow	North East Harrow	July 2017	Jan 2018
Harrow	The Pinn	TBC	TBC
Hillingdon	North Hillingdon	April 2017	Sept 2017
Hillingdon	Uxbridge and West Drayton	July 2017	Jan 2018
Hounslow	Chiswick Health Centre	April 2017	Sept 2017
Hounslow	Heart of Hounslow	TBC	TBC
Hounslow	Heston Health Centre	Feb 2017	Sept 2017
Hounslow	Brentford Health Centre	July 2017	Jan 2018
West London	Violet Melchett	April 2017	Sept 2017
West London	St Charles	July 2017	Nov 2017

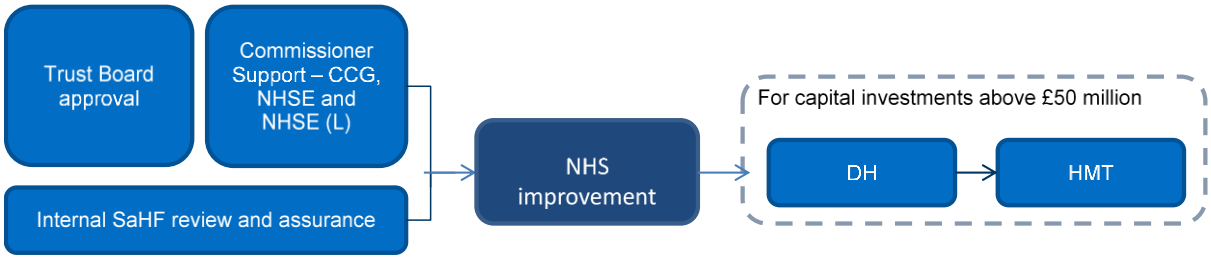
*To be confirmed when Central Middlesex Hospital and Willesden timeline is finalised

5.6.11 In addition to the 18 hubs above which are requiring capital investment, there are also an additional 2 hubs included within outer NW London hospitals at Ealing and Central Middlesex hospital sites and an additional 2 hubs to be included within inner NW London hospitals at St Mary's and Charing Cross hospital sites. There is a further hub still under review (West Middlesex hospital site).

Hospital business cases

5.6.12 Should SOC part 1 be approved, provider trusts will commence development of the OBCs based on the strategic direction of the programme. Figure 7 below shows the assumed approvals route for the hospital OBCs which will require capital investment funded by the Public Dividend Capital (PDC) or loan via the Independent Trust Financing Facility (ITFF) or the Private Finance Initiative (PFI).

Figure 7: Hospital OBC approvals route



Timescales for hospital business cases for accelerated and traditional timeline

5.6.13 Following approval of each OBC, the required procurements and commercial negotiations will commence as outlined in the Commercial Case, and the development of the FBCs will begin. The expected dates by which approvals for both the OBC and FBCs under both timelines are planned are shown in Table 3. Dates shown refer only to the business cases, and developments that the capital accessed through business cases enable will then begin.

Table 3: Comparison of accelerated and traditional timeline for OBC and FBC approval

Hospital Site	Estimated timeline (traditional)		Estimated timeline (accelerated)	
	OBC approval	FBC approval	OBC approval	FBC approval
Hillingdon	Sept 2018	March 2022	September 2017	March 2019
West Middlesex	Sept 2018	March 2022	September 2017	March 2019
Central Middlesex	August 2018	April 2020	August 2017	December 2018
Northwick Park	January 2019	November 2020	January 2018	March 2019
Ealing	February 2019	May 2021	February 2018	April 2019

Implementation plan and build start for hospital reconfiguration and out of hospital

5.6.14 Figure 8 provides a summary of the hospital reconfiguration implementation plans and build start for SOC part 1 including the OBC and FBC timeline to approval, based on the traditional timeframe. Figure 9 provides a similar summary but based on an accelerated timeline. The timescales shown are aligned to the analysis outlined in the Economic and Financial Cases. Although the exact timings of the plans are still to be agreed, the interdependencies between plans remain as shown with:

- A major dependency on sufficient capacity and the range of services becoming available at the right time within the hubs to enable a shift of activity from acute hospital settings to enable all transitions
- Dependency on the requirement for additional capacity at West Middlesex, Northwick Park and Hillingdon Hospitals in order to enable the transition of Ealing Hospital to become a local hospital with out of hospital capacity.

Out of hospital hub implementation

5.6.15 The planned implementation of the out of hospital hubs and the current status of their development is supported by a full list of services they will provide. As already indicated a number of the hubs are already partially or fully operational.

5.6.16 Figure 8 shows the estimated timescales for the schemes over the medium term, showing the development from OBC to FBC and on to construction for each site, along with their estimated opening dates.

Figure 8: Out of hospital hubs implementation timeline and estimated opening dates

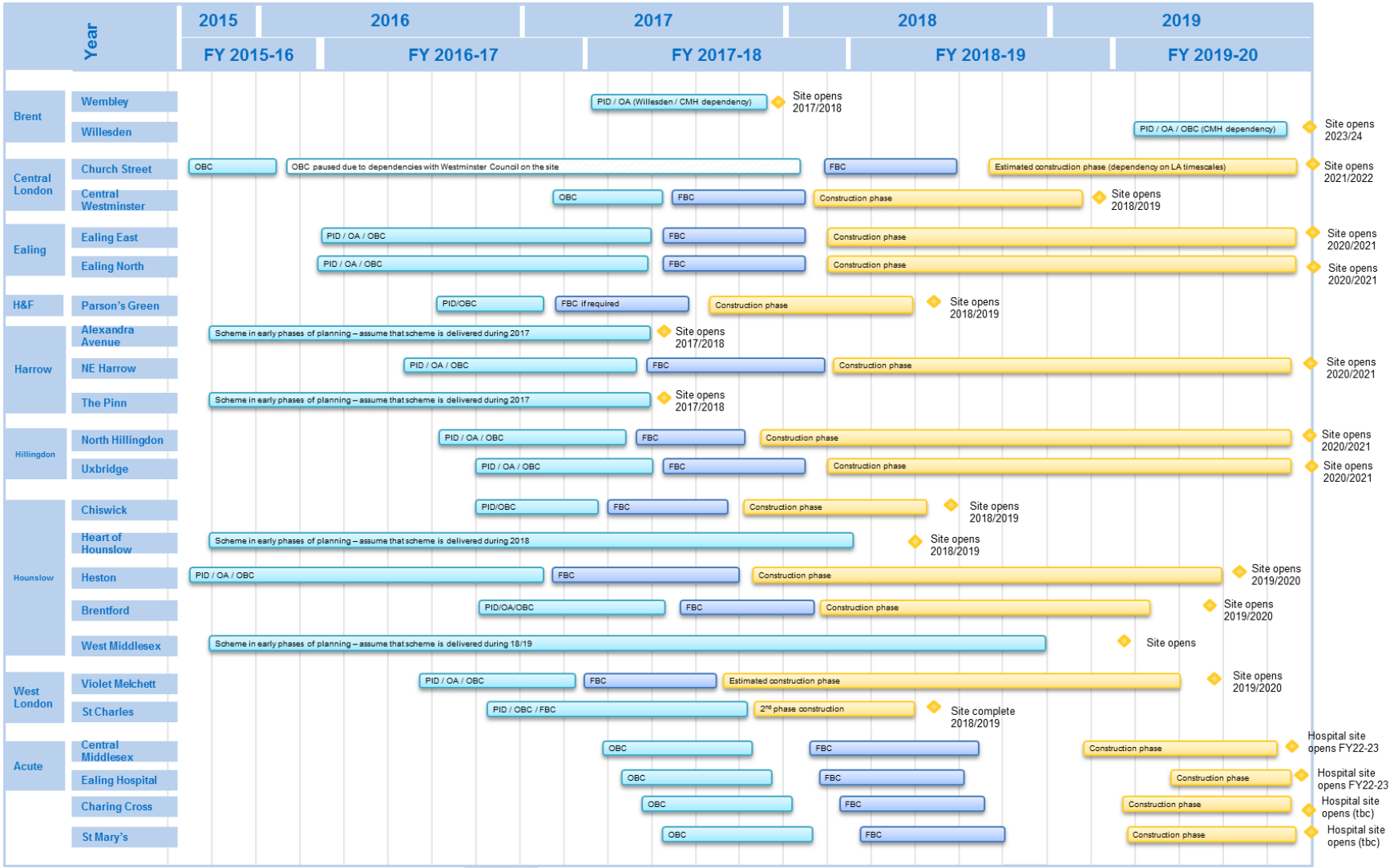


Figure 9: Implementation plan and build start for accelerated timeline of hospital reconfiguration in SOC part 1

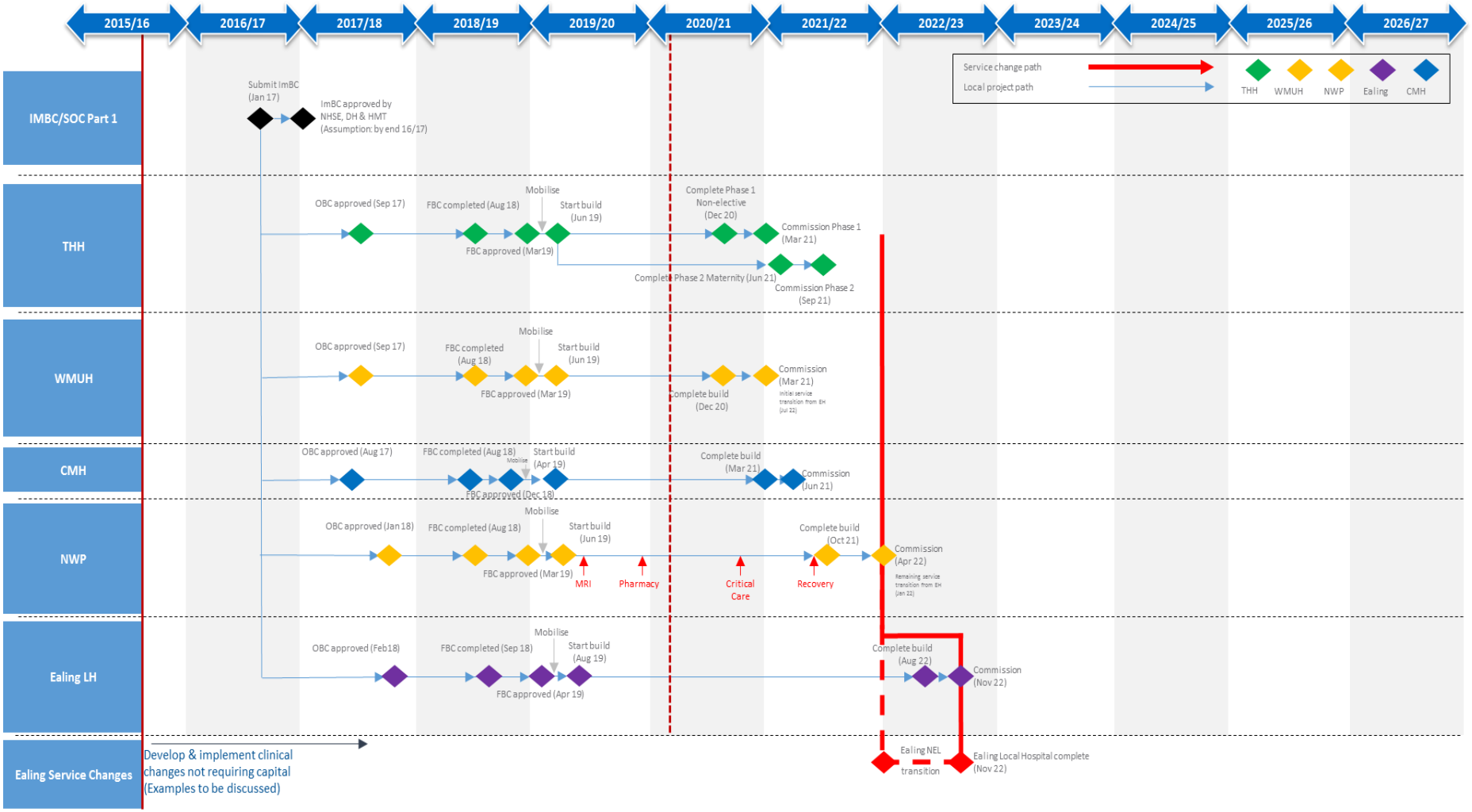
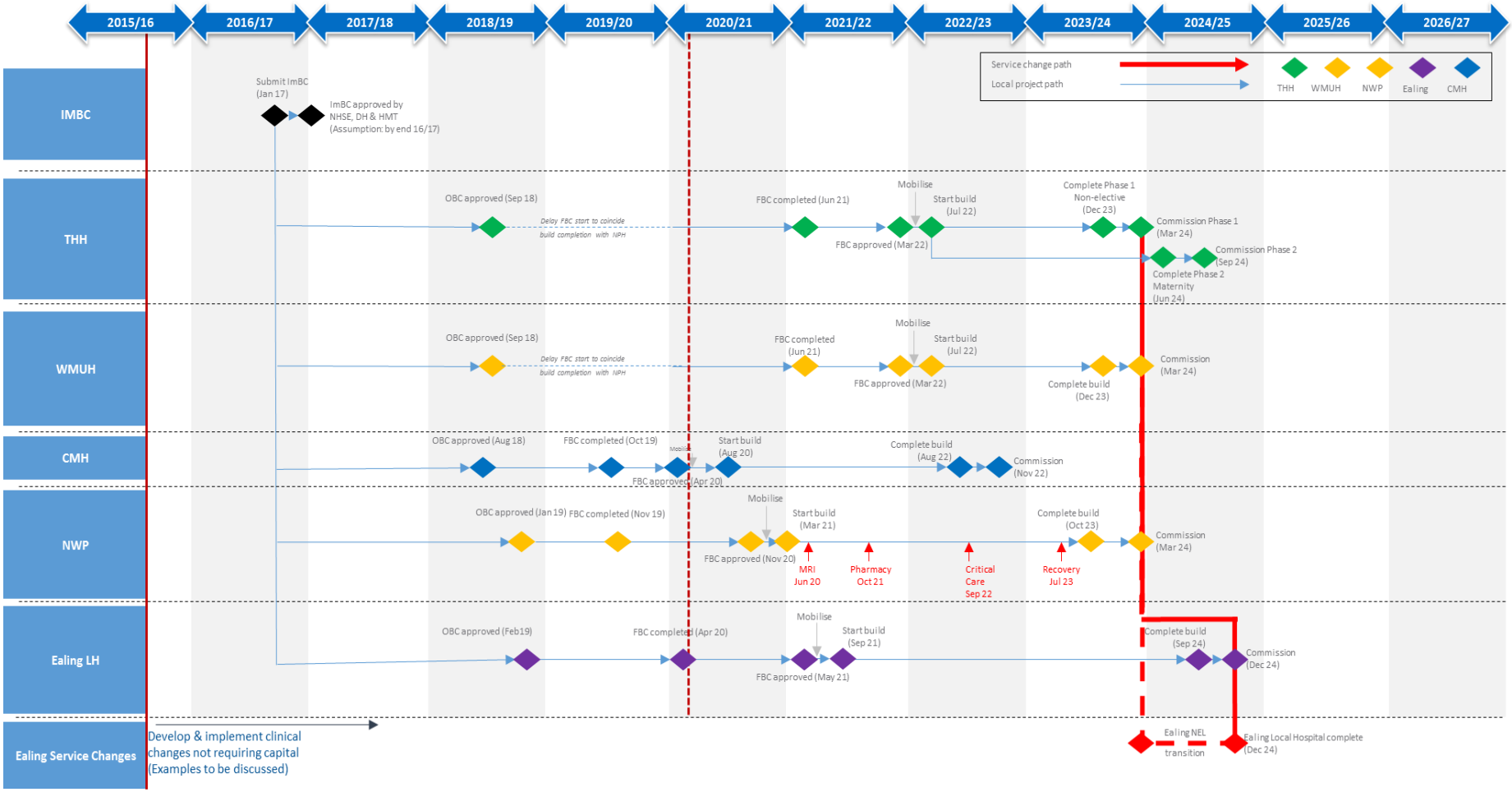


Figure 10: Implementation plan and build start for traditional timeline of hospital reconfiguration in SOC part 1



Plan to work with the trusts during transition

5.6.17 Once the strategic direction of the programme has been agreed through approval of SOC part 1, OBCs will be developed and trusts' plans refined. The SaHF programme will retain a central coordinating role during implementation. A key role of the programme at this stage will be to identify specific dependencies on a service-by-service basis to ensure that the appropriate levels of capacity is available at all times throughout transition. To facilitate this an inventory of beds available at each site throughout this period will be held centrally, and updated on a frequent basis.

5.6.18 No service will be moved until the required capacity is available at all receiving sites and the programme has been assured that the service can be safely transferred. Where plans show the risk of a temporary shortfall in capacity, for example where there is a short gap between planned service closure date and new capacity becoming available, trusts will be asked to put mitigations and fall back plans in place.

5.6.19 Clinical risks will be discussed and resolved at the Clinical Board followed by recommendations to the Programme Implementation Board.

5.6.20 Each change process will be managed according to the type of change being proposed, the specific issues affecting staff, the organisations involved in the change and the most effective way of managing that change, in accordance with the NW London CCG's Programme Management Framework.

5.6.21 Each process has a management of change paper outlining how staff will be managed throughout the change, the employment law premise underpinning how the change is proposed to be managed, the timescale and method of transferring staff to support services.

5.6.22 A range of transformational changes have been delivered under this governance structure that have delivered tangible benefits to patients.

5.6.23 Workforce changes are managed by a cross-cutting workstream for all STP programmes. Health Education North West London (HENWL) will ensure that trainees and students are given full consideration, and the workforce and education workstreams of these projects have both the SaHF HR and Workforce leads on them.

5.6.24 Alongside this, the central SaHF programme has established and used a range of forums to ensure that the work relating to the NW London workforce is coordinated across the system. These include:

- NW London HR Directors Forum**:** the programme has used this existing forum to ensure that there is awareness across NW London's HR community of the workforce programme
- SaHF Partnership Forum**:** a forum for engaging full-time officers of the unions and staff-side bodies about the SaHF programme as a whole
- Joint Workforce Steering Group**:** with representation from commissioners, providers, higher education institutions, NHS England and HENWL, this group provides strategic oversight and guidance to workforce elements of strategic initiatives (such as SaHF)

5.6.25 All three groups have been successfully used to date to ensure that the transitions are made in alignment to the overarching workforce strategy for NW London. The NW London trusts and SaHF programme are managing and coordinating the workforce elements of the programme through these pan-NW London and local arrangements.

HR transition principles

5.6.26 As described in the Commercial Case, a set of nine HR transition principles for the management of staff transitions in NW London have been developed and agreed:

- Patients first
- Continued employment with no redundancies where practicably possible
- Equality of opportunity
- Transparency

- Working in partnership with staff unions
- Treating people as individuals
- Individual responsibility
- Common approach
- Working in partnership between trusts.

5.6.27 These have been signed off by the NW London Joint Workforce Steering Group, the NW London HR Directors Forum, SaHF Partnership Forum and the SaHF Implementation Programme Board and are helping to steer the changes that are underway and proposed.

Engagement with staff and unions

5.6.28 The unions and staff-side bodies have been engaged in two main ways. A regular partnership forum (as mentioned above) has been established with the following purposes:

- To provide the main forum of engagement with the full time officers of key unions on issues affecting the whole SaHF programme, retaining an overview of the whole programme and an understanding of the vision for workforce changes that are being proposed
- To provide a forum for debate and contribution to the emerging plans for the workforce in NW London
- To ensure the HR principles are considered in planning change
- To provide advice and support to local staff-side representatives and ensure consistency of approach where this is necessary and agreed.

5.6.29 The partnership forum is not a decision making group nor does it supersede or replace the need for consultation to be managed at a local level by trusts and staff-side bodies, and reporting is for information only and in the capacity of acting as an advisory body.

5.6.30 Secondly, the programme have also attended local staff-side forums and joint consultative committees to discuss changes affecting staff in particular organisations and this will continue to be a feature of how we work with unions whilst recognising and supporting local staff-side/ trust partnership arrangements.

Our workforce approach to successful management of change at Ealing Hospital so far

5.6.31 With the transfer of maternity, neonatal and paediatric services from Ealing Hospital, all receiving trusts as well as Ealing agreed to use the principles inherent in TUPE to enable the change. A full consultation process was held with staff affected by each change in line with their local management of change policy, and an appeals and mediation process established to deal with any issues raised.

5.6.32 During the change process, all affected staff at Ealing Hospital were provided with paid time off work to enable them to visit receiving sites and understand their services. Receiving hospitals were also invited to Ealing to explain their services, provide prospectuses outlining their units and to answer any questions the staff had. Together these enabled staff to make an informed decision about where they would like to work. As there was a need to match experience and skill to units and the supply of staff to where services were being transferred it was not possible to afford everyone their first choice. However, over 90% of Ealing staff were given their first choice hospital for future employment.

A similar process is envisaged with other changes processes affecting staff

5.6.33 A memorandum of understanding has been agreed with all of the trusts in the NW London sector to enable staff to move between hospitals prior to formal transfer of employment without the need to undertake additional security checks, occupational health clearance and/ or mandatory training.

5.6.34 The SaHF programme has worked in partnership with HENWL to support the change process through funding for individual learning accounts for staff to permit them to undertake training and education to ensure they have the skills necessary for new roles.

5.6.35 Staff being transferred to new units will be provided with induction and orientation, preferably before they join their new units in substantive roles. It is the intention that all staff are given two weeks of funded supernumerary experience to gain experience before being roistered to work as part of the usual shift numbers. Training will also be provided for managers in receiving units so that they understand the basis under which staff have transferred and how they can integrate and manage new staff.

Support from HENWL

5.6.36 The programme is managed in partnership with HENWL which oversees the placement and training of student nurses and midwives and trainee doctors. The quality of training experience including existing trainee/ student numbers, feedback from existing and past trainees and students and the number of qualified and experienced mentors and trainers, have been used as guide to establishing the placement of trainees and students after each change. Communication with trainees and students is managed through HENWL and host organisation with individuals being informed well in advance of any change.

Recruitment and retention planning

5.6.37 An oversight of recruitment and retention of staff in staffing groups affected by the changes is managed through the programme. This includes understanding the baseline position with each organisation, what effect anticipated changes will have on their workforce, what plans they have in place to address shortfalls and manage risks and on-going evidence that the plans are working or being adjusted to ensure they are effective.

5.6.38 This work has been undertaken in depth for midwifery, neonatal nursing, and paediatric services and with medical staffing in obstetrics, gynaecology and neonatology and will be undertaken with other staffing groups as the changes are rolled out across the sector.

New models of staffing to meet new models of care

5.6.39 To address shortfalls in staffing and the need to change services to meet different patient needs, the partnership has developed new ways of working. For example in paediatrics and neonatology, a pan-sector group was established to develop new staffing models including a new middle grade non-training grade position that would provide training and education opportunities and be attractive to individuals currently out of training rotas; nursing roles in transitional care who can gain neonatal experience but do not need to be neo-natal qualified.

Risk management contingency planning

5.6.40 A full risk assessment of each workforce change will be undertaken including understanding the key risks, the consequence and likelihood of each risk and the impact and mitigation. Contingency plans will be developed to ensure there active and detailed planning for the more significant risks.

Programme assurance

5.6.41 This section outlines the programme assurance arrangements for the capital elements of the SaHF programme and its constituent projects. It sets out the assurance for both SOC part 1 the implementation of the individual business cases which will result from the agreement of the SOC part 1 itself.

5.6.42 This section sets out the ongoing programme assurance process which includes:

- SOC part 1 programme assurance (NHSE/NHSI/NHS London and DH/HMT)
- Individual business case assurance with CCGs for local services and trusts for OBCs and FBCs
- Post implementation monitoring and assurance.

5.6.43 The programme as a whole is assured through this engagement, as well as through the approval of this SOC. The SOC will be reviewed by, and assured through, the following processes and committees:

- Decision making
  - Trust Boards
  - CCG Governing Bodies
  - NHS England Investment Committee
  - NHS Improvement Capital and Cash Committee
  - NHS Improvement Resources Committee
- Review and assurance
  - CCG Finance Committees
  - NHS England (London) financial assurance
  - NHS England Process Assessment Unit
  - Patient and Public Representative Group

5.6.44 This represents an overview of the major assurance steps and this list is not exhaustive. It refers only to this SOC part 1. Each subsequent individual business case will require assurance and approval through the appropriate route. These processes are explained in the next section.

Individual business case assurance

5.6.45 As part of the SaHF programme there will also need to be assurance on the individual business cases for each change. This assurance will ensure that they support the overall SOC part 1 and its objectives, as well as meeting the relevant required standards. Assurance will be undertaken for all out of hospital hub and acute hospital business cases. This will also ensure ongoing monitoring of benefits for patients, consistency and integrity of activity and financial modelling across the whole programme.

Out of hospital hubs OBCs assurance process

5.6.46 Governance for the out of hospital programme is being managed by individual CCGs. Once the following groups and committees have approved the business cases, they will be submitted to the NHSE CFO.

Table 4: Out of hospital hubs business case assurance process

Dimension	Body	Areas of assurance
Overall accountability	CCG Governing Body	• Accountability for delivery of the business case and implementation • Solutions are safe and reflect clinical standards • Proposed solution meets out of hospital requirements and results in acceptable patient pathways • Patients and other stakeholders have been appropriately engaged • Business case abides by all statutory provider and commissioner obligations regarding equality of protected groups
Finance and activity	CCG Finance Committee	• Responsible for activity and finance inputs to the business case
Primary care	NHS England Primary Care	• Responsible for primary care activity and finance inputs • Responsible for ensuring clinical standards are met
Estates	NHS PS or CHP Boards	• Responsible for ensuring that the quality of estates analysis is robust
Implementation	Individual project scheme boards	• Implementation management approach and timetable is sensible and aligned with programme requirements • Commercial approach is appropriate

Hospital OBCs assurance

5.6.47 The programme will work closely with the trusts to provide support in developing and finalising the OBCs, such as conducting internal reviews against detailed checklists ahead of formal approval processes and maintaining the overall system integrity of finance and activity modelling.

Post implementation monitoring and assurance

5.6.48 In line with the HM Treasury Green Book guidance this programme will continue to be monitored following the completion of the implementation phase. The primary component of this monitoring will be the benefits realisation approach. This will ensure that the project continues to deliver the benefits which the economic and financial cases are predicated on.

5.6.49 In addition, as part of business as usual activities, the performance of those providers involved within the SaHF programme will continue to be monitored to ensure that all elements of the programme deliver the maximum benefits to the populations that they serve.

Programme risk management

5.6.50 This section describes the risk management arrangements which have been put in place for the programme and how risks are escalated through the robust governance process. It also outlines how the risk management process will be managed going forward.

5.6.51 The key areas this section include:

- Risk management approach
- Key programme risks and mitigations
- Risk management going forward.

Risk management approach

5.6.52 The programme takes a proactive approach to ensuring that risks are managed appropriately in line with best practice requirements. The programme's approach to risk and issue management has been based around a number of principles:

- The risk management process, as with all other elements of the programme, is clinically led
- Risks are proactively managed locally, at the work stream level
- Risks associated with central cross-cutting projects are owned by individual work stream central project managers
- Risks are escalated where they cannot be resolved within the work stream's resources or impact across more than one programme
- CCGs and providers work locally to ensure that risks are reported to CCG Governing Bodies and provider boards where relevant
- The Clinical Board monitors and manages clinical risk across NW London during implementation, agreeing collective action to address any issues as required
- The Implementation Programme Board brings together local commissioners and providers to jointly manage issues and risks as required
- Risks are regularly reviewed to ensure that they are managed as an integral part of the programme.

Key programme risks and mitigations

5.6.53 Based on the principles set out above, a comprehensive risk register for the both the construction and implementation of the SOC part 1 has been constructed and can be found at Appendix G. This is based on an assessment of risk severity and impact, both at the inherent level i.e. before mitigation, and the residual level i.e. after mitigation.

5.6.54 Table 5 lists those risks which have been assessed as the most critical from the overall programme risk register.

Table 5: Key programme risks

Risk Description	Category	Proposed Mitigations	Residual Risk Rating
There is a risk that CIP/QIPP plans are not robust enough	Quality and Sustainability	• Close working between CCGs, Trusts and SaHF Programme to highlight potential shortfalls and then to jointly identify opportunities to increase the quantum of the plans.	16
There is insufficient development of the workforce to support the ambitions of clinical improvements.	People and Workforce	• Ongoing engagement with HEE North West London to ensure training offer and roles are appropriate and attractive. • Ongoing programme of clinical engagement via Clinical Board and Implementation planning groups, who review and develop transition planning. Clinical Implementation Groups (or equivalent) continue to meet to manage implementation in clinical areas, for example looking at training, workforce development strategy (with HEE NWL) and clinical pathway design and implementation • SaHF internal workforce team will work with CCGs and Trusts to ensure workforce is aligned to clinical improvements	16
There is a risk that we will not achieve the return on investment or deliver long term financial benefits	Operational and performance	• Close working with CCGs to resolve funding issues and agree Heads of Terms as part of agreeing OBC by Trust Boards	16
There is a risk of a deterioration of operational performance - particularly variance from control totals - by Trusts and / or CCGs impacting ability to realise programme benefits	Operational and performance	• Close working between the SaHF Programme, Trusts and CCGs to identify any issues arising as early as possible	16
There is a risk that local services are not developed sufficiently enough to re-provide alternatives to absorb acute activity	Operational and performance	• Further development of delivery plans with robust governance.	16
There is a risk that I&E (including a shortfall in cash releasing savings) and cash constraints mean that the costs of capital, transition costs or loan repayments are not affordable	Finance and estates Quality and Sustainability	• Close working between CCGs, Trusts and SaHF Programme to highlight potential shortfalls and then to jointly identify opportunities to increase the value of the cash flow savings	16
There is a risk that the focus on capital will be at the expense of clinical aspirations, impacting on clinical quality of care in programme delivery	Quality and Sustainability	• The STP and SaHF Programme are clinically-led programmes, led by Medical Directors. For example there are 3 clinical leads who are part of the acute reconfiguration workstream and each clinical lead has contributed/ or acted as a critical friend to SOC part 1 to ensure the programme continues to be clinically-led and clinical benefits will be realised. In addition Mark Spencer has specifically contributed to the ensuring the model of care is fit for purpose	16

Risk management going forward

5.6.55 This risk register will continue to be reviewed and risks re-assessed through the lifecycle of the programme. As risks are mitigated, changed or introduced over time, the implications of these will be assessed and managed through the process set out in Figure 11. As the STP governance processes are fully implemented, as described in Section 5.1.7, these arrangements will also be refined based on lessons learnt.

Figure 11: Approach to risk reviews

5.7 We have drawn up a benefits framework which we will use to track benefits realisation

5.7.1 This section describes the proposed benefits realisation approach for the SaHF programme to ensure all of the anticipated benefits are successfully achieved following implementation.

5.7.2 This section outlines:

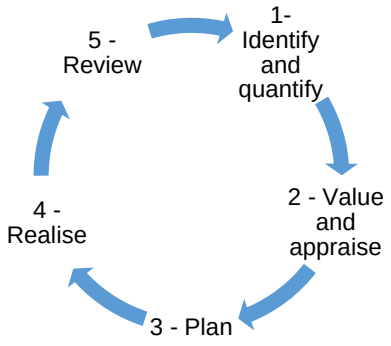
- Benefits realisation approach
- Programme reporting approach
- Monitoring the benefits from changes to maternity and paediatric services.

Benefits realisation approach

5.7.3 Benefit realisation will be important to ensure that the programme delivers on its promise to be clinically led and deliver better outcomes for the population of NW London. It will need careful management and close measurement, forming an integral part of the implementation process and then adopted into business as usual.

5.7.4 The approach taken towards benefits realisation is tried and tested and will be as follows[2]:

Figure 12: Benefits realisation approach



5.7.5 In line with the Major Projects Authority (MPA) which is now the Infrastructure and Projects Authority (IPA) guidance each of the OBCs for the individual providers will clearly identify a benefits realisation approach, how this will be managed and how the associated benefits will be realised. As the individual business cases are developed to FBCs these approaches will need to be further developed to ensure a detailed approach is in place before individual projects are initiated.

Identify and quantify

5.7.6 Stage 1 of the approach requires that all of the potential benefits to the programme have been identified and quantified. All of the individual providers' benefit realisation plans will link into the programme delivery plan and show how they deliver against this.

5.7.7 They will be developed as part of the OBC process for each of the individual projects which form the preferred option.

5.7.8 We will develop a comprehensive list of project benefits and a benefits management framework for each project that can be monitored and tracked.

Value and appraise

5.7.9 For an Outline Business Case (OBC) we select the most important benefits and assign a value, to ensure the project is justified on economic grounds. We do so in accordance with

[2] Source: MPA Assurance of benefits realisation in Major Projects: Supplementary guidance, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/476740/Supplementary_Guidance_to_Assurance_Reviews.pdf

Green Book guidance. Those benefits which are cash releasing are considered as part of the financial case.

Plan

5.7.10 By the time of a Full Business Case (FBC), we put in place a plan for benefits realisation that includes allocating responsibility for delivery of each benefit; and determining the best metric for tracking progress. These metrics may be the same as the original estimates, but are very often revised with updated data and information.

Realise

5.7.11 As the project transitions into implementation, we are focused on making sure we have plans in place to ensure the benefits from the project are delivered. We assess what changes in operations, or behavioural changes in the health economy we need to influence and support to ensure the benefits can be realised as fully as possible.

Review

5.7.12 By this stage our projects will assess how they have performed relative to the original and most up-to-date business cases. We ensure are that benefits are well embedded within common business processes and lessons learnt have been captured.

Programme reporting approach

5.7.13 The progress made by providers against each of the performance indicators will be reported to demonstrate the progress made against the anticipated trajectory and trend. The level of detail required will be agreed by the Implementation Programme Board.

5.7.14 Poor performance against one or more of the proposed performance indicators would not necessarily mean that the reconfiguration has been unsuccessful. A number of factors external to the reconfiguration of services could influence our performance measures (particularly outcome measures), making it difficult to isolate the impact of reconfiguration on patient and clinical outcomes. The implementation programme team and commissioners will need to take such factors into account when tracking benefits realisation.

5.7.15 The reporting against the performance indicators will inform two sets of checkpoints:

- Quarterly benefits checkpoints: these checkpoints will focus on formally assuring that the performance indicators remain valid and that they are providing stakeholders with the view on benefits realisation they require. The discussion on progress will be against the full set of performance indicators. The benefits checkpoints will be an agenda item for the Implementation Programme Board
- Implementation decision making framework: a number of the key performance indicators will be used to inform implementation decision making, allowing the programme to confirm we are ready to make the next proposed change on the implementation plan. It is envisaged that a sub-set of the key performance indicators will be used for each decision to include quality as well as activity measures.

5.7.16 For both sets of checkpoints, performance dashboards will be developed to clearly show the performance indicators being measured and the impact the changes are having, with supporting commentary.

Monitoring the benefits from changes to maternity services

5.7.17 Following the changes to maternity services within NW London, the programme has been monitoring the benefits delivered. The model of care for maternity services in NW London set out a clear objective and expected outcomes that the transition of services should achieve.

5.7.18 The objective was to introduce a consistent model of care for maternity and new-born services in NW London to:

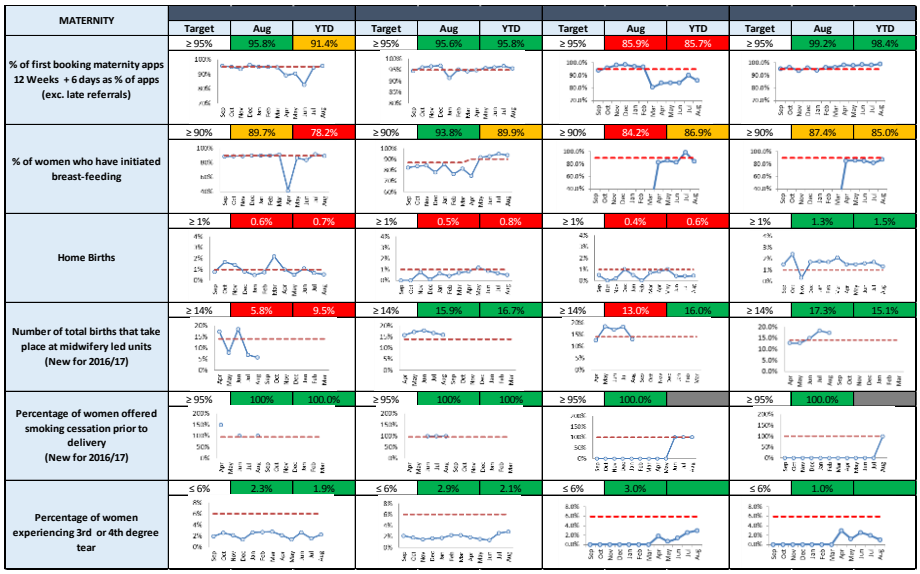
- Improve equity of access to the same levels of care.
- Provide care closer to home.

- Offer a choice in location of antenatal care, birth setting and postnatal care.
- Improve continuity of care for women throughout their antenatal and postnatal pathway.

5.7.19 Since implementation this has been subject to ongoing monitoring against the original objectives

5.7.20 Figure 13 shows the ongoing performance dashboard for maternity and neonatal service transition against clinical aims and targets.

Figure 13: Performance dashboard for maternity and neonatal service transition



5.7.21 A review report was published in March 2016, detailing progress made against expected benefits, key recommendations and lessons of best practice to be shared with the wider NHS. Post-decision, further work will be undertaken to develop the most appropriate way to report implementation progress to the public and this is likely to include information about benefits realisation.

5.7.22 We also have a similar approach that is adopted for paediatric services.

5.8 Conclusion

5.8.1 NW London has well established collaborative working arrangements, including a CCG Collaboration Board and an Implementation Programme Board as a result of our longstanding clinical strategy Shaping a Healthier Future (SaHF). The SaHF programme is clinically led. There are three medical directors who provide general clinical oversight of the programme and ensures that all decisions are clinically led and focused. A Clinical Board provides clinical input to the programmes of work.

5.8.2 We have a strong and effective Programme Management Office (PMO) with a Programme Executive in place. We have built strong relationships with stakeholders and engaged widely on our proposals with patients and the broader community.

5.8.3 As a result of this, we have already made significant progress, with a proven track record of successful and safe transformation.

5.8.4 We have built on our existing arrangements and are updating our governance to ensure it is fit for purpose to deliver the Sustainability and Transformation Plan (STP) and the next phase of SaHF. As part of our preparation for the next phase, we clear project plans, established programme assurance, identified key risks and drawn up a benefits framework which we will use to track benefits realisation.

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A CLINICAL STANDARDS

The first step to transforming care is to define the standards expected of all providers so that patients and the public can be confident that as changes are made to where and how patients are treated and cared for, high clinical quality is always the priority.

This appendix outlines the standards which have been set and agreed by local clinicians for the provision of high quality out of hospital care, primary care and acute services across NW London.

A.1 Out of hospital care

The eight NW London CCGs have identified the critical opportunities for delivering high-quality and cost-effective care outside hospitals to improve care for individuals as well as support the wider changes required across the health economy. The quality standards support and drive the changes required by:

- Setting aspirations for the future
- Focusing on the areas that will drive how services are delivered
- Establishing standards that will be equally applicable to all out-of-hospital providers
- Supporting the shift in care delivery from reactive unplanned care to more proactive planned care
- Emphasising the central role of the GP in the coordination of out-of-hospital care.

The standards to deliver these changes are set out against the four domains:

- Individual empowerment and self-care
- Access, convenience and responsiveness
- Care planning and multi-disciplinary care delivery
- Information and communications.

A summary of the standards agreed by local clinicians for out-of-hospital care are set out in Table 1 to Table 4. The standards support and drive the changes required by providing a common set of standards that will be equally applicable to all out-of-hospital providers, to set out their aspirations for the future in line with the four core themes.

Table 1: Out-of-hospital quality standards – Individual Empowerment and Self Care

#	Standard
Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.	
1	Individuals will have access to relevant and comprehensive information, in the right formats to inform choice and decision making
2	Individuals will be actively involved together with the local community health and care services to support personal goals and care plans.
3	Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support

Table 2: Out-of-hospital quality standards – Access, Convenience and Responsiveness

#	Standard
	Out-of-hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
1	Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. This will be either through their General Practice or known care provider's telephone number or through the telephone single point of access for all community health and care services (111). As a result of the triage process, cases assessed as urgent will be given a timed appointment or visit with the appropriate service provider (including a doctor where required) within 4 hours of the time of calling. For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment with the appropriate service provider within 24 hours or an appointment to see a GP in their own practice within 48 hours, or at a subsequent time convenient to them.
2	An individual who is clinically assessed to be at risk of an admission to hospital which could be prevented by expert advice, services, diagnostics, or the supply of equipment, will have their needs met in less than 4 hours
3	Clinical protocols with access times to routine investigations will be made available and followed by service providers. This will include simple radiology, phlebotomy, ECG and spirometry.

Table 3: Out-of-hospital quality standards – Care Planning and Multidisciplinary Care Delivery

#	Standard
	Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
1	All individuals who would benefit from a care plan will have one. Care plans will be agreed with individuals (i.e. patients, users, carers) and will: • Be co-created, kept up-to-date and monitored by the individual and appropriate professional(s) • Include a common approach to assessment covering both health and social care, with an onward package of care in place to meet the individual's needs • Include a carer's assessment where appropriate • Be available in the format suited to the individual, with the relevant sections shared amongst those involved in delivery of their care • Include sources of further information to help patient's decision-making and choice about treatment and self-care.
2	Everyone who has a care plan will have a named "care coordinator" who will work with them to coordinate care across health and social care. The role of the care coordinator will be clearly defined and understood by the individual and those involved in providing care. Clinical accountability will remain with the patient's GP.
3	GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists
4	Pooled funding and resources between health and social care will be included in commissioning plans to ensure that efficient, cost-effective and integrated services are provided

Table 4: Out-of-hospital quality standards – Information and Communication

#	Standard
	With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records.
1	With the individual's consent, relevant information will be visible to health and care professionals involved in providing care. This should be available electronically and in hard copy.
2	Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, in particular, when a patient is admitted or discharged from hospital. This should ensure that care providers are aware of any planned or outstanding activities required for the individual.
3	Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan (including intermediate care and reablement) as well as continuing care needs
4	Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, in particular, when a patient is admitted or discharged from hospital. This should ensure that care providers are aware of any planned or outstanding activities required for the individual.

All providers will be held to account against these standards during the implementation phase of the Shaping a healthier future programme and local GPs in their CCGs are putting in place processes to ensure they are delivered. A clear clinician-led system based around peer review will be critical to ensure that performance is transparent. In addition, a system led by clinicians will be put in place to manage performance so that benefits for patients are delivered

A.2 Primary care

NW London has agreed a clear set of primary care standards that the CCGs will support providers to deliver over the next five years. These are shown below and are aligned to the General Practice Forward View and the Strategic Commissioning Framework.

Table 5: Primary care quality standards – Accessible care

#	Standard
	Individuals using primary care can effectively use accessible care services. These include being understandable, effective and tailored to meet local needs. Service access arrangements will include but not limited to face-to-face, telephone, email, SMS texting and video consultation.
1	**Patient choice** Patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs.
2	**Contacting the practice** Patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations).
3	**Routine opening hours** Patients can access pre-bookable routine appointments with a primary health care professional at all practices 8am-8pm, 7 days, via network coverage where appropriate.
4	**Extended opening hours** Patients can access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.

#	Standard
5	**Same-day access** Patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network.
6	**Urgent and emergency care** Patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.
7	**Continuity of care** All patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate.

Table 6: Primary care quality standards – Co-ordinated care

#	Standard
	Individuals using primary care services will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
1	**Case finding and review** Practices identify patients who would benefit from co-ordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis.
2	**Named professional** Patients identified as needing co-ordinated care have a named professional who oversees their care and ensures continuity.
3	**Care planning** Each individual identified for co-ordinated care is invited to participate in a holistic care planning process in order to develop a single care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in their care.
4	**Patients supported to manage their health and wellbeing** Primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing, including their mental wellbeing, including through health coaching and other forms of education.
5	**Multi-disciplinary working** Patients identified for co-ordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

Table 7: Primary care quality standards – Pro-active care

#	Standard
Pro-active care will be initiated so that Individuals using primary care services can more effectively manage their health and wellbeing and have access to relevant sources and information to achieve their health goals. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.	
1	**Co-design** Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.
2	**Developing assets and resources for improving health and wellbeing** Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community.
3	**Personal conversations focused on an individual's health goals** Where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
4	**Health and wellbeing liaison and information** Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
5	**Patients not currently accessing primary care services** Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

A.3 Hospital care

To drive the improvements in clinical quality and reduce the variation that has been documented in the Strategic Case, clinicians have developed a set of clinical standards. The clinical standards have been defined for three clinical areas:

- Emergency and urgent care
- Maternity
- Paediatrics

Delivery of the clinical standards creates the need for changes that drive the hospital reconfiguration proposals, ultimately leading to improved clinical outcomes for patients as well as improved experiences for both patients and staff.

These standards include the latest evidence from:

- Royal Colleges
- London Health Programmes' (LHP's) London Quality Standards
- National Clinical Advisory Team (NCAT) feedback
- National Institute for Health and Care Excellence (NICE) guidelines
- Evidence from literature
- Relevant feedback received during consultation
- Input from reviews by the NHS in London

A.3.1 Emergency and urgent care clinical standards

The Shaping a Healthier Future emergency and urgent care standards are detailed in Table 8 to Table 14.

Table 8: Emergency and urgent care standards

#	Standard
1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.
3	24/7 access to the minimum key diagnostics: • X-ray: immediate access with formal report received by the ED within 24 hours of examination • CT: immediate access with formal report received by the ED within one hour of examination • Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination • Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken • Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken. When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours. All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. computerised tomography; interventional radiology) in a timely manner 24 hours a day, seven days a week, to support decision making

#	Standard
4	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.
5	A clinical decision/ observation area is to be available to the emergency department for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team.
6	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.
7	Streaming to be provided by a qualified healthcare professional and registration is not to delay triage.
8	Emergency departments to have a policy in place to access support services seven days a week including: • Alcohol liaison • Mental health • Older people's care • Safeguarding • Social services Single call access for mental health referrals should be available 24/7 with a maximum response time of 30 minutes.
9	Timely access 7 days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.
10	Timely access 7 days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.
11	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24/7. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.
12	The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant on-going training.
13	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
14	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.
15	Acute medicine inpatients should be seen twice daily by a relevant medical consultant.
16	When on-take for emergency / acute medicine and surgery, a medical or surgery consultant and their team are to be completely freed from any other clinical duties / elective commitments that would prevent them from being immediately available.
17	Any surgery conducted at night should meet NCEPOD requirements and be under the direct supervision of a consultant surgeon and consultant anaesthetist.
18	All hospitals admitting emergency general surgery patients should have access to an emergency theatre immediately and should have an appropriately trained consultant surgeon on site within 30 minutes at any time of the day or night.
19	The Critical Care Unit should have dedicated senior medical cover (ST4 and above) present in the facility 24 hours per day, 7 days per week.

#	Standard
20	Prompt screening of all complex needs inpatients should take place by a multi-professional team which has access to pharmacy, psychiatric liaison services and therapy services (including physiotherapy and occupational therapy, 7 days a week with an overnight rota for respiratory physiotherapy).
21	The majority of emergency general surgery should be done on planned emergency lists on the day that the surgery was originally planned and any surgery delays should be clearly recorded.
22	On a site without 24/7 emergency general surgery cover, patients must be transferred, following a clear management process, to an Emergency Surgery site if a surgical emergency is suspected without delay.

Table 9: Urgent care centre standards, governance

#	Standard
1	Each urgent care service is to have a formal written policy for providing urgent care. This policy is to adhere to the urgent care clinical quality standards. This policy is to be ratified by the service's provider board and reviewed annually.
2	All urgent care services are to be within an urgent and emergency care network with integrated governance structures. All urgent care services to participate in national and local audit, including the use of the Urgent and Emergency Care Clinical Audit Tool Kit to review individual clinician consultations.

Table 10: Urgent care centre standards, core service

#	Standard
1	During the hours that they are open all urgent care services to be staffed by multidisciplinary teams, including: at least one registered medical practitioner (either a registered GP or doctor with appropriate competencies for primary and emergency care), and at least one other registered healthcare practitioner.
2	An escalation protocol is to be in place to ensure that seriously ill/high risk patients presenting to the urgent care service are seen immediately on arrival by a registered healthcare practitioner.
3	All patients are to be seen and receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival at the urgent care service.
4	Within 90 minutes of the time of arrival at the urgent care service 95 per cent all patients are to have a clinical decision made that they will be treated in the urgent care service and discharged, or arrangements made to transfer them to another service.
5	At least 95 per cent of patients who present at an urgent care service to be seen, treated if appropriate, and discharged in under 4 hours of the time of arrival at the urgent care service.
6	During all hours that the urgent care service is open it is to provide guidance and support on how to register with a local GP.
7	The service is to have a clear pathway in place for patients who arrive outside of opening hours to ensure safe care is delivered elsewhere.
8	Access to minimum key diagnostics during hours the urgent care service is open, with real time access to images and results: • Plain film x-ray: immediate on-site access with formal report received by the urgent care service within 24 hours of examination • Blood testing: immediate on-site access with formal report received by urgent care service within one hour of the sample being taken Clinical staff to have the competencies to assess the need for, and order, diagnostics and imaging, and interpret the results.

#	Standard
9	Appropriate equipment to be available onsite: • A full resuscitation trolley • An automated external defibrillator • Oxygen • Suction and • Emergency drugs All urgent care service to be equipped with a range of medications necessary for immediate treatment.
10	Urgent care services to have appropriate waiting rooms, treatment rooms and equipment according to the workload and patient's needs.
11	All patients to have an episode of care summary communicated to the patient's GP practice by 08.00 on the next working day. For children the episode of care to be communicated to their health visitor or school nurse, where known and appropriate, no later than 08.00 on the second working day.

Table 11: Urgent care centre standards, staff competencies

#	Standard
1	All registered healthcare practitioners working in urgent care services to have a minimum level of competence in caring for adults, and children and young people (where the service accepts children), including: • Basic life support; • Recognition of serious illness and injury; • Pain assessment; • Identification of vulnerable patients At any time the service is open at least one registered healthcare practitioner is to be trained and competent in intermediate life support and paediatric intermediate life support, where the service accepts children.
2	All registered healthcare practitioners working in urgent care services to have direct access referral to specialist on-call services when necessary, and the right to refer those patients who they see within their scope of practice.

Table 12: Urgent care centre standards, supporting services

#	Standard
1	Urgent care services to have arrangements in place for staff to access support and advice from experienced doctors (ST4 and above or equivalent) in both adult and paediatric emergency medicine or other specialties without necessarily requiring patients to be transferred to an emergency department or other service.
2	Single call access for mental health referrals to be available during hours the urgent care service is open, with a maximum response time of 30 minutes.

Table 13: Urgent care centre standards, patient experience

#	Standard
1	Patient experience data to be captured, recorded and routinely analysed and acted on. Data is to be regularly reviewed by the board of the urgent care provider and findings are to be disseminated to all staff and patients.
2	All patients to be supported to understand their diagnosis, relevant treatment options, ongoing care and support by an appropriate clinician.

#	Standard
3	Where appropriate, patients to be provided with health and wellbeing advice and sign-posting to local community services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

Table 14: Urgent care centre standards, training

#	Standard
1	Urgent care services to provide appropriate supervision for training purposes including both: • Educational supervision • Clinical supervision
2	All healthcare practitioners to receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues. All registered medical practitioners working independently to have a minimum of safeguarding training level 3.

A.3.2 Paediatrics standards

The Shaping a healthier future paediatrics standards are detailed in Table 15 to Table 19.

Table 15: Paediatric standards

#	Standard
1	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission. All paediatric emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.
2	All emergency departments which see children to have a named paediatric consultant with a designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
3	Paediatric inpatients should be seen twice daily by a paediatric consultant.
4	A consultant paediatrician is to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership to be available to cover extended day working (up until 10pm), seven days a week.
5	All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on-site consultant presence during times of peak attendance. Paediatric Assessment Units should have clearly defined responsibilities, with clear pathways, and should be appropriately staffed to deliver high quality care as locally as possible.

#	Standard
6	All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU. (See standard 20)
7	When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.
8	Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be Band 6 or above) with appropriate skills and competencies for the emergency area.
9	Paediatric inpatient ward areas are to have a minimum of two paediatric trained nurses on duty at all times and paediatric trained nurses should make up 90 per cent of the total establishment of qualified nursing numbers.
10	All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour • Urgent – imaging and reporting within 12 hours • All non-urgent – within 24 hours.
11	Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning.

Table 16: Paediatric standards for admissions, patient review and theatre

#	Standard
1	All inpatient paediatric services units need to have paediatric consultant availability within 30 minutes. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
2	At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant.
3	A unified clinical record to be in place, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the emergency pathway.
4	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. GPs to be informed when patients are admitted and patients to be discharged to their registered practice. Where there are concerns relating to safeguarding, children are to only be discharged home after discussion and review by the responsible consultant with a clear plan written in the notes detailing follow up and involvement of other agencies.
5	All hospitals admitting emergency surgery patients to have access to a fully staffed emergency theatre available and a consultant surgeon and a consultant anaesthetist with appropriate paediatric competencies on site within 30 minutes at any time of the day or night.
6	All patients admitted as emergencies are discussed with the responsible consultant if surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.
7	Clear policies to be in place to ensure appropriate and safe theatre scheduling and implementation of clear policies for starvation times.
8	Anaesthetists who perform paediatric anaesthesia to have completed the relevant level of training, as specified by the Royal College of Anaesthetists, and have on-going exposure to cases of relevant age groups in order to maintain skills.

#	Standard
9	All emergency surgery to be done on planned emergency lists on the day that the surgery was originally planned (within NCEPOD classifications). The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications – immediate life, limb or organ-saving interventions.
10	The responsible consultant must be directly involved and in attendance at the hospital for the initial management and referral of all children requiring critical care. The paediatric intensive care retrieval consultant is responsible for all decisions regarding transfer and admission to intensive care. The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the joint responsibility of the referring and accepting consultants. Staff and equipment must be available for immediate stabilisation and time appropriate transfer by the local team when this is required.
11	All general acute paediatric rotas are made up of at least ten WTEs, all of whom are EWTD compliant.

Table 17: Paediatric standards for key services

#	Standard
1	Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call.
2	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are safeguarding concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

Table 18: Paediatric standards for training

#	Standard
1	Organisations have the responsibility to ensure that staff involved in the care of children and young people are appropriately trained in a supportive environment and undertake on-going training.
2	All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis.

Table 19: Paediatric standards for patient experience

#	Standard
1	Consistent and clear information should be readily available to children and their families and carers regarding treatment and on-going care and support.
2	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.

A.3.3 Maternity standards

The Shaping a healthier future maternity standards are detailed in Table 20 to Table 23.

Table 20: Maternity standards

#	Standard
1	Obstetric units to be staffed to provide 168 hours (24/7) of obstetric consultant presence on the labour ward. The consultant will conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and Bank Holidays, with a physical round every evening, reviewing midwifery-led cases following referral.
2	Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings.
3	Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.
4	All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings. All women's care should be coordinated by a named midwife throughout pregnancy, birth and the postnatal period. Where specialist care is needed this should be facilitated by her named midwife. Clinical responsibility for women with complex care needs should remain with the specialist, but these women should still receive midwife coordinated care.
5	There is to be one supervisor of midwives to every 15 WTE midwives.
6	A midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care.
7	All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart. Consultant involvement is required for those women who reach trigger criteria.
8	Obstetric units to have 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance. All birth settings to have a midwife who is trained and competent in neo-natal life support (NLS) present on site 24 hours a day, 7 days a week.
9	**Immediate postnatal care to be provided in accordance with NICE guidance, including:** • advice on next delivery during immediate post-natal care, before they leave hospital • post-delivery health promotion • care of the baby • consistent advice, active support and encouragement on how to feed their baby • skin to skin contact • Follow-up care is to be provided in writing and shared with the mother's GP

Table 21: Maternity standards for key services

#	Standard
1	Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week. Units that have over 5,000 deliveries a year, or an epidural rate greater that 35%, or a caesarean section rate greater than 25%, to provide extra consultant anaesthetist cover during periods of heavy workload.
2	Obstetric units to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.
3	Obstetric units should have a competency assessed duty anaesthetist immediately available 24 hours a day, 7 days a week to provide labour analgesia and support complex deliveries. The duty anaesthetist should not be primarily responsible for elective work or cardiac arrests.

#	Standard
4	There should be a named consultant obstetrician and anaesthetist with sole responsibility for elective caesarean section lists.
5	All labour wards to have onsite access to a monitored and nursed facility (appropriate non-invasive nursing monitoring) staffed with appropriately trained staff.
6	Obstetric units to have access to interventional radiology services 24 hours a day, 7 days a week and onsite access to a blood bank.
7	Obstetric units to have access to emergency general surgical support 24 hours a day, 7 days a week. Referrals to this service are to be made from a consultant to a consultant. There must be access to emergency theatre when required.
8	Consultant delivered obstetric services should include a collocated midwife-led unit to provide best care and choice for women and babies. Women should be able to choose the option of an out-of-hospital pathway (home birth and standalone midwife-led unit) if appropriate

Table 22: Maternity standards for training

#	Standard
1	Maternity services to be provided in a supportive training environment which promotes multi-disciplinary team working, simulation training and addresses crisis resource management.

Table 23: Maternity standards for women's experience

#	Standard
1	Both quantitative and qualitative data on women's experience during labour, birth and immediate post-natal care to be captured (including but not limited to standards 2 – 10), recorded and regularly analysed and continually acted on. Feedback to be collected from the range of women using the service, including non-English speakers. Review of data and action plans is to be a permanent item on the trust board agenda. Findings to be disseminated to all levels of staff, service users and multidisciplinary groups including MSLCs (maternity services liaison committee).
2	During labour, birth and immediate post-natal care, all women who do not speak English or women with minimal English should receive appropriate interpreting services.
3	During labour, birth and immediate post-natal care all women and their families/birthing partner to be treated as individuals with dignity, kindness, respect.
4	During labour, birth and immediate post-natal care all women and their families/birthing partners to be spoken with in a way that they can understand by staff who have demonstrated competency in relevant communication skills.
5	During labour, birth and immediate post-natal care all women (with assistance from birthing partners where appropriate) to be given the opportunity to be actively involved in decisions about their care.
6	During labour, birth and immediate post-natal care all women and their families/birthing partner are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
7	During labour, birth and immediate post-natal care all women and their families/birthing partner are to be supported by healthcare professionals to understand relevant birthing options, including benefits, risks and potential consequences to help women make an informed decision about their care. All healthcare professionals are to support women's decisions to be carried out.
8	During labour, birth and immediate post-natal care all women (with assistance from their birthing partners where appropriate) are to be made aware that they can ask for a second opinion before making a decision about their care.
9	Women to receive care during labour and birth that support them to safely have the best birth possible.

#	Standard
10	During immediate post-natal care women to receive consistent advice, active support and encouragement on how to feed their baby.

Given the co-dependencies with paediatric services and neo-natal units, clinicians recommended that maternity units should be co-located with A&Es and paediatric units.

B SETTINGS OF CARE

This appendix provides a description of each of the eight settings of care defined by the Shaping a Healthier Future programme to provide a seamless sequence of delivery models that cater for all conditions and all degrees of severity.

These settings span primary, secondary and tertiary care with a Local Hospital for each borough providing the bridge between primary and acute care.

B.1 Out-of-hospital care

Patients will be able to receive care in a variety of settings. When possible, care will be at home, or close to home. As care becomes more specialised, patients will have to travel to the specialist centres that have the most appropriate skills and equipment to support their care. Improving access will mean opening at convenient times, offering a wider-range of services and being located in the right places. Convenience is crucial for patients and services need to be available when people want to use them.

B.1.1 Home

Some services can be provided in people's homes, for example through nursing care or telephone support. Services like tele-care enable people living with long term conditions to live more independently at home for longer.

B.1.2 GP Practice

The GP practice will be at the centre of out-of-hospital care, with overall accountability for the patient's health. GP practices can provide lots of services other than GP appointments, such as immunisation, screening, blood tests and therapy services. Of course, individual GPs will not have to co-ordinate the patient's care across providers personally but they will be expected to make sure that this is happening. All NW London CCGs are investing in tools and new roles to support primary care to coordinate care better.

B.1.3 Care networks

Improving quality will mean ensuring that care is being delivered to the right clinical standards, in excellent facilities and with good patient service. Practices will work in networks to support each other in providing extended opening hours and a wider range of services. This will make it more cost effective to provide the skilled workforce and specialist equipment needed. This includes some diagnostic tests (such as ECG) and therapies, and services for some long term conditions. Grouping practices together also means urgent cases can be seen within four hours. All of this means patients will have an improved experience of primary care.

Change will be introduced across a range of areas, including front of house, planning and scheduling, back office, referrals, prescriptions and the consultation itself, to support the best use of the different skills, resources and tools within GP practices. This will allow GP practices to invest more time to improve patient and carer experience and outcomes.

Community and social services will align their services, where appropriate, to these networks to co-ordinate care. For example, in each health network, there may be a member of the district nursing team leading district nursing, who will work with the GP chair of a multi-disciplinary team to ensure effective working.

Services operating at a network level could include:

- Rapid response teams
- Specialist primary care
- Community outpatients
- District nursing
- Social services re-ablement
- End of life care

B.1.4 Health centres or 'hubs'

Certain intermediate services benefit from co-location in a single building within a health network, as patients can receive a range of complementary services that would otherwise need to be provided at a centralised site. These health centres, or 'hubs', have sufficient scale to offer a range of services to our GP networks, including extended primary care, management of patients with long-term conditions, diagnostics, therapies and outpatient services (including consultant-led clinics).

Locating services within a network health centre enables us to offer services closer to patients' homes while also ensuring we have sufficient scale to ensure clinical viability.

B.2 Hospital care

As set out in the Strategic Case, none of the current existing nine acute hospital sites in NW London is able to deliver the desired level of service quality that will be sustainable in the future. Four acute settings of care have therefore been defined based on the clinical standards and which also take into account clinical dependencies.

B.2.1 Local Hospitals

The Local Hospital is a site from which most care currently delivered in traditional district general hospital (DGH) will be delivered in the future. We estimate that over 75% of the care that would be delivered in a DGH in 2014/15 can be delivered from a Local Hospital. It will be a place that provides specialist staff (many of whom will also work in Major Hospitals) and equipment to support the networks of GP practices where much care in the future will be delivered, and a place for access to urgent care when required. Specialists will be full members of the wider out-of-hospital team, making their contribution to planned and personalised health and care. Indeed, GP services, community services, and social care may also be co-located in Local Hospitals, bringing the full range of services together around the needs of patients, close to home.

Urgent care centres

When individuals have urgent needs, it is important that they can access the advice or care that they need as rapidly as possible. In the new system of out-of-hospital care, people will be able to access services through a number of routes. These include community pharmacy, extended GP opening hours, such as weekends and evenings (within an individual practice or the practice network), greater availability of telephone advice from the practice or through 111, and GP out-of-hours services.

Today, many people with a wide range of urgent illnesses and injuries are seen by A&E departments when they could be cared for more appropriately and closer to home by a primary care urgent care service. For that reason, all Local Hospitals will have an urgent care centre (UCC) that will be open 24/7 – and fully integrated with the

wider integrated and coordinated out-of-hospital system to ensure appropriate follow up. UCCs specialise in the treatment of patients with emergency conditions that do not need hospital admission. They have strong links with other related services, including GP practices and pharmacies in the community. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend a UCC with a more severe complaint can quickly receive the most appropriate specialist care.

B.2.2 Major Hospitals

Major Hospitals will provide a full range of acute clinical services. They will have sufficient scale to support a range of clinically interdependent services and to provide high quality services for patients with urgent and/or complex needs. At their core they will be equipped and staffed to support a 24/7 A&E with 24/7 urgent surgery and medicine and a level 3 ICU. Major Hospitals will also provide a psychiatric liaison service as well as maternity services with appropriate consultant cover alongside interventional radiology services. They may also host complex surgery, a hyper-acute stroke unit (HASU), inpatient paediatrics, a heart attack centre (HAC) and a major trauma centre. In NW London each Major Hospital would also provide Local Hospital services, particularly access to an urgent care centre.

B.2.3 Elective Hospitals

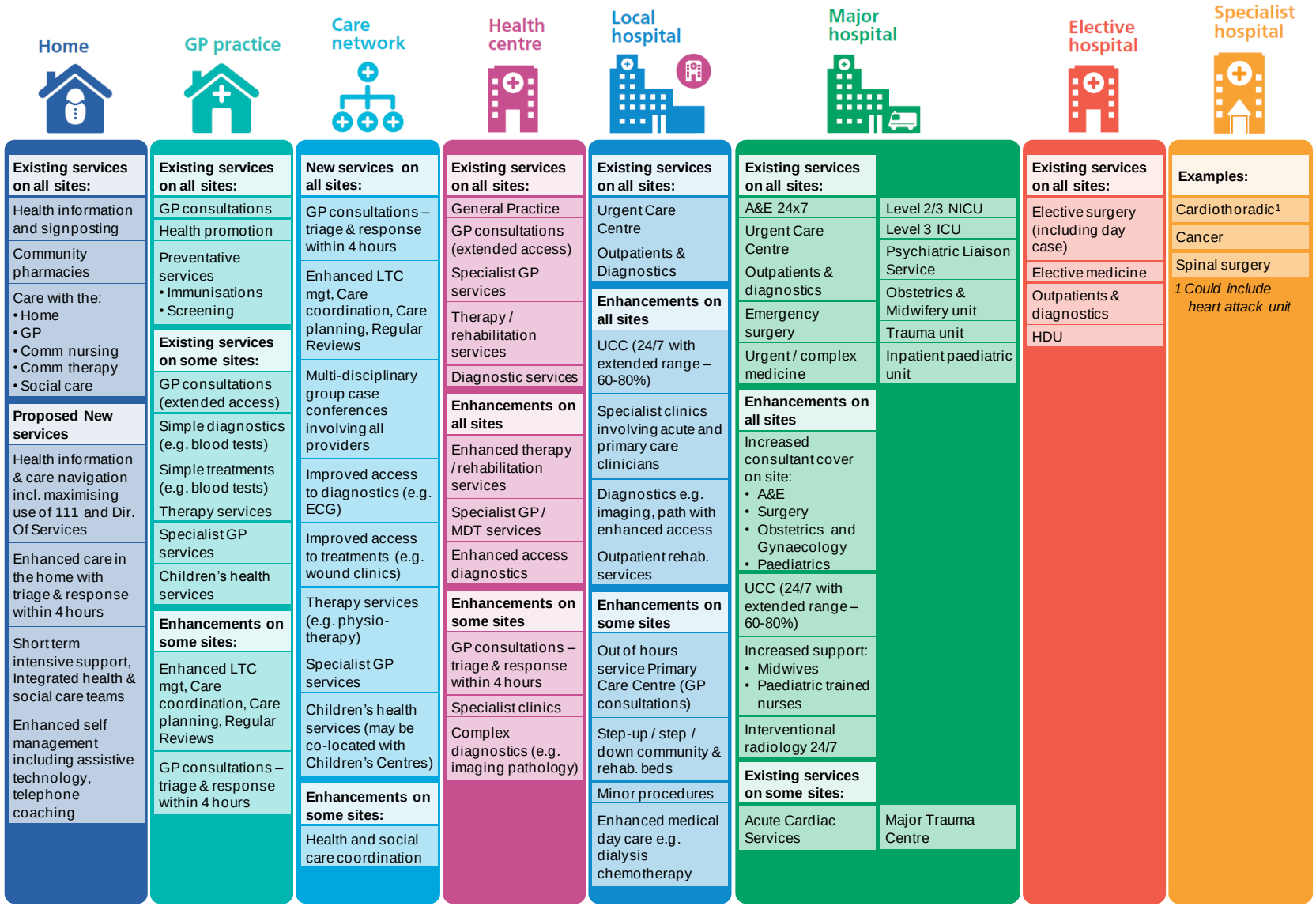
Elective services are planned, non-emergency services. Elective Hospitals will provide patients with non-complex elective medicine and elective surgery services, including operations such as hip replacements and cataract operations. The advantage of dedicated elective centres is that they allow clinicians to focus on the delivery of elective services without complexity of also seeking to provide unscheduled services, which can reduce efficiency. Elective Hospitals can be located within, or independently of, Major Hospitals as they do not rely on any of the specialist services of a Major Hospital.

B.2.4 Specialist Hospitals

Specialist Hospitals will provide specialist clinical services which are either not dependent on co-location with other specialties for high quality/safe care (e.g. ophthalmology), or which can be operated at scale to sustain dedicated co-located services (e.g. stand-alone cancer hospital).

More detail on the proposed services to be delivered in each setting is shown in Figure 1.

Figure 1: Proposed services to be provided at the eight settings of care in NW London



C BENEFITS FRAMEWORK AND REGISTER

This appendix provides a detailed patient and clinical benefits framework, describing the inputs, outputs and outcomes expected in each of the areas for which clinical standards have been defined as well as overarching operational benefits:

- Out-of-hospital care benefits:
  - Patient empowerment and self-care
  - Access, convenience and responsiveness
  - Care planning and multi-disciplinary care delivery
  - Information and communication about patients benefits
- Hospital care benefits:
  - Emergency surgery and A&E
  - Maternity services
  - Paediatrics services
- Overarching operational benefits:
  - Capacity
  - Finance
  - Research and development, education and training

It also provides the Benefits Register for the Shaping a Healthier Future programme, which summarises the benefits which will be tracked as part of the benefits realisation plan.

The register also defines the owner responsible for the delivery of specific benefits, how and when they will be delivered and the required counter-measures, as required.

Figure 1: Out-of-hospital care: Patient empowerment and self-care

Figure 2: Out-of-hospital care: Care planning and multi-disciplinary care delivery benefits

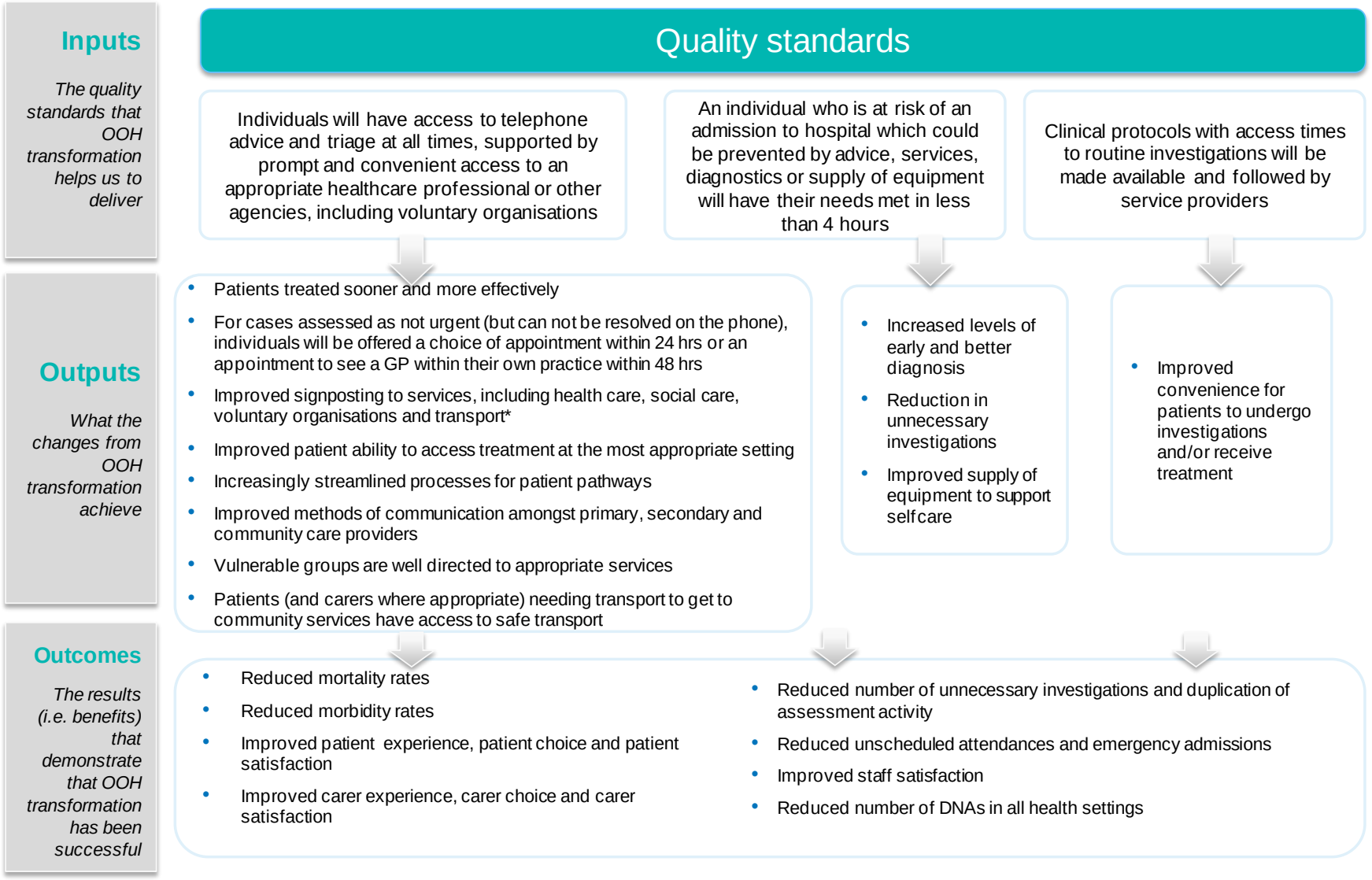


Figure 3: Out-of-hospital care: Care planning and multi-disciplinary care delivery benefits

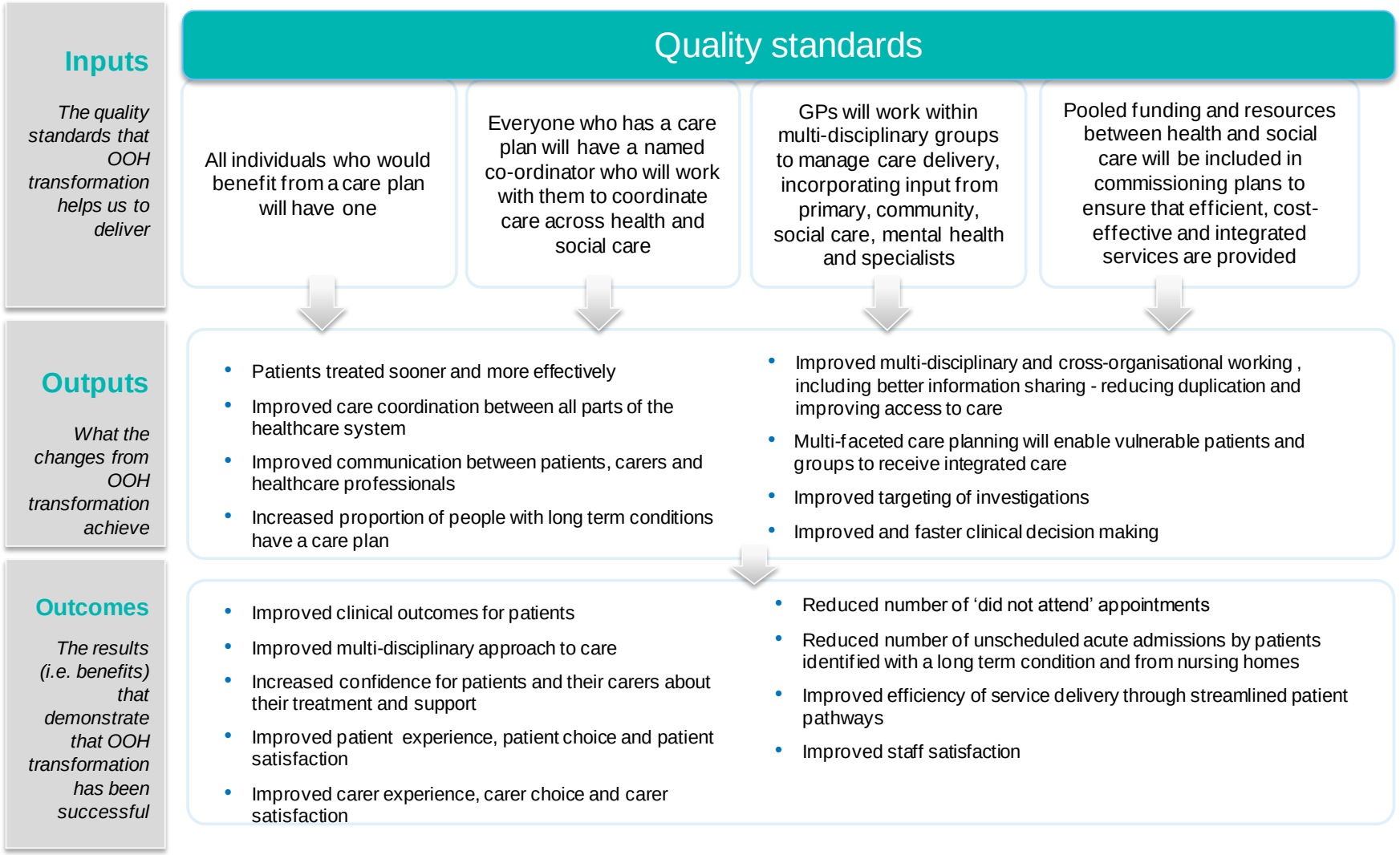


Figure 4: Out-of-hospital care: Information and communication about patients benefits

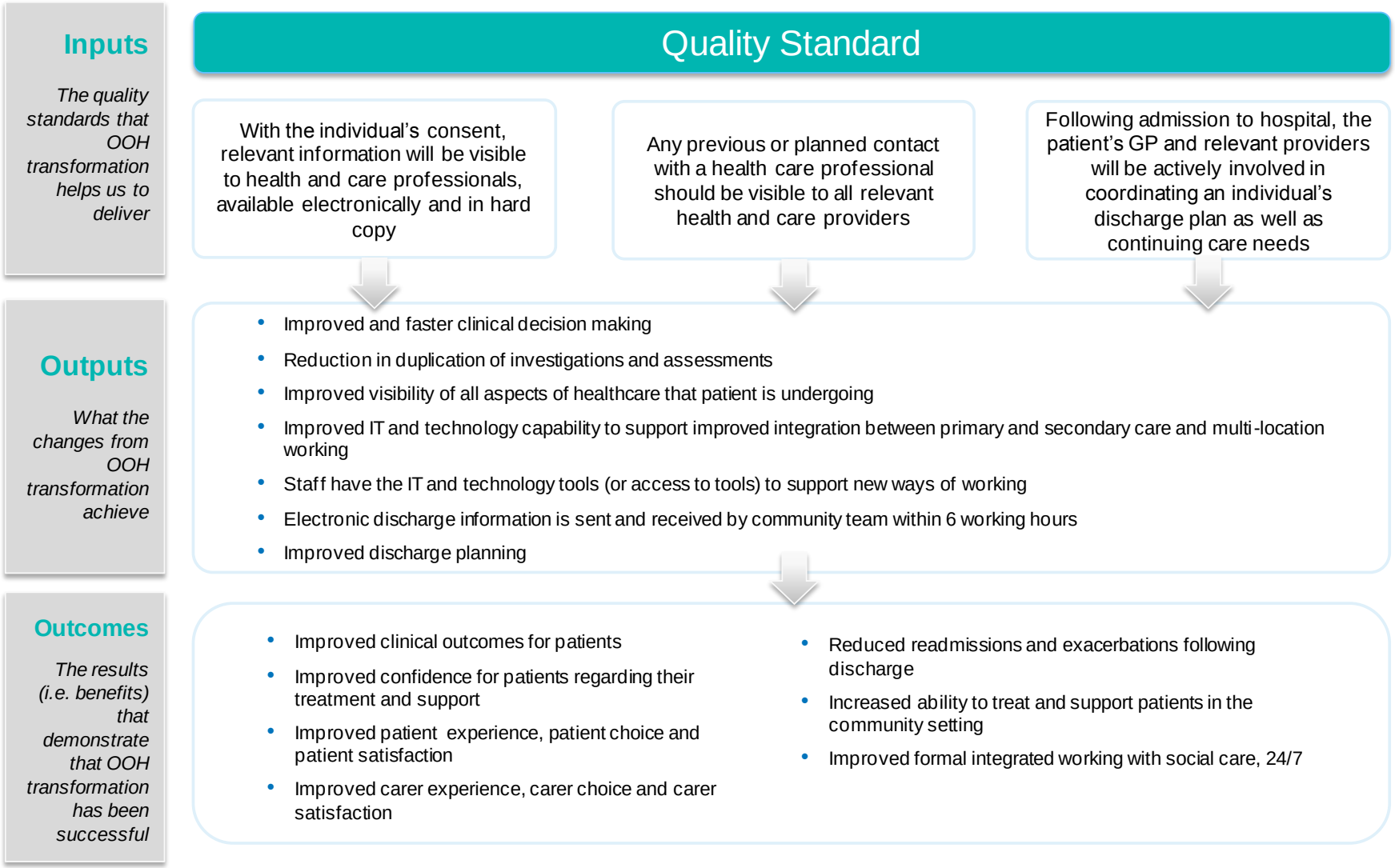


Figure 5: Emergency Surgery and A&E benefits

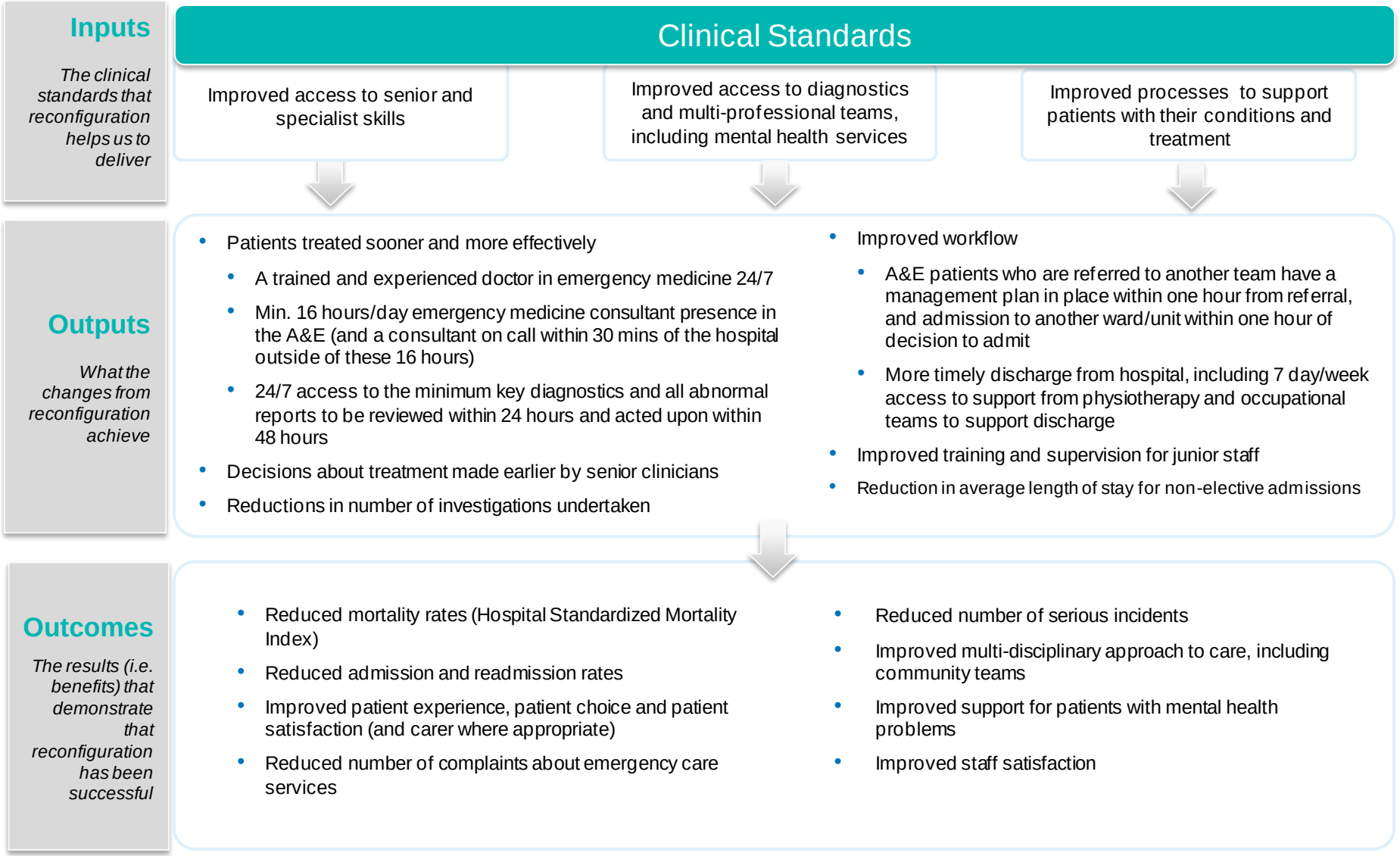


Figure 6: Maternity services benefits

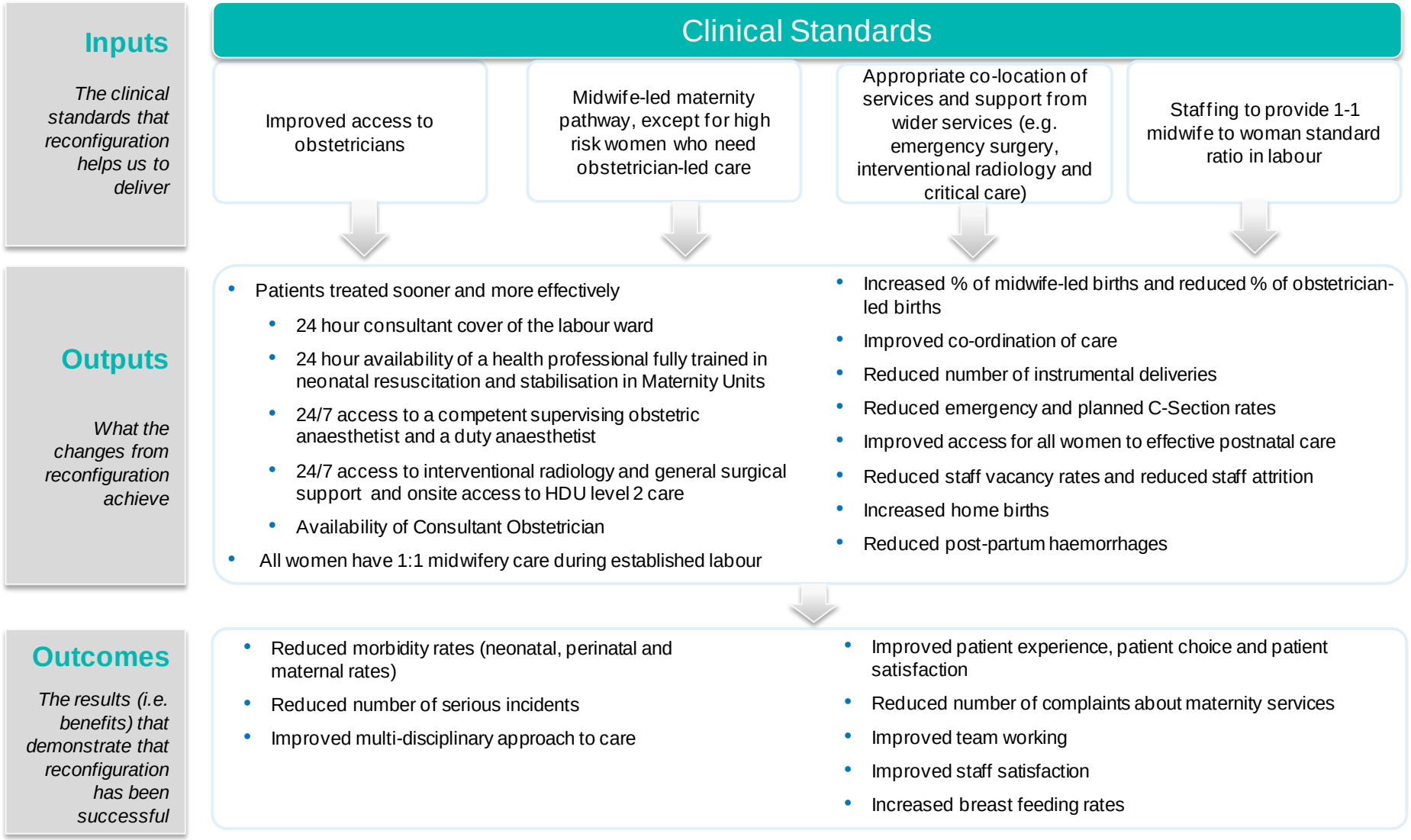


Figure 7: Paediatrics services benefits

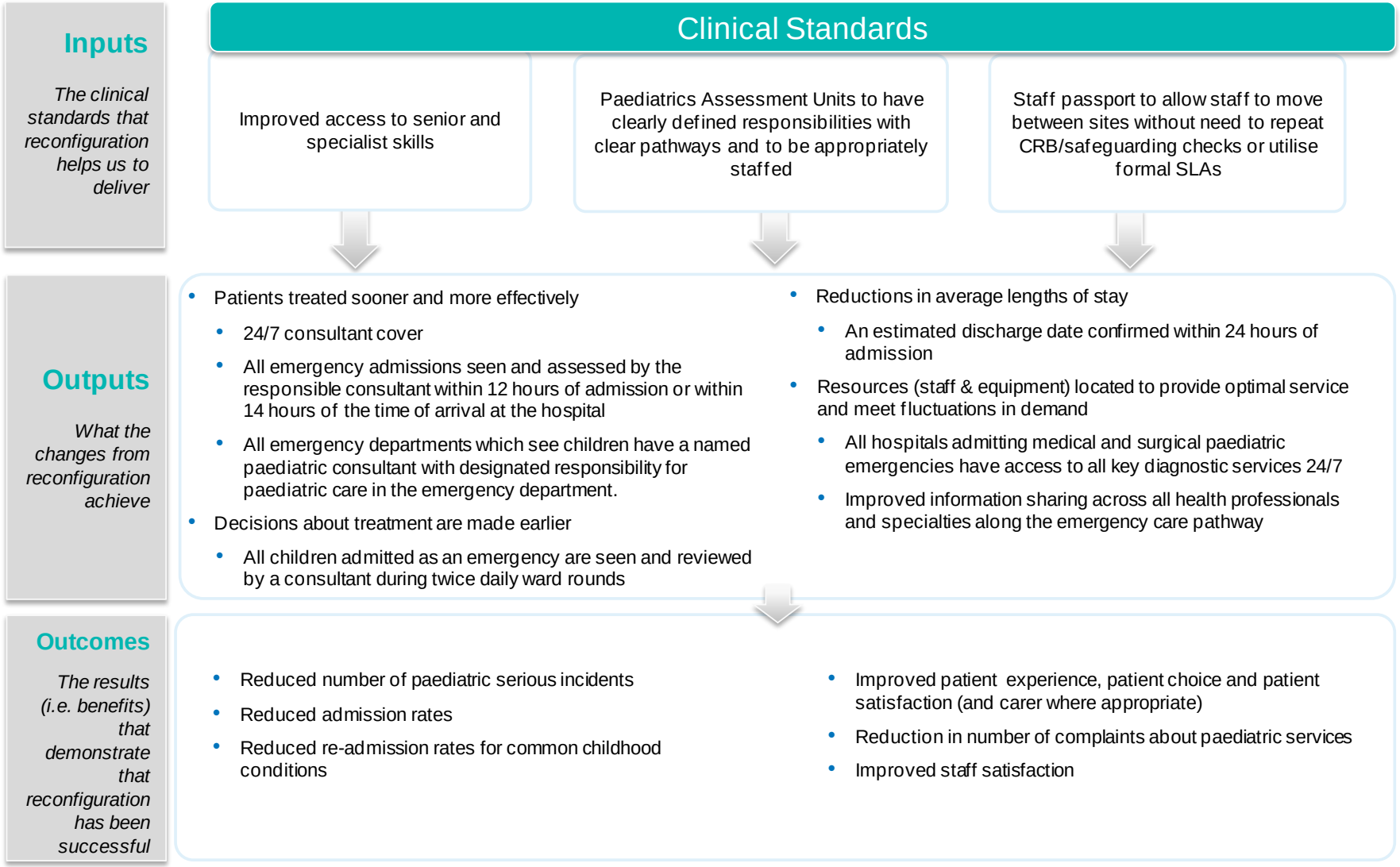


Figure 8: Capacity

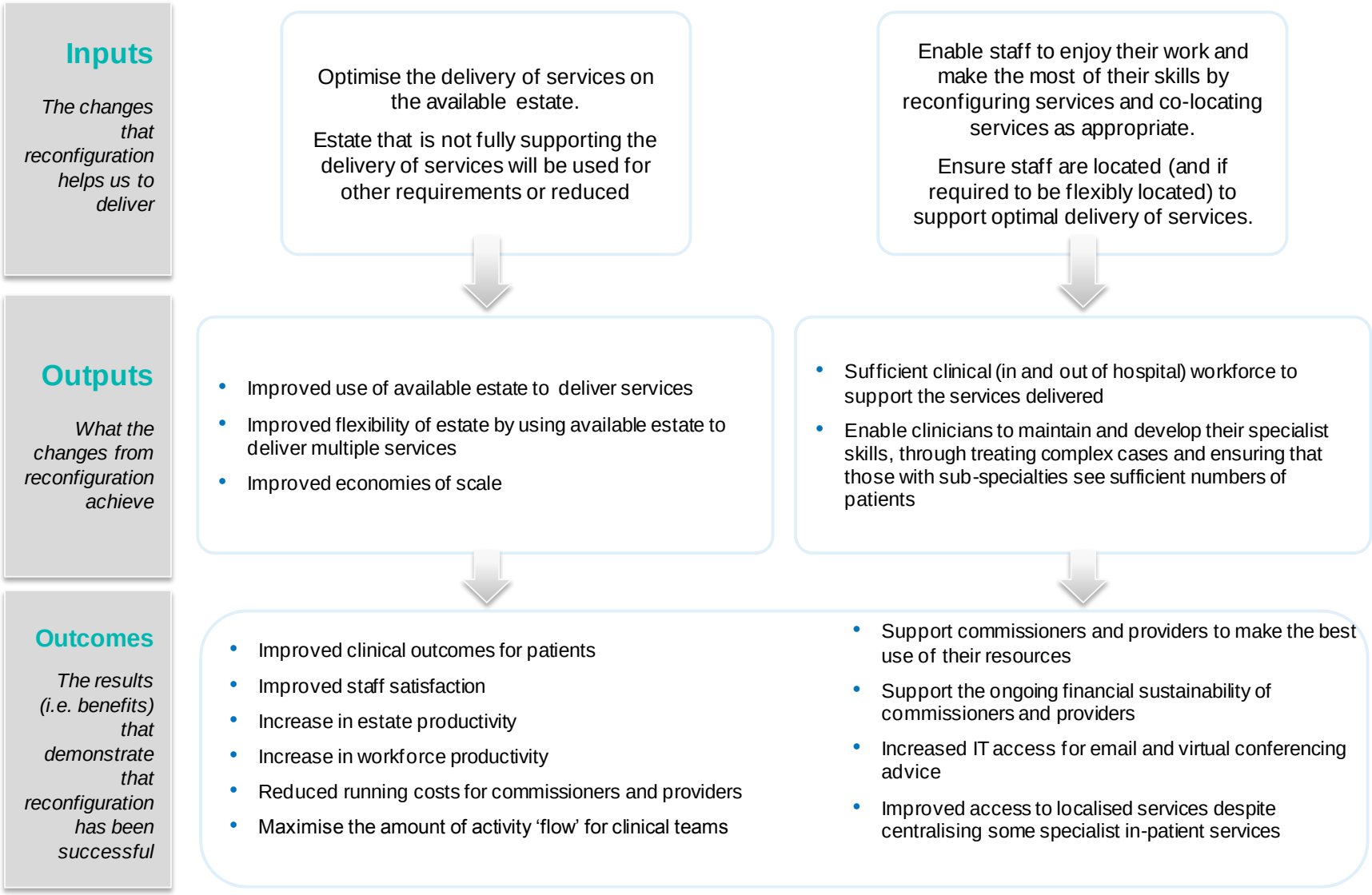


Figure 9: Finance

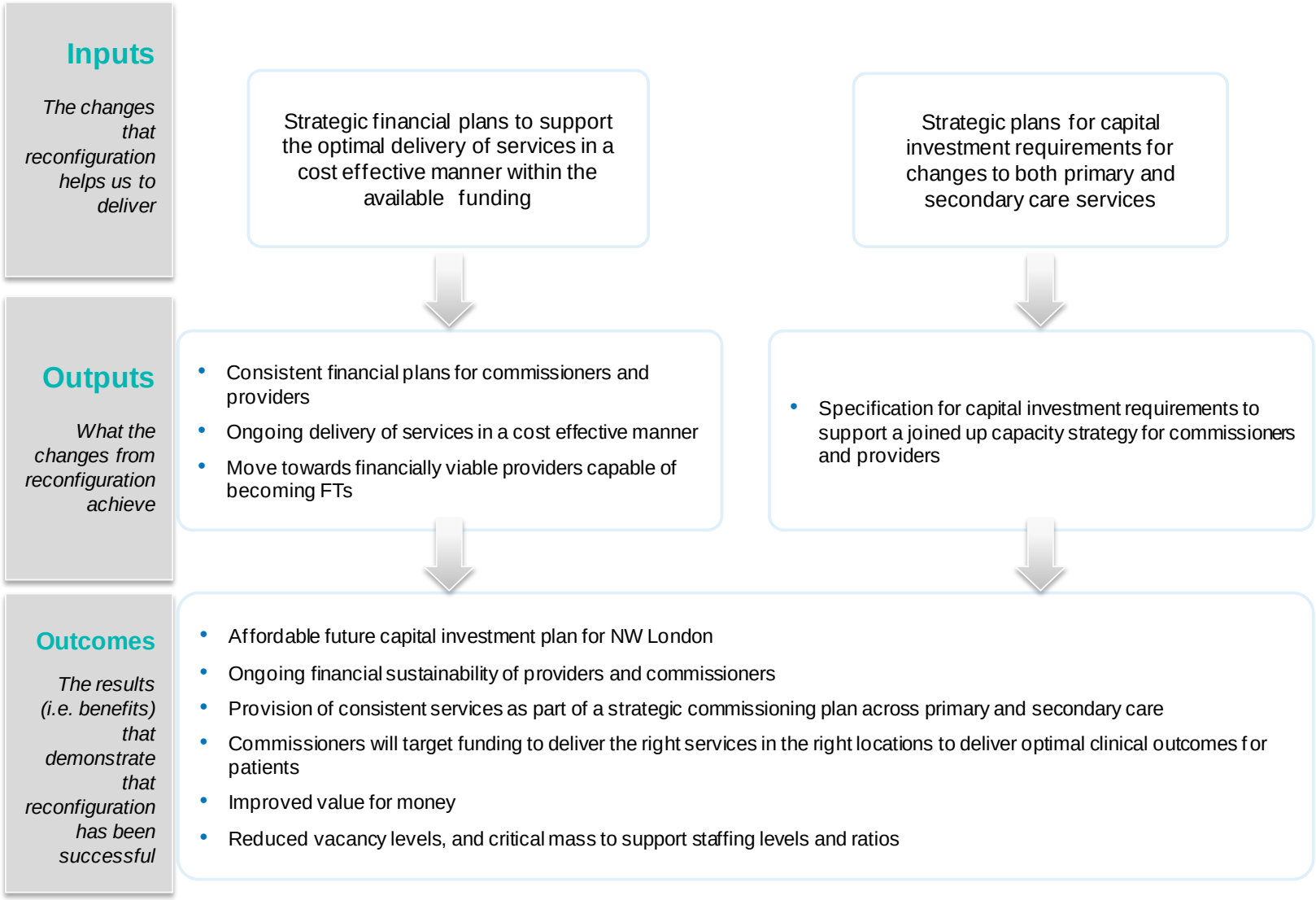
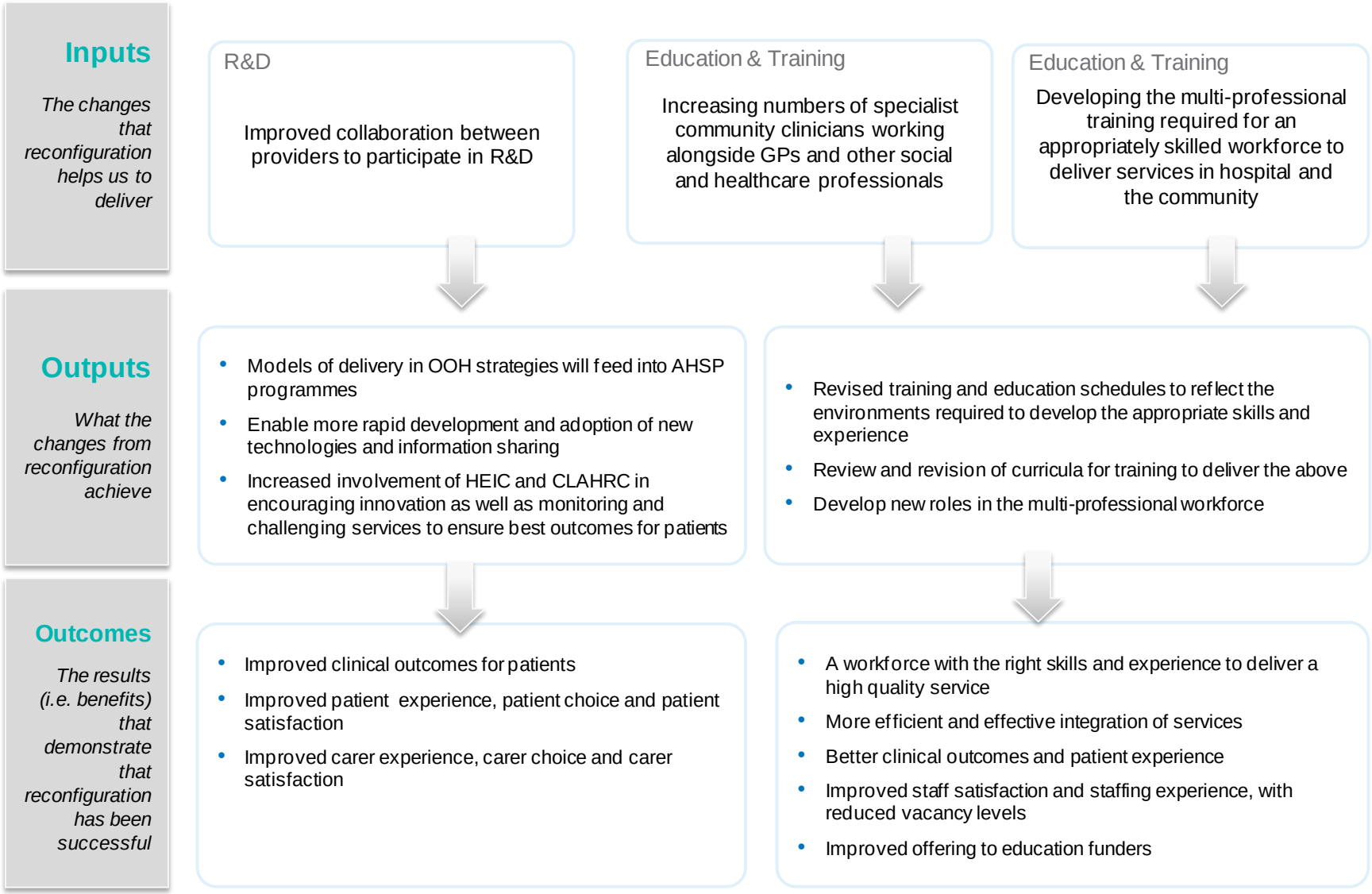


Figure 10: Research and development, education and training



C.1.1 Benefits register

This section provides the Benefits Register for the SaHF programme, which summarises the benefits which will be tracked as part of the benefits realisation plan.

The register also defines the owner responsible for the delivery of specific benefits, how and when they will be delivered and the required counter-measures, as required.

No.	Benefit	Owner	Measure	Direction / Target	Proposed Measurement Method	Frequency
1	Improved patient satisfaction, patient experience and confidence in treatment	Providers	*Patient satisfaction rating*	*Increased from baseline*	**Acute** Existing surveys, including national patient survey, NPEU annual survey of women's experience of maternity care, Friends and Family test, as well as local surveys collated by CCG. London Quality standards – emergency and maternity states this should be part of the Trust Board agenda. **Out-of-hospital** *As above for acute – all providers should adhere to the same standard of patient engagement and feedback, wherever possible, to enable comparison across organisations.*	*Bi-annual*
2	Improved carer satisfaction and experience	Providers	*Carer satisfaction rating*	*Increased from baseline*	**Acute** *Local surveys* **Out-of-hospital** *Surveys by social care and community providers*	*Bi-annual*
3	Improved patient choice	CCGs	*Patient view, e.g. % of patients who were involved in their care as much as they want*	*Increased from baseline*	*Local patient surveys*	*Bi-annual*
4	Improved support for patients with mental health problems	Providers	*Psychiatry liaison team available within 30 minutes of referral* *Access to community support in a crisis*	*100% of the time*		*Bi-annual*

No.	Benefit	Owner	Measure	Direction / Target	Proposed Measurement Method	Frequency
5	Reduced mortality rates	Providers	*% of neonatal, foetal, peri-natal and maternal deaths per 1,000 births* *Mortality rates among acutely admitted patients including those occurring in hospitals and those occurring 30 days post discharge (adjusted for case mix and palliative care)* *Paediatric mortality rates – including those occurring in hospitals and those occurring 30 days post discharge.* *Reduction in mortality rates:* • *Coronary Heart Disease* • *MS* • *Stroke* • *COPD* • *Diabetes*	*Decreased from baseline*	*Maternity network, SUS and local data sets*	*Quarterly*
6	Reduced morbidity rates	Providers	*% of neonatal, peri-natal and maternal morbidities per 1,000 births* *General morbidity rates*	*Decreased from baseline*	*Maternity network, SUS data*	*Quarterly*
7	Reduced admission and readmission rates	Providers	*Admission and readmission rates*	*Decreased from baseline*	*SUS data*	*Quarterly*
8	Reduced number of serious incidents	Providers	*No. of serious and untoward incidents* *No. of complications*	*Decreased from baseline*	*Internal Acute Trust reports*	*Quarterly*
9	Reduced number of attendances at GP surgeries	GPs	*No. of GP attendances*	*Decreased from baseline*	*Local data sets*	*Quarterly*
10	Reduced number of did not attend (DNA) appointments	GPs	*No. of DNAs*	*Decreased from baseline*	*Local data sets*	*Quarterly*

No.	Benefit	Owner	Measure	Direction / Target	Proposed Measurement Method	Frequency
11	Improved clinical outcomes	Providers	*Measures to be developed for the following conditions: Stroke, MS, COPD, Diabetes, Care of the elderly and CHD*	*Increased from baseline*	*QOF indicators*	*Quarterly*
12	Increased breast feeding rates	Providers	*% of women breast feeding at 6-8 weeks ('Breastfeeding initiation')*	*Increased from baseline*	*VSMR*	*Quarterly*
13	Reduced number of unnecessary investigations and duplication of assessment	Providers	*No. of unnecessary investigations*	*Decreased from baseline*		*Bi-annual*
14	Improved co-ordination and streamlining of information and reduced duplication	Providers	*Measure to be further considered*	*Increased from baseline*		*Bi-annual*
15	Improved staff satisfaction	Providers	*Staff satisfaction measure*	*Increased from baseline*		*Bi- annual*
16	Improved team working	Providers	*Staff view of team working*	*Increased from baseline*		*Bi-annual*
17	Improved multi-disciplinary approach to care	CCGs	*Staff view of multi-disciplinary working to include social care and private nursing home providers.* *Patient view*	*Increased from baseline*		*Bi-annual*

No.	Benefit	Owner	Measure	Direction / Target	Proposed Measurement Method	Frequency
18	Improved patient condition data to support clinical decision making	Providers	*Reductions in outpatients, district nurse visits, etc., for people with Long Term Conditions (LTCs).* *Data on whether people repeat 6 week re-enablement programmes.*	*Increased from baseline*		*Quarterly*
19	Improved efficiency of service delivery through streamlined patient pathways	Providers	*Measure to be further considered*	*Increased from baseline*		*Quarterly*
20	Increased ability to treat and support patients in the community setting	Providers	*Number of unscheduled acute admissions*	*Decreased from baseline*		*Quarterly*

D DMBC EVALUATION CRITERIA AND OPTIONS APPRAISAL

This appendix provides an overview of the evaluation criteria and decision making analysis used in the DmBC to determine the preferred reconfiguration approach for acute services in NW London as part of the Shaping a Healthier Future programme. The five main evaluation criteria were:

- Quality of care
- Access to care
- Value of money
- Deliverability
- Research and education.

Each of these is explored in more detail in the sections below, followed by an excerpt from the DmBC on the decision making analysis and process to arrive at the preferred option.

D.1 Quality of care

The quality of care evaluation criterion is made up of two sub-criteria. Table 24 shows the purpose of each of the sub-criteria and the supporting analysis performed in the evaluation.

Table 24: Quality of care sub-criteria

Sub-Criterion	Purpose	Analysis
Clinical quality	Examine which options would provide better clinical quality in future	Review whether or not the option can deliver against the clinical standards – assessment of ability of option to deliver access to experienced, skilled staff and specialist equipment Comparison of current clinical quality of sites which are expected to deliver future inpatient activity under each option.
Patient experience	Examine which options would provide a better experience for patients	Patient experience data using Care Quality Commission (CQC) standardised scores for the following measures: • How would you rate the care you received? • Did you feel you were treated with respect? • Were you involved as much as you wanted to be? Quality of estates, looking at: • Area of not functionally suitable NHS space • Estate dating post-1964 • Estate dating post-1984

D.2 Access to care

The access to care evaluation criterion is made up of two sub-criteria. Table 25 shows the purpose of each of the sub-criteria and the supporting analysis performed in the evaluation.

Table 25: Access to care sub-criteria

Sub-Criterion	Purpose	Analysis
Distance and time to access services	Evaluate which options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car (at off-peak and peak times) and public transport	Impact on population weighted average travel times for each option due to reconfiguration, based on activity volume and travel time estimations: • Blue light travel times • Off-peak car times • Peak car times • Public transport times
Patient choice	Examine which options would give people in NW London the greatest choice of hospitals for emergency care, maternity care and planned care across the greatest number of trusts.	The reduction in the number of sites delivering: • Emergency care • Obstetrics • Elective Care • Outpatients and diagnostics The number of trusts with Major Hospital sites.

D.3 Value for money

The value for money evaluation criterion is made up of five sub-criteria. Table 26 shows the purpose of each of the sub-criteria and the supporting analysis performed in the evaluation.

Table 26: Value for money sub-criteria

Sub-Criterion	Purpose	Analysis
Capital cost to system	Estimate which options would have the least capital cost	Estimate capital requirements of each option to: • Add capacity and/or reconfigure current facilities to accommodate changes in activity due to the reconfiguration • Build new Local Hospital facilities • Dispose of estate (net receipts from disposal) • Cover high risk and significant risk backlog maintenance
Transition cost	Estimate which options would have the least costs occurring as services transfer	Estimate transition costs of each option, including: • Double running (staff) • Redundancy • Training • Travel or pay protection • Double running (estate)
Viable trusts and sites	Assess the financial impact of the changes to each site in each option	Estimate net surplus/deficit of each site due to cost drivers: • Pay cost changes • Fixed cost changes • Other effects
Surplus for acute sector	Assess the overall net surplus for each option	Estimate the total surplus across all sites within the option

Sub-Criterion	Purpose	Analysis
Net present value	Assess which option provides best overall value for money	Calculate the net present value of the option, comparing discounted costs and benefits over a 20 year timeframe

D.4 Deliverability

The deliverability evaluation criterion is made up of three sub-criteria. Table 27 shows the purpose of each of the sub-criteria and the supporting analysis performed in the evaluation.

Table 27: Deliverability sub-criteria

Sub-Criterion	Purpose	Analysis
Workforce	Examine which options will provide the best workplace for staff	Staff turnover rates Staff sickness rates Staff recommendation as a place to work or receive treatment Staff job satisfaction Staff satisfied with the quality of work and patient care
Expected time to deliver	Examine how long it will take to deliver the proposed changes in each option – a shorter delivery time means that benefits can be delivered earlier	Qualitative assessment of ease of delivering option within 3-5 years based upon the following measures: • Number of sites that are already delivering relevant services • Additional capacity required • Required movements of beds within the system • The volume of maternity beds that would be moved
Co-dependencies with other strategies	Examine how well each option fits with what is happening, or may happen, nationally or in London	Fit with previous Major Trauma designation Fit with previous stroke designation for Hyper-Acute Stroke Units and Stroke Units Fit with national initiatives: • Transparency agenda • Enhancing and improving out-of-hospital care • Integrated care • Driving improvements in acute services, particularly out of hours • National QIPP challenge Fit with broader London initiatives: • Primary care • Integrated care Fit with local strategies in place or in development: • Inner NW London Integrated Care Pilot (ICP) • Mental Health ICP • Pathology modernisation programme • Ongoing work by cancer, cardiac and other networks

D.5 Research and education

The research and education evaluation criterion is made up of two sub-criteria. Table 28 shows the purpose of each of the sub-criteria and the supporting analysis performed in the evaluation.

Table 28: Research and education sub-criteria

Sub-Criterion	Purpose	Analysis
Disruption	Examine which options best fit with current research and education to minimise disruption in these areas	Research spend at non-Major Hospital and non-specialist hospital sites Education spend at non-Major Hospital and non-specialist hospital sites
Support current and developing research and education delivery	Examine which options best support what is happening in research and education across NW London	Qualitative assessment of whether each configuration option supports current and developing research and education delivery, this includes: • Fit with government research and development strategy • Support for Academic Health Science Partnership and Imperial College's strategy to concentrate research activity onto the Hammersmith and St Mary's sites • Alignment with GMC trainee plans • Fit with emerging Local Education and Training Boards' (LETBs) strategy and plans Quantitative assessment of the space allocated to research on each site

D.6 Decision making analysis (excerpt from DmBC Executive Summary)

Decision making analysis

We used the seven-stage process described earlier to identify options for consultation. The feedback received during consultation was considered and new analysis was undertaken based on this feedback (including re-appraisals of the latest evidence, activity and financial data). The analysis for each stage is defined below.

Stage 1 – Case for Change

Our work before, during and after consultation enabled us to conclude that:

- A robust platform exists for service change
- Improvements and clinical benefits could be delivered by changes
- 'Doing nothing' is not an option.

Stage 2 – Vision

Our work before, during and after consultation enabled us to conclude that the vision created by local clinicians for Shaping a healthier future will deliver the required improvements and clinical benefits.

Stage 3 – Clinical standards

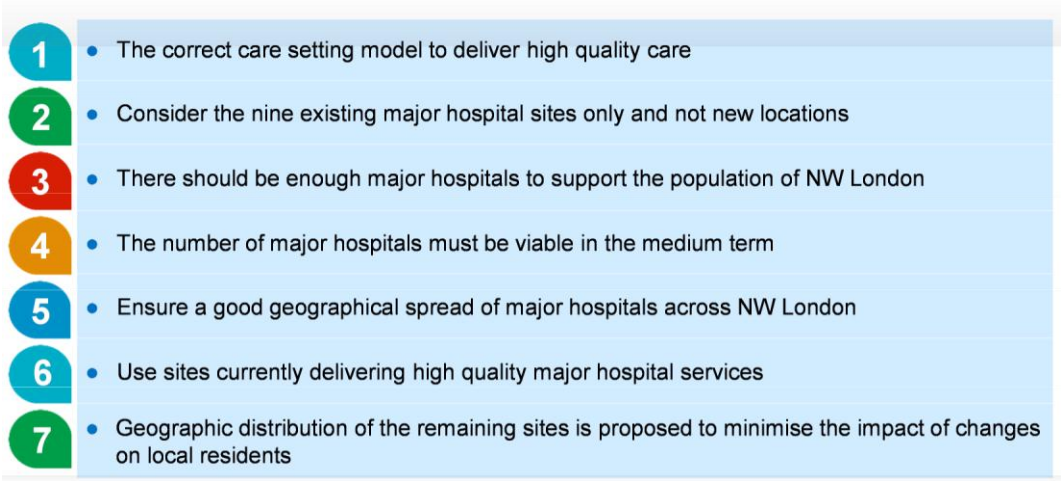
Our work before, during and after consultation, particularly with the CIGs, confirmed that the clinical standards are based on the latest evidence and clinical thinking, in particular LHP's London Quality Standards. It also established that if the standards are achieved they will contribute to the improvements outlined in the Case for Change.

Stage 4 – Service models

Our work before, during and after consultation, particularly with the CIGs, confirmed the service models reflect the latest clinical thinking, in particular LHP's London Quality Standards, and reflect relevant feedback received during consultation. It also established that if the service models are implemented they will contribute to the improvements outlined in the Case for Change.

Stage 5 – Hurdle criteria

The purpose of this stage was to use seven hurdle criteria, developed by clinicians, to establish the right number of major hospitals in the options. Within this stage, there were seven hurdles:



The millions of options for the configuration of major hospitals were considered against the hurdle criteria. This enabled us to determine that five major hospitals were needed to balance access with meeting the clinical standards. To ensure a good geographic distribution of major hospitals across NW London and minimise the impact of changes on local residents, we concluded that:

- For all options, a major hospital should be located at Hillingdon and Northwick Park
- For all options, Central Middlesex should be a local hospital and an elective hospital
- The remaining options should compare the remaining sites in pairs:
    - Either Charing Cross or Chelsea & Westminster
    - Either Ealing or West Middlesex
    - Either Hammersmith or St Mary's.

This produced a list of eight configuration options, shown below, which we analysed in more detail. Note that Options 5, 6 and 7 were renamed as Options A, B and C for public consultation.

Site	Option 1	Option 2	Option 3	Option 4	Option 5 (A)	Option 6 (B)	Option 7 (C)	Option 8
St Mary's	Local hospital	Local hospital	Local hospital	Local hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hammers-mith	Major hospital	Major hospital	Major hospital	Major hospital	Specialist hospital	Specialist hospital	Specialist hospital	Specialist hospital
Charing Cross	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital
Chelsea & Westminster	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital
West Middlesex	Major hospital	Major hospital	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Major hospital	Major hospital	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'
Ealing	Local hospital	Local hospital	Major hospital	Major hospital	Local hospital	Local hospital	Major hospital	Major hospital
Central Middlesex	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'	Local hospital/ Elective hosp'
Northwick Park	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hillingdon	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital

Local hospital | Local Hospital & Elective hospital
Major hospital | Specialist hospital

Stage 6 – Evaluation criteria

The purpose of the sixth stage was to test in detail the eight options using evaluation criteria agreed by clinicians and the public. We reviewed the feedback from consultation about the evaluation criteria and concluded we should use the same set before and after consultation as shown below:

	Criteria	Sub-criteria
1	Quality of care	• Clinical quality • Patient experience
2	Access to care	• Distance and time to access services • Patient choice
3	Value for money	• Capital cost to system • Transition costs • Viable Trusts and sites • Surplus for acute sector • Net Present Value
4	Deliverability	• Workforce • Expected time to deliver • Co-dependencies with other strategies
5	Research and Education	• Disruption • Support current and developing research and education delivery

For Quality of care, clinicians have been clear since the start of Shaping a healthier future that clinical quality is at the heart of the programme and that it is the driving force behind all the proposals and recommendations. Clinicians agreed that all the eight options under consideration had been designed to achieve the highest levels of clinical quality and that the additional data reviewed at this stage of the evaluation did not provide information that allowed them to differentiate between options on this basis. For the patient experience element, we analysed patient experience data and the quality of the estate. This identified that Options 1 and 5 were stronger and Options 4 and 8 were weaker against this sub- criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

For Access to care, we analysed the distance and time to access services based on blue light, off-peak car, peak car and public transport travel times. The analysis showed that that any impact on travel times as a result of the proposed options would be clinically acceptable and that changes in travel times across all options were so similar it did not enable any differentiation between the options so all options are evaluated identically. For patient

choice, we considered the reduction in the number of sites delivering emergency care, obstetrics, elective care, outpatients and diagnostics as well as the number of trusts with major hospital sites. This identified that Options 5 and 7 were stronger and Options 2 and 4 were weaker against this sub-criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

The Finance and Business Planning (F&BP) group was tasked with overseeing the evaluation of the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The group was tasked with advising on the value for money of the options consulted upon both relative to each other, and compared to the 'do nothing' (i.e. current configuration) situation. The analysis indicates that:

- Commissioner forecasts over the five years involve gross QIPP of £550m with reinvestment in out of hospital services of £190m.
- The acute trust I&E forecast in the 'do nothing' is that most sites would move into deficit with no overall net surplus. In the downside scenario there would be an overall deficit of £89m with all bar one acute site in deficit.

The value for money evaluation criteria used to assess the options are:

- Capital costs
- Transition costs
- Site viability
- Total trust surplus/deficit
- Net present value.

The evaluation shows that all three options score less well than in the pre-consultation analysis but that option A remains the highest scoring. Option A requires net capital investment of £206m to implement the major hospital model, results in a positive I&E position of £42m for the acute sector and has a positive net present value. For all three options, the capital investment in out of hospital estates required to deliver the required changes has been assessed at £6m-112m for hubs and up to £74m for GP premises.

For deliverability we considered three sub-criteria. Firstly, analysis of the impact on workforce (done through staff satisfaction data) showed that Options 2 and 6 were weaker with all other options equally strong as each other. Secondly, analysis of the expected time

to deliver the options showed Options 5 and 6 were stronger and that Options 3, 4, 7 and 8 were weaker. Thirdly, we analysed co-dependencies with other strategies – previous Major Trauma designation, previous stroke designation, national initiatives, broader London initiatives and local strategies in place or in development. This identified that Options 5 and 6 were stronger and Options 3 and 4 were weaker against this sub-criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

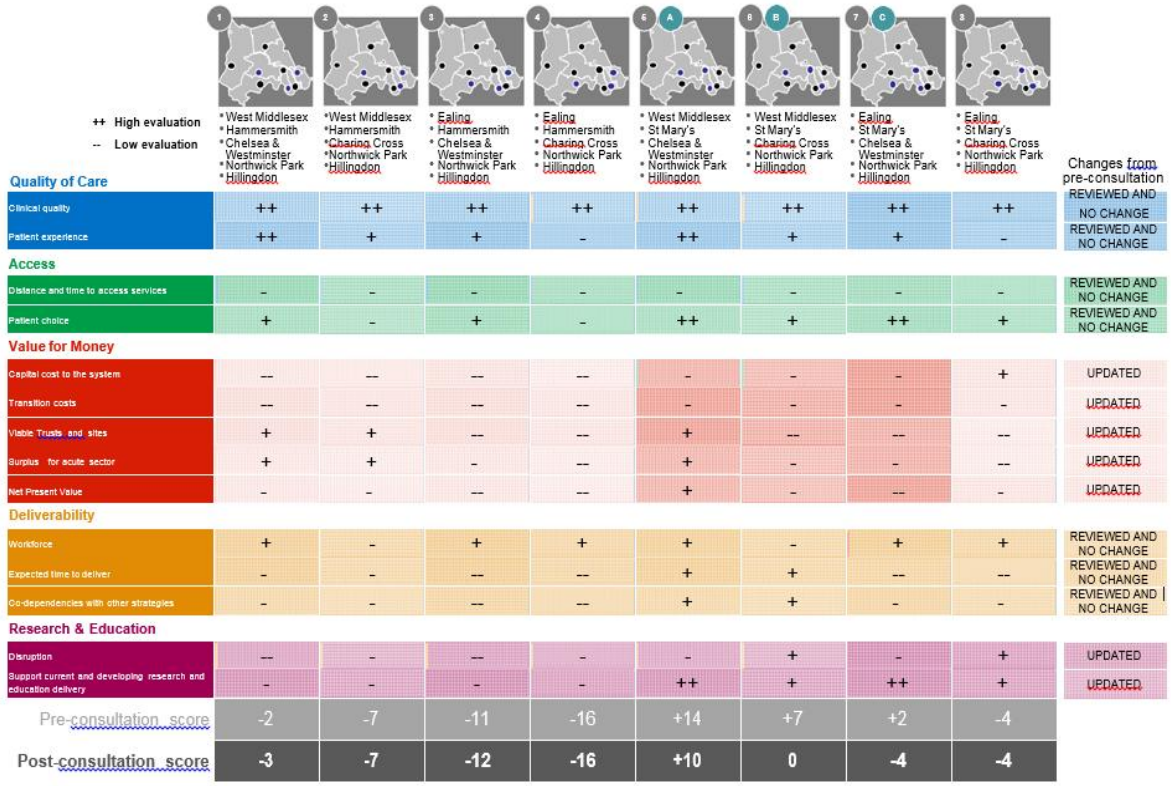
For Research & Education, we considered disruption and support current and developing research and education delivery. Our evaluation of both sub-criteria was reviewed and updated post-consultation. Options 6 and 8 were stronger and Options 1 and 3 were weaker against the disruption sub-criterion. For the second sub-criterion, Options 5 and 7 were stronger followed by Options 6 and 8 followed by the remaining options.

Stage 7 – Sensitivity analysis

At the end of stage 6, we concluded that overall options 5, 6 and 7 were the strongest. Sensitivity analysis was used to test the options to establish whether the ranking changed under testing. Sensitivity analysis supports the conclusion that option 5 is the preferred financial option both before and after consultation. However, as highlighted in the PCBC the programme needs to mitigate against the risk of a number of downside sensitivities happening simultaneously if the overall financial benefits are to be realised.

The proposed future configuration of hospitals in NW London

The evaluation was brought together and a summary is shown below. Note that Options 5, 6 and 7 were renamed as Options A, B and C for public consultation.



++ High evaluation -- Low evaluation	1 *West Middlesex *Hammersmith *Chelsea & Westminster *Northwick Park *Hillingdon	2 *West Middlesex *Hammersmith *Charing Cross *Northwick Park *Hillingdon	3 *Ealing *Hammersmith *Chelsea & Westminster *Northwick Park *Hillingdon	4 *Ealing *Hammersmith *Charing Cross *Northwick Park *Hillingdon	6 A *West Middlesex *St Mary's *Chelsea & Westminster *Northwick Park *Hillingdon	8 B *West Middlesex *St Mary's *Charing Cross *Northwick Park *Hillingdon	7 C *Ealing *St Mary's *Chelsea & Westminster *Northwick Park *Hillingdon	5 *Ealing *St Mary's *Charing Cross *Northwick Park *Hillingdon	Changes from pre-consultation
Quality of Care									
Clinical quality	++	++	++	++	++	++	++	++	REVIEWED AND NO CHANGE
Patient experience	++	+	+	-	++	+	+	-	REVIEWED AND NO CHANGE
Access									
Distance and time to access services	-	-	-	-	-	-	-	-	REVIEWED AND NO CHANGE
Patient choice	+	-	+	-	++	+	++	+	REVIEWED AND NO CHANGE
Value for Money									
Capital cost to the system	--	--	--	--	-	-	-	+	UPDATED
Transition costs	--	--	--	--	-	-	-	-	UPDATED
Viable Trusts and sites	+	+	--	--	+	--	--	--	UPDATED
Surplus for acute sector	+	+	-	--	+	-	-	--	UPDATED
Net Present Value	-	-	--	--	+	-	--	-	UPDATED
Deliverability									
Workforce	+	-	+	+	+	-	+	+	REVIEWED AND NO CHANGE
Expected time to deliver	-	-	--	--	+	+	--	--	REVIEWED AND NO CHANGE
Co-dependencies with other strategies	-	-	--	--	+	+	-	-	REVIEWED AND NO CHANGE
Research & Education									
Disruption	--	-	--	-	-	+	-	+	UPDATED
Support current and developing research and education delivery	-	-	-	-	++	+	++	+	UPDATED
Pre-consultation score	-2	-7	-11	-16	+14	+7	+2	-4	
Post-consultation score	**-3**	**-7**	**-12**	**-16**	**+10**	**0**	**-4**	**-4**	

As a result of the decision-making analysis, the Clinical Board agreed that Option 5 (Option A in the table above) was the strongest option. The Finance & Business Planning Working Group agreed that Option 5 was better than the other options.

The Programme Board reviewed the completed evaluation and analysis and considered the recommendations of the Clinical Board and the Finance & Business Planning Working Group. The Board noted the two recommendations and agreed with the assessment that Option A should be the recommended configuration.

The recommended hospital configuration proposes the following service models at each site. At:

- Chelsea & Westminster – a local hospital and a major hospital
- Hillingdon – a local hospital and a major hospital
- Northwick Park – a local hospital and a major hospital
- St Mary's – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)
- West Middlesex – a local hospital and a major hospital

- Central Middlesex – a local hospital and an elective hospital
- Charing Cross – a local hospital1
- Ealing – a local hospital2
- Hammersmith – a specialist hospital with obstetric-led maternity unit and a local hospital

E PROPOSED APPROACH TO DELIVER SHAPING A HEALTHIER FUTURE

This appendix provides an overview of the site services recommended in this business case. These summaries are provided separately for:

- Out-of-hospital hubs, Local and Elective Hospitals; and
- Major and Specialist Hospitals

E.1 Out-of-hospital hubs capabilities, sites and investment

In this section we provide a high-level overview of the capabilities proposed in each of the out-of-hospital hubs proposed for each CCG.

CCG	Hub	Primary Care	Out Patients	Mental Health	Diagnostics	Therapies	Status of Site	Status of Investment
Central London	Church Street Hub	✓	✓				New out-of-hospital hub	Requires capital investment
	South Westminster	✓	✓				Operational as an out-of hospital hub	No capital investment
	St Mary's Hub	✓	✓				New out-of-hospital hub	Capital investment (SOC part 2)
	Central Westminster	✓	✓				New out-of-hospital hub	Requires capital investment
Brent	Wembley Centre for Health and Care	✓	✓	✓	✓	✓	Operational as an out-of hospital hub	Requires capital investment
	Willesden Centre for Health and Care	✓	✓	✓		✓	Operational as an out-of hospital hub	Requires capital investment
	Central Middlesex Hospital Hub	✓	✓				Operational as small district general hospital	Capital investment (SOC part 1)
Ealing	Ealing East Hub	✓	✓				New out-of-hospital hub	Requires capital investment
	Ealing North Hub	✓	✓	✓			New out-of-hospital hub	Requires capital investment

CCG	Hub	Primary Care	Out Patients	Mental Health	Diagnostics	Therapies	Status of Site	Status of Investment
	Ealing Local Hospital Hub	✓	✓				Operational as mid-sized district general hospital	Capital investment (SOC part 1)
Hammersmith and Fulham	Parkview Centre for Health and Social Care	✓	✓				Operational as an out-of hospital hub	No capital investment
	Parson's Green Centre for Health and Social Care	✓	✓				Operational as an out-of hospital hub	Requires capital investment
	Charing Cross Local Hospital	✓	✓				New out-of-hospital hub on hospital site	Capital investment (SOC part 2)
Harrow	East and North East Harrow Hub	✓	✓	✓		✓	New out-of-hospital hub	Requires capital investment
	Alexandra Avenue Health and Social Care Centre	✓	✓				Operational as an out-of hospital hub	Requires capital investment
	The Pin Medical Centre	✓	✓		✓		Operational as an out-of hospital hub	Requires capital investment
Hillingdon	Hesa Health Centre	✓	✓				Operational as an out-of hospital hub	No capital investment
	Uxbridge and West Drayton Hub	✓	✓	✓			New out-of-hospital hub	Requires capital investment
	North Hillingdon Hub	✓	✓	✓			New out-of-hospital hub	Requires capital investment

CCG	Hub	Primary Care	Out Patients	Mental Health	Diagnostics	Therapies	Status of Site	Status of Investment
Hounslow	Heston Health Centre	✓	✓	✓		✓	New out-of-hospital hub	Requires capital investment
	West Middlesex Hospital*	✓	✓				New out-of-hospital hub on hospital site	Requires capital investment
	Heart of Hounslow Centre for Health	✓	✓				Operational as an out-of hospital hub	Requires capital investment
	Brentford Health Centre*	✓	✓	✓		✓	Operational as an out-of hospital hub	Requires capital investment
	Chiswick Health Centre	✓	✓	✓		✓	Operational as an out-of hospital hub	Requires capital investment
	Feltham Health Centre	✓	✓				Operational as an out-of hospital hub	No capital investment
West London	St Charles Hub Plus	✓	✓		✓		Operational as an out-of hospital hub	Requires capital investment
	Violoet Melchett/South Localiity Hub	✓	✓				New out-of-hospital hub	Requires capital investment

Note: A review is underway to assess the potential benefits of two separate hubs based in the Brentford Health Centre and on the West Middlesex Hospital site, or whether a single hub would be preferred. For the purposes of the Economic and Financial cases a single HUB has been modelled.*

E.2 Summary of proposed changes at Local and Elective Hospital Sites

Ealing Hospital

Site	Trust	Setting of Care
Ealing Hospital	London North West Healthcare NHS Trust	Local hospital

Existing provision

Ealing Hospital currently operates as a mid-sized district general hospital (DGH). In October 2014, the Ealing Hospital Trust merged with North West London Hospitals Trust to form London North West Healthcare NHS Trust.

Until recently Ealing Hospital provided a full range of general acute and emergency services. In 2015, under the SaHF transformation, the maternity unit (excluding ante and postnatal outpatients) closed and, in 2016, inpatient paediatrics ceased to be provided.

Proposed approach

Following the original SaHF consultation, the response by the Independent Reconfiguration Panel and the Secretary of State in October 2013, and subsequent public engagement, the services proposed for the Ealing local hospital are:

- GP services
- Full range of diagnostics
- Outpatient services
- Community hub
- Local A&E including:
  - Ambulatory assessment and care
  - Frailty assessment
  - Frail elderly beds

Central Middlesex Hospital

Site	Trust	Setting of Care
Central Middlesex Hospital	London North West Healthcare NHS Trust	Elective hospital

Existing provision

CMH provides a range of general elective services as part of the care delivered by LNWHT. It acts as a "cold" site, focusing on elective and non-emergency care, with Northwick Park and Ealing Hospital offering emergency care and trauma services at their "hot sites". The A&E department at CMH was closed in September 2014 and over recent years, several services including emergency surgery, inpatient paediatrics and obstetrics have ceased to be offered.

Services currently provided at Central Middlesex Hospital include an UCC operating 24/7, outpatients and diagnostics, elective surgery, elective medicine and HDU.

Proposed approach

The proposals for Central Middlesex Hospital include developing the site into a local elective hospital. The Brent out-of-hospital strategy that was also agreed as part of Shaping a healthier future set out a range of non-acute services that will also be provided at Central Middlesex Hospital, as it becomes one of the local primary care hubs. The proposed approach for Central Middlesex therefore focuses on optimising current services as well as providing more out-of-hospital care on the site.

The proposal are:

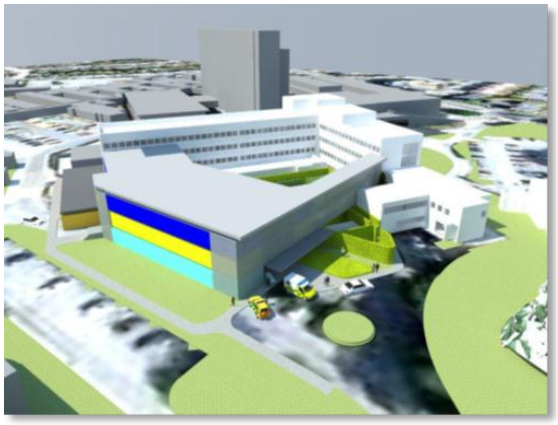
1. Health and Wellbeing Centre that will include:
   - Urgent Care Centre
   - Brent CCG reprovision of outpatients
   - GP practice
   - Community zone
2. Relocated services:
   - Clinical genetics,
   - Willesden rehabilitation beds (44 beds)
   - Community services
3. Services remaining:
   - Acute outpatients activity (including paediatrics and care of the elderly)
   - Elective inpatient and day case activity which includes the SaHF Ealing transfers
   - Trust orthopaedic elective services
   - Therapeutic services (physiotherapy, occupational therapy, dietetics and speech & language)
   - Renal (diagnostics and outpatients provided by Imperial)
   - Other clinical support services Central Middlesex Hospital will also host the Regional Genetics Service, serving residents of Hertfordshire, Hillingdon, Brent, Harrow, Ealing, Hammersmith, Hounslow, Kensington, Chelsea, Westminster and Edgware.

E.3 Summary of proposed changes at major and specialist hospital sites

Hillingdon Hospital

Site	Trust	Setting of Care
Hillingdon Hospital	The Hillingdon Hospitals NHS Foundation Trust	Major hospital

Existing provision



The Hillingdon Hospitals NHS Foundation Trust (THHFT) is an acute and specialist services provider in NW London, close to Heathrow Airport for which it is the emergency receiving hospital.

Providing the majority of services for the Trust, Hillingdon Hospital is the only acute hospital in Hillingdon, with a busy A&E, inpatients, day surgery, and outpatient clinics and a catchment population of over 350,000. The tower and podium accommodates the main critical care service departments at Hillingdon Hospital.

The Hillingdon Hospitals (THH) became a Foundation Trust in 2011. Much of the hospital infrastructure was created in the 1960s, with the result that significant investment is now required to update the mechanical and electrical plant and building stock.

Proposed approach

Hillingdon Hospital has already established an expansion of its short-stay emergency facilities with a new Acute Medical Unit co-located to the A&E and will continue to offer its full range of existing services to patients. Further proposed improvements to deliver the necessary changes for the Shaping a healthier future programme include:

- **Maternity:** A new two-floor extension providing an additional 2,791 m^2 of new build and 653 m^2 refurbishment in the existing building. This will enable the hospital to meet the demand for an additional 1,800 births per year through development of a midwife-led unit and existing obstetric unit. An additional new post-natal ward will be delivered on level with existing beds.
- **Emergency Department:** A modular build extension into the central courtyard of the hospital, creating additional and replacement majors cubicles to modern standards and to allow existing cubicle space to ease ambulance reception delays. On the second floor of the extension additional theatre recovery space will be provided to ease bottlenecks and improve theatre throughput.
- **Critical Care:** A four bed extension to ITU (two additional and two re-provided) to create access to modern space standards and to refurbish one Drayton Ward bed bay to create two HDU-appropriate spaces co-located with CCU able to be used at peak periods.

Northwick Park Hospital

Site	Trust	Setting of Care
Northwick Park Hospital	London North West Healthcare NHS Trust	Major hospital

Existing provision

Northwick Park Hospital forms part of London North West Healthcare NHS Trust which also comprises St. Mark's Hospital, Central Middlesex Hospital and Ealing Hospital.

Northwick Park currently provides major acute and specialist services and will continue to do so as a Major Hospital within the Shaping a healthier future proposals.

Services include:

- A&E, UCC and trauma care
- Intensive care
- Emergency and general medicine and surgery
- Specialist and tertiary medicine and surgery
- Obstetrics and midwifery unit
- Inpatient paediatrics.

Proposed approach

The proposed approach for the expansion of non-elective care and maternity facilities to provide additional capacity in line with the activity increases as a result of Shaping a healthier future. The additional physical capacity will also help to address current capacity issues.

The investment is a key requirement to deliver the vision for Northwick Park to continue as a Major Hospital site in NW London providing acute and specialist care. The proposed expansions include:

- High acuity and recovery – Newly built extension to create 28-bedded unit
- Maternity – Develop dedicated triage and assessment suite, with one additional delivery space. Additional neonatal cot, ultrasound room and paediatric bed.
- Clinical support services – Conversion of pharmacy space and replace mobile MRI and redevelop the Imaging department.
- Essential backlog maintenance works are also required to secure the infrastructure of the site. This includes replacing the heating and hot water system.

West Middlesex Hospital

Site	Trust	Setting of Care
West Middlesex University Hospital	Chelsea & Westminster Hospital NHS FT	Major hospital

Existing provision

West Middlesex University Hospital is a busy urban acute hospital located in Isleworth, west London. It provides services primarily to residents of the London Boroughs of Hounslow and Richmond-upon-Thames.

West Middlesex provides a range of services to the local health sector including emergency assessment and treatment services; elective surgical and medical treatments; comprehensive maternity services; children's services; diagnostic services.

Proposed approach

The proposed approach to deliver the necessary changes for the Shaping a healthier future programme are split across the following three areas:

- **Maternity:** Maintain maternity in it's existing location through the buy-out the leased modular maternity units, which were put in place at the time of transfer of maternity services from Ealing Hospital
- **Emergency Department:** Emergency department services are forecast to see a 25.5% increase in activity to 69,221 attendances. The current ED footprint will be reconfigured and extended so that it meets all activity requirements and space standards. There will be a total of 25 'majors' adult cubicles and eight paediatric cubicles. An additional 7 ITU/HDU beds are also planned in order to increase critical care capacity.
- **Adult and paediatric inpatients:** Office space in 2nd floor East Wing will be reclaimed and specialist outpatient services will be displaced from Marjory Warren to accommodate the adult inpatient requirements. Additional paediatrics inpatient beds will be provided within the existing outpatient footprint on the 3rd floor, allowing for more efficient ways of working.

F SUSTAINABILITY AND TRANSFORMATION PLAN

North West London

Sustainability and Transformation Plan Summary

Being well, living well: a sustainability and transformation plan for North West London

EXECUTIVE SUMMARY

November 2016

Have your say

We want to hear your views as we develop this plan. We welcome your comments on any aspect of this plan.

You can send us your comments either online at www.healthiernwlondon.commonplace.is or email healthiernwl@nw.london.nhs.uk.

This document is a summary. More details are available on our website www.healthiernorthwestlondon.nhs.uk.

Our vision

Everyone living, working and visiting North West (NW) London should have the opportunity to be **well and live well** – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers.

For this to happen, the health service needs to turn the current model, which directs most resources into caring for people when they become ill, on its head. The new model must support patients to stay well and take more control of their own health and wellbeing, as close to home as possible.

Sustainability

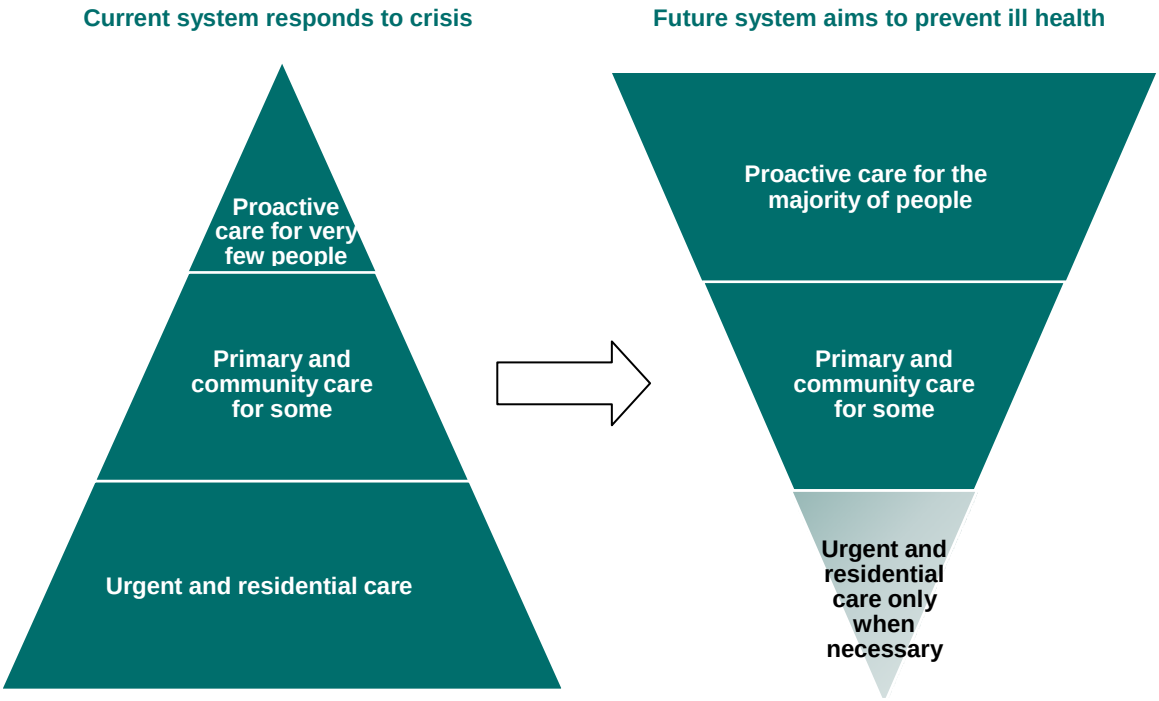
Using resources to meet the needs of people today without causing problems for future generations.

The NHS and councils of NW London have developed this draft Sustainability and Transformation Plan (STP). The STP takes its starting point from the ambitions and knowledge in the national **NHS Five Year Forward View** strategy and translates it for our local situation.

NHS Five Year Forward View

The NHS Five Year Forward View is a strategy for the NHS in England. It describes the gaps in health and social care; how the quality of NHS care can be variable; with widespread health inequalities and preventable illnesses. People's needs are changing, new treatments are emerging every day, and there are challenges in areas such as mental health, cancer and support for frail older patients.

The NHS Five Year Forward View also sets out the benefits of new ways of delivering care; the critical importance of better public health and preventing ill health; how services across health and social care need to be joined up and patients and communities need to be empowered; why primary care needs to be strengthened; and the need for further efficiencies in the health service.



Working together to achieve change

Over four billion pounds a year is spent on providing NW London's health and care services for our two million residents. There are 400 GP practices, ten hospitals and four mental health and community health trusts across the eight boroughs.

Doctors, nurses and other clinicians have worked with key stakeholders to propose how care should evolve to provide a high quality and sustainable system that meets your needs. The STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well and has involved over 30 organisations:

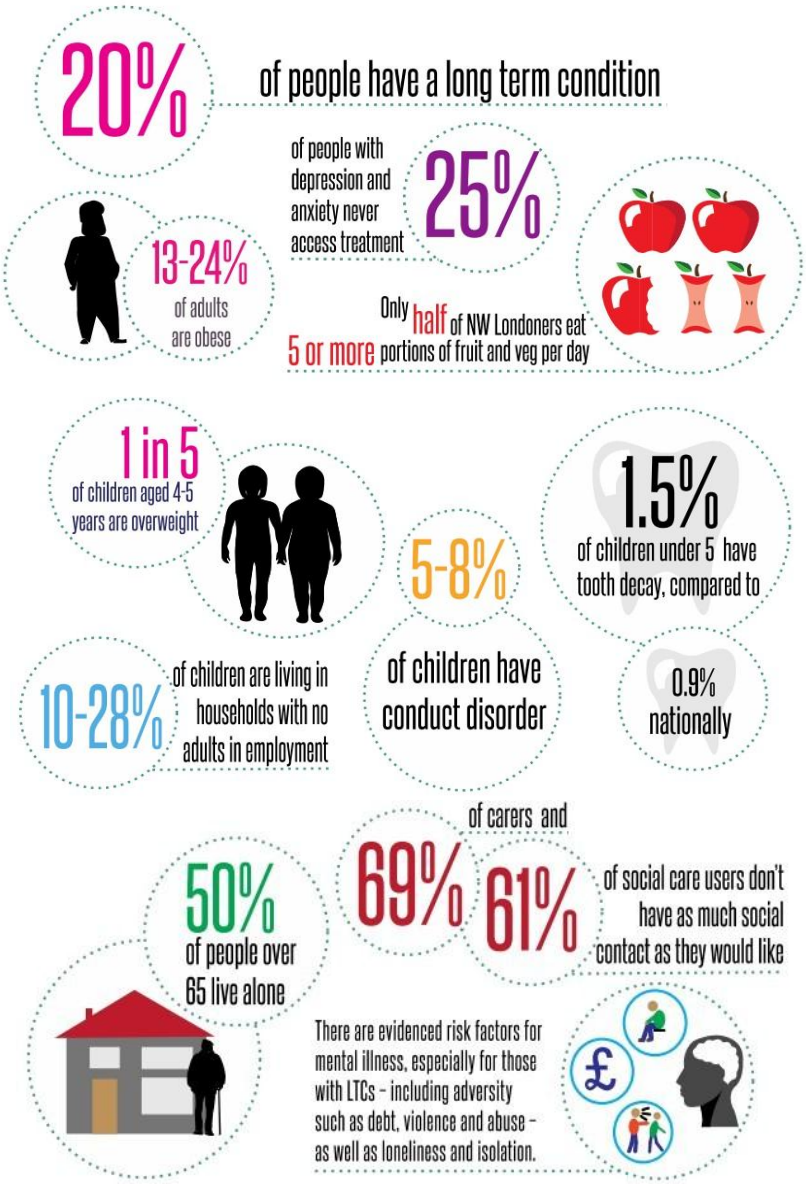
- **Clinical commissioning groups (GP-led groups responsible for planning and buying NHS services):** Brent; Central London; Ealing; Hammersmith and Fulham; Harrow; Hillingdon; Hounslow; and West London.
- **Local authorities:** Brent; Hammersmith & Fulham, Harrow; Hillingdon; Hounslow; Kensington and Chelsea; and the City of Westminster.
- **NHS providers (hospitals, community services and mental health services):** West London Mental Health NHS Trust; Central and North West London NHS Foundation Trust; Chelsea and Westminster Hospital NHS Foundation Trust; London North West Healthcare NHS Trust; The Hillingdon Hospitals NHS Foundation Trust; Hounslow and Richmond Community Healthcare NHS Trust; The Royal Marsden NHS Foundation Trust; Royal Brompton and Harefield NHS Foundation Trust; London Ambulance Service NHS Trust; Imperial College Healthcare NHS Trust; Central London Community Healthcare NHS Trust

We are also working with colleagues from a range of regional and national health and care organisations and federations.

Why we need an STP

Many people live in an unhealthy situation and make unhealthy choices:

- Only half of our population is physically active
- half of over-65s live alone and over 60 per cent of adult social care users want more social contact
- many people are living in poverty
- people with serious long-term mental health needs live 20 years less than those without.



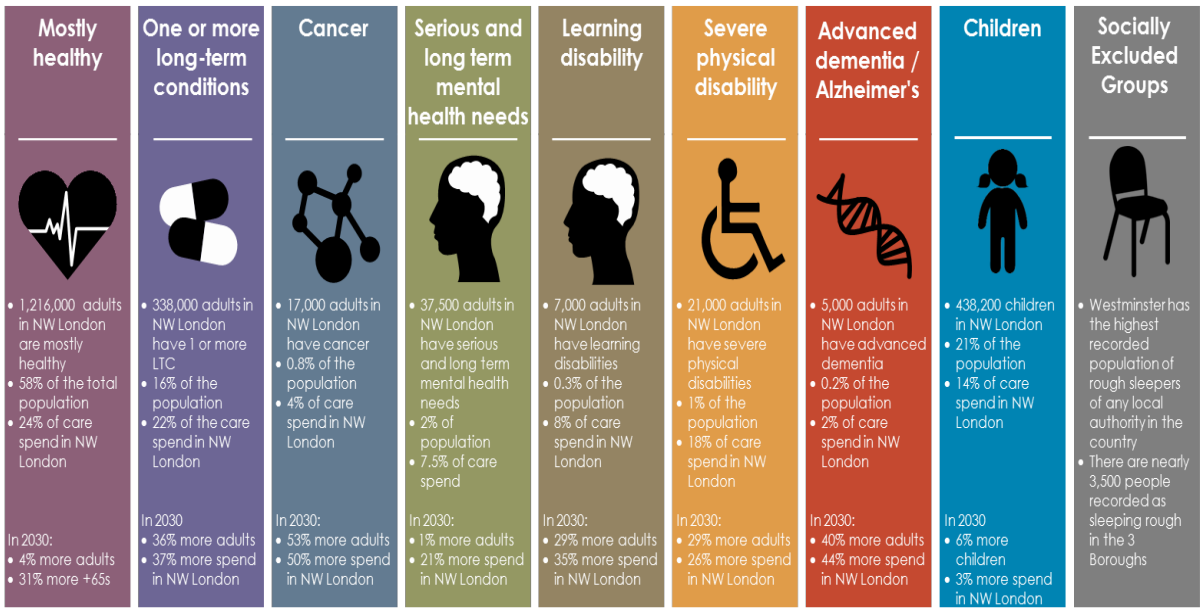
Some of our services are of poor quality and inefficient

- Over 30 per cent of patients in acute hospitals do not need to be there, and could be treated in or nearer to home
- 1,500 people under 75 die each year from cancer, heart diseases and respiratory illness. If we were to reach the national average, we would save 200 people a year
- over 80 per cent of people want to die at home, but only 22 per cent do so.

The cost of health and social care is outstripping the budget

- Despite a growing NHS budget, if we don't take action, there will be a £1.3billion shortfall by 2021. Local authorities have faced cuts in adult social care budgets.

Our population and some likely changes over the next 15 years if we don't take action now



Our aims and priorities

We aim to improve:

1. health and wellbeing
2. care and quality
3. efficiency, to balance the budget

	Our Priorities	Primary Alignment*	Delivery areas (DA)
1	Support people who are mainly healthy to stay mentally make healthy choices and look after themselves and physically well, enabling and empowering them to		Improving your health and wellbeing
2	being		
3	Reduce health inequalities and unequal outcomes for the top three killers: cancer, heart diseases and respiratory illness		
4	Reduce social isolation		
5	Reduce unfair variation in the management of long-term conditions – diabetes, cardio vascular disease and respiratory disease		Better care for people with long-term conditions
6	Ensure people access the right care in the right place at the right time		
7	Improve the quality of care for people in their last phase of life, enabling them to die in their place of choice		Better care for older people
8	Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population		Improving mental health services
9	Ensure services and experiences are of a high quality every day of the week		Safe, high quality sustainable services

Delivery areas

Delivery area 1: Improving your health and wellbeing

Your health is affected by the environment and communities you live and work in and the choices you make. Your local NHS and councils want to support you to have a healthy life by:

- Reducing loneliness by encouraging everyone to be part of their local community
- supporting campaigns to increase self-care; to prevent cancer; and to reduce the stigma of mental health problems
- encouraging exercise and healthier eating; and reducing smoking and drinking
- encouraging employment for people with a learning disability or mental health problem

- tackling issues that affect health such as housing, employment, schools and the environment
- supporting children to get the best start in life by increasing immunisation rates, tackling childhood obesity and providing more mental health care and support.

Delivery area 2: Better care for people with long-term conditions

With many different organisations involved in care for people with health conditions, services can be confusing and vary in quality. We want to coordinate services better, and help every patient with a long-term mental or physical condition to get the care and support they need to manage their condition by:

- Catching cancers earlier and starting treatment more quickly
- developing new ways of preventing and managing long-term conditions, like diabetes
- improving access to mental health services
- helping the voluntary sector to support self-care; for instance offering people with long-term conditions access to expert patient programmes; and increasing the availability of personal health budgets.

Delivery area 3: Better care for older people

We are pleased that so many of our residents are living longer than previous generations thanks to better medicines, new treatments and cures. We want to improve care for our older people by:

- Tackling the lack of nursing and care homes
- providing specialist teams which can react quickly when there is a problem
- commissioning all services for older people with local government and coordinating care between the NHS, social care and other organisations
- improving end of life care, supporting people to die in the place of their choice.

Delivery area 4: Improving mental health services

We all have mental health. Most of us have a difficulty with our mental health at some point in our lives. Poor mental health has the potential to affect our physical health. We want to support people with serious and long-term mental health problems, learning disabilities, autism or challenging behaviour by:

- Providing a more proactive service focused on recovery
- supporting more GPs to become experts in mental health care
- improving early intervention services and crisis support services; and introduce 24/7 mental health A&E teams
- improving child and adolescent services - particularly in the evenings and weekends.

Delivery area 5: Safe, high quality and sustainable services

Whilst the vast majority of care in NW London is of a high quality, we know there is more to do and we can make services more efficient. Our buildings and ways of working make it difficult to take advantage of new technology. This means the health service is not as efficient or patient-focused as other public or high street services. We want to:

- Provide more services at night and weekends - particularly assessments by a consultant and access to vital tests
- introduce specialist children's assessment units and improve children's services, for example by recruiting more children's nurses
- make the most of new technology to save everyone time and worry, and improve services
- concentrate our skills and experience where they make the biggest difference for patients.

What will primary, intermediate and hospital care look like?

Primary care

- There will be a greater focus on keeping people healthy, like more health screening and better management of long-term conditions
- there will be more appointments earlier in the day, later at night, and at weekends. Already 280,000 patients can use online consultations and 60,000 can use video consultations. We want everyone to be able to use online advice if they wish.
- GP practices will work together and in partnership with other services. Patients won't have to go to lots of different places to get simple treatments. Other health professionals will take on some responsibilities from GPs, like treating coughs, colds and minor injuries.

Our residents' responsibilities

Our plans are dependent on people recognising their responsibility to:

- Look after themselves
- ask for help when necessary
- use services sensibly and fairly
- be an active part of their own community.

In 2016/17 we will produce a People's Health and Wellbeing Charter so that people can understand their responsibilities and access the right care in the right place at the right time.

Intermediate care

- Intermediate health and social care will respond more quickly when people become ill
- to help people get home as soon as they are medically fit, more services will be available in, or close to people's homes; in GP practices; in local services hubs or in hospitals.

Hospital services

- Concentrating specialist doctors, teams and equipment in 24/7 units leads to better outcomes for patients. In 2012 the NHS agreed to reduce the number of major hospitals in north west London from nine to five. This will improve urgent care, planned surgery, maternity services and children's care.
- major hospitals at Chelsea and Westminster, Hammersmith, Hillingdon, Northwick Park, St Mary's and West Middlesex, will be supported by local hospitals at Charing Cross, Central Middlesex and Ealing.
- all three local hospitals will have a local A&E and a range of services to meet the needs of the vast majority of the local population e.g. services for elderly people; access to appropriate beds; and a range of outpatient and test facilities. No substantive changes to A&Es in Ealing or at Charing Cross will be made until there are sufficient alternatives in place through local services or in other major hospitals.

Supporting the transformation

To transform services and make them sustainable, we need to invest in our workforce and digital technology, improve our buildings and make services more efficient.

Workforce

- We need to **recruit and retaining a permanent workforce** that works in multi- disciplinary teams with new roles and careers
- invest £15million in **developing, educating and training staff**, to support changing population needs
- establish **leadership development forums** to drive transformation and share good practice and learning.

Digital

- Increase the use of technology to **reduce unnecessary trips to and from hospital**
- reduce paper and **share electronic care records** across the NHS to make sure patients are properly cared for at all times
- **patient records, online information and support** should be readily available and understood by patients and carers so they can become more involved in their own care
- use **population care data** to make better decisions about future services and to support integrated health and social care.

Buildings and facilities

- **Share facilities** between health, social care and local government and develop local services hubs to maximise the use of space, be more efficient and make services more integrated
- use an investment fund of up to £100million **to improve the condition of primary care buildings and facilities**
- improve hospital buildings and facilities and introduce new ways of working which will reduce the £625million we need to maintain outdated buildings.

Make every contact count

Everyone in the NHS who comes into contact with members of the public has the opportunity to have a conversation to improve their health, whether they are a receptionist, heart surgeon or GP. We want to help those staff in having (sometimes difficult) conversations with people.

We welcome your comments on any aspect of this plan but in particular:

- Do you think we have chosen the right priorities and overall vision?
- Are there specific ideas that you agree or disagree with?
- Are there bits missing?

You can send us your comments either online at **www.healthiernwlondon.commonplace.is** or email **healthiernwl@nw.london.nhs.uk**

We look forward to hearing from you.

G RISK REGISTER

This appendix provides the programme risk register including risk ratings and mitigations. (note: Finance risks are covered separately in the economic and finance chapters.)

Risk Description	Category	Avoidance / Mitigation Action	Residual Risk Rating
There is insufficient development of the workforce to support the ambitions of clinical improvements.	People and Workforce	Ongoing engagement with HEE North West London to ensure training offer and roles are appropriate and attractive. Ongoing programme of clinical engagement via Clinical Board and Implementation planning groups, who review and develop transition planning. Clinical Implementation Groups (or equivalent) continue to meet to manage implementation in clinical areas, for example looking at training, workforce development strategy (with HEE NWL) and clinical pathway design and implementation SaHF workforce team will work with CCGs and Trusts to ensure workforce is aligned to clinical improvements	16
There is a risk that we will not achieve the returns on investment of implementing changes as per case submission	Operational and performance	Consistent review of key drivers of added value, timing of cash flows, benefits tracking	16
There is a risk of a deterioration of operational performance - particularly variance from control totals - by Trusts and / or CCGs impacting ability to realise programme benefits	Operational and performance	Close working between the SaHF Programme, Trusts and CCGs to identify any issues arising as early as possible	16
There is a risk that local services are not developed sufficiently enough to reprovide alternatives to absorb acute activity	Operational and performance	Further development of delivery plans with robust governance.	15
There is a risk that the focus on capital will be at the expense of clinical aspirations, impacting on clinical quality of care in programme delivery	Quality and Sustainability	The STP and SaHF Programme are clinically-led programmes, led by Medical Directors. For example there are 3 clinical leads who are part of the acute reconfiguration workstream and each clinical lead has contributed/ or acted as a critical friend to SOC Part 1 to ensure the programme continues to be clinically-led and clinical benefits will be realised. In addition Mark Spencer has specifically contributed to the ensuring the model of care is fit for purpose	12
There is a risk that the chosen option does not deliver long term financial benefits	Operational and performance	Close working with CCGs to resolve funding issues and agree Heads of Terms as part of agreeing OBC by Trust Boards	12
There is a risk that the strategic outline case focus too heavily on estate rather than the technological systems required to implement the clinical model	Information and Technology	A piece of work has been commissioned to focus on driving the clinical aspects of the programme forward as well as those that are not reliant on major capital expenditure. The programme is working with each provider regarding capital development to ensure that exchequer capital estimates are robust, balancing affordability and clinical responsibility of the programme. Delivery architecture initiatives will also focus on system wide technological improvement to ensure future capital needs are fit for purpose. The Outline Business Cases in later stages will include this aspect in more detail.	9

There is a risk that activity levels is higher than planned - capacity built is insufficient to meet demand as planned transfer of activity is not achieved	Quality and Sustainability	Consider risk early in planning stage	9
There is a risk that individual hospital strategies contradict the aims of the strategic outline case	Partnership working Operational and Performance	The programme team are working with regulator partners to ensure Trusts are aware of their commitment to the SaHF programme. The programme roadmap is also refreshed for implementation, including more detailed 12-18 months plans for the programme. As part of the refreshed plan, all partners will be requested to support a refreshed Project Initiation Document (PID).	8
Staff turnover/inability to recruit and retain high calibre staff affecting the ability of stakeholder organisations to lead and deliver new service arrangements	People and workforce Partnership working	Include staff in wider communications of the programme's purpose and objectives. Through the completion of medium to long term planning processes partner organisations will reconfirm commitment to the programme's purpose, outcomes and detailed plans and the roadmap to deliver outcomes.	8
There is a risk that the movement towards Accountable Care Partnerships promotes a different approach to delivering the aims of the inner/outer business cases	Quality and Sustainability	Alignment with the Sustainability and Transformation Plan (STP) and regular review at Programme Executive and Programme Board which will ensure the ImBC remains aligned	4
There is a risk that the strategic trend towards a population based approach to delivering healthcare outcomes contradicts the Trust based approach of the inner/outer business cases	Quality and Sustainability	Alignment with the Sustainability and Transformation Plan (STP) and regular review at Programme Executive and Programme Board which will ensure the ImBC remains aligned	4

H OUT-OF-HOSPITAL OPTION REVIEW

This is a standard approach to site selection adopted across all CCGs in NWL.

Hub space requirements

The process that we have gone through to develop detailed estate plans for the hubs has been developed working closely with NHS Property Services and CCGs.

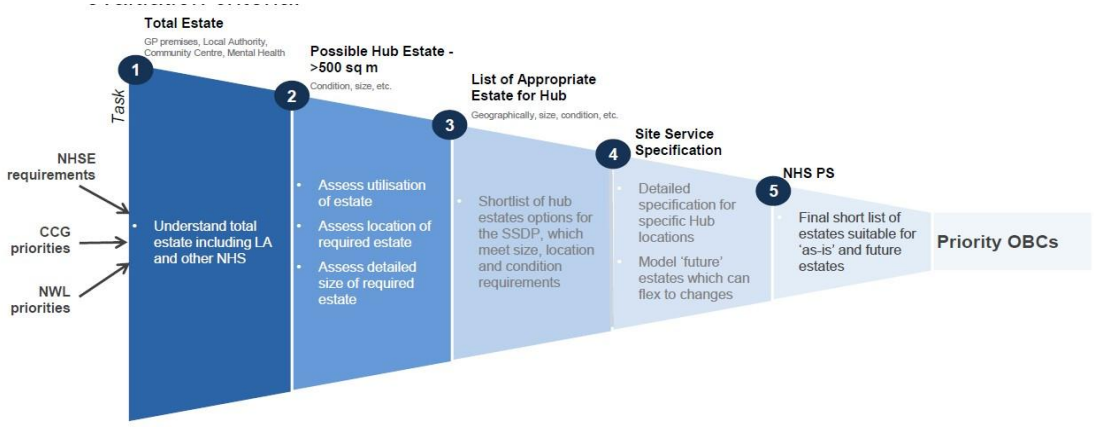
The assumptions in the process are:

- There will be one hub per locality unless the activity analysis suggests another approach is sensible;
- Existing sites will be utilised before building any new sites;
- NHS property will be prioritised above other public sector or commercial properties.

Methodology for selecting hubs

A selection process has been developed with NHS Property Services to allow each CCG to select suitable hub properties. The diagram below shows these stages:

1. The total CCG / Borough wide NHS (and available local authority) estate;
2. The possible hub estate – any clinical property >500m2 GIFA, with available space;
3. Hub estate options – shortlist of hub estates taking into account size and the evaluation criteria.



Application of evaluation criteria for hub sites

Evaluation criteria were signed off in December 2013 by Collaboration Board. Following this the scoring mechanism has been developed against which individual hub sites for each locality can be tested. At OBC, we will also test a, Do Nothing and Service Redesign option without a hub, to ensure that the hub option always offers the best value in each locality.

Figure 1: Methodology for application of the evaluation criteria to hubs

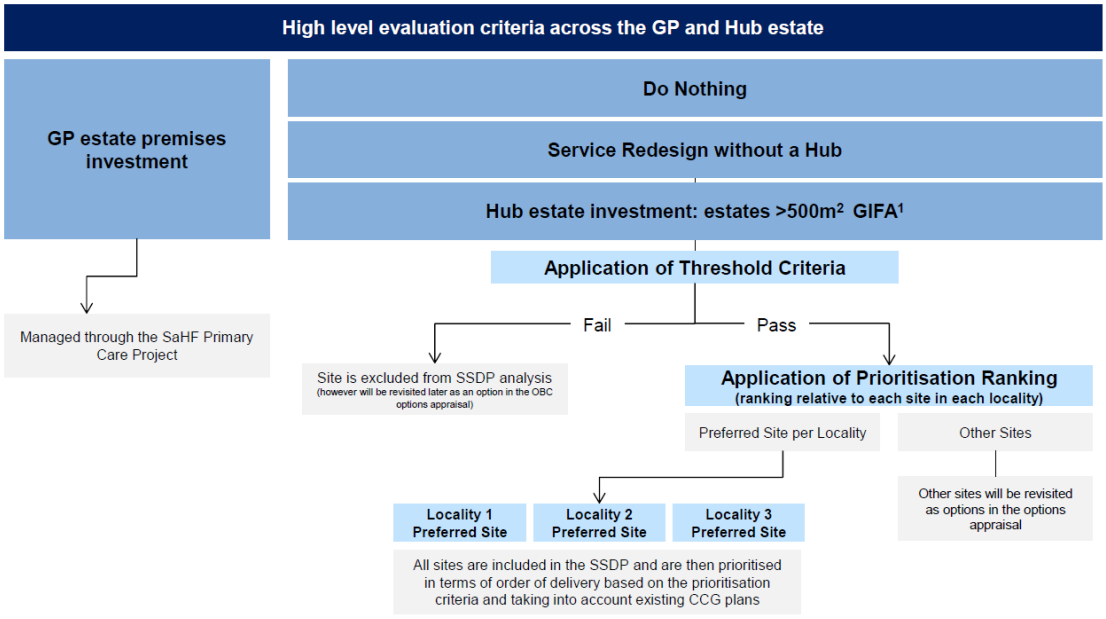


Figure 2: Threshold criteria for hub evaluation

	Agreed at Collaboration Board			Scoring Approach for Hubs	
	Category	**Description**	**Hubs Criteria**	**Supporting Materials**	**SSDP CCG-wide Scoring Approach**
Threshold - SSDP	Population size (catchment area/list size)	**Catchment area meets minimum threshold**	▪ Proposed number of hubs provides sufficient throughput ▪ Demand levels in each area are large enough to support proposed configuration	▪ Data on planned activity within catchment area held (a locality)	▪ Pass or fail based on whether the service is expected to be utilised i.e. is there evidence that the future service model is based on a reasonable estimate of future demand
	Commitment to space utilisation	**Plans for estate make maximum use of spare capacity**	▪ Proposed overall configuration fully utilises all spare capacity across the borough before committing to additional investment	• Estates baseline utilisation score	• Assuming existence of surplus, pass or fail on whether utilisation of existing supply is addressed • One single hub is preferred over a hub and spoke model
	Condition of estate	**Estate meets, or can be improved to meet, minimum standards**	▪ Proposed sites must not have a DX/CX condition rating	• Estates baseline condition rating	• Pass or fail • Proposed sites must not have DX/D/CX rating
	Scope for expansion	**When expanding or building new, proposed estate can accommodate new services**	▪ Proposed buildings must be able to accommodate additional services, either through expansion or improved utilisation	▪ Estates baseline ▪ NHS PS assessment	▪ Pass or fail (fail if no capacity to expand or no alternative use)
	Affordability and value for money	**Plans are affordable**	▪ Funding sources are identified and available	• N/A at this stage	• N/A at this stage

Figure 3: Prioritisation criteria for hub evaluation

	Agreed at Collaboration Board			Scoring Approach for Hubs	
	Category	**Description**	**Hubs Criteria**	**Supporting Materials**	**SSDP Scoring Approach**
Prioritisation	Achieving our OOH strategy	**Plans that make a larger contribution to the delivery of the OOH strategy will be prioritised**	▪ Plans that can deliver the widest range of key OOH services and/or the largest volume of OOH activity will be prioritised	▪ OOH Delivery Strategy	▪ Ranking based on assessment of contribution to key delivery elements in the OOHDS
	Affordability and value for money	**Plans offer good value for money**	▪ Proposed capital and revenue expenditure are affordable to all parties affected (including providers, CCG and NHSE) ▪ Impacts across the system are clear ▪ Investment is proportional to population covered	▪ Capital costs agreed with NHS PS	▪ Scoring based on high level capital costs
	Accessibility	**Accessibility**	▪ Site accessible by public transport ▪ Site meets DDA requirements	▪ Accessibility: Public Transport Accessibility Level rating (PTAL) ▪ DDA rating, from the estates baseline	▪ Scoring based on accessibility (PTAL) and DDA rating
	Commitment to space utilisation	**Flexible solutions**	▪ Plans include flexible spaces that can be adapted to different purposes (including multi-function rooms) ▪ GIFA of at least 500m²	▪ NHS PS qualitative assessment ▪ GIFA from estates baseline	▪ Ranking against other sites based on flexibility ▪ It is expected that the NHS estates would be utilised before looking at other public sector and then commercial space
	Condition of estate	**Plans improve the overall suitability of the borough estate**	▪ Plans that reduce the number of DX/CX rated building are prioritised	▪ Estates baseline ▪ Number of DX / D / CX rated properties in the catchment area	▪ Ranking based on number of DX/D/CX buildings in the local catchment area
	Population size (catchment area/list size)	**The maximum number of people are affected**	▪ Plans where hubs cover larger populations are prioritised ▪ Areas with higher levels of demand are prioritised	▪ Population density data (ONS)	▪ Ranking based on population density scores
	Deprivation	**Areas with higher deprivation are prioritised**	▪ Configurations prioritising more deprived areas are prioritised	▪ Deprivation data – Indices of Deprivation	▪ Ranking based on deprivation scores

I ACUTE TRUST LONG LIST OPTIONS

Trust	Site	Option		Description	Shortlisted?	Reason for Decision
THH	THH	1	Option 1 Do nothing	Minimum Backlog maintenance only	Yes	
		2	Option 2 Do minimum	This option entails: Maternity: 2 storey extension; Non-elective theatres: Reschedule sessions between HH and MVH; Non-elective critical care: ITU additional capacity (4 beds) + Drayton Ward bays for HDU use; Non-elective A&E: Increase cubicles by building into courtyard; BLM: Minimum Backlog maintenance; and BLM: Prioritised schedule of works to deliver SaHF.	Yes	Unlikely to cause major service disruption. Services remain on current site. May represent good value for money in the short term. **Shortlist.**
		3	Option 3 Do minimum + Refurbishment Tower and Podium	This option is as above, however in addition there would be a Prioritised schedule of works to deliver SaHF plus Tower & Podium sustainable works.	No	Will cause some level of disruption. Provides a high quality environment for patient care. Services remain on current site. The level of funding is not available to the Trust through SaHF. May represent best value for money in the long term. **Shortlist.**
		4	New build on HH site	Provide new clinical accommodation for maternity, A&E, theatres and ITU on the current site. Work would be phased and services would be decanted to temporary accommodation to enable the work to take place	No	The site masterplan has identified a potential for gradual redevelopment which requires the release of clinical areas in advance but does not address the clinical adjacencies associated with these departments. Disruptive to services. The level of funding is not available to the Trust through SaHF. **Reject.**
		5	Re-provide HH on a new greenfield site	Identify another location in Hillingdon where a new hospital could be built, providing sufficient capacity and quality of accommodation for all services	No	The level of funding required is not affordable to the Trust. There is no certainty of suitable land being available or affordable. The level of funding is not available to the Trust through SaHF. **Reject.**
		6	Re-provide departments requiring additional space on a new site	Provide new accommodation for maternity, A&E, theatres and ITU – this would have to be done on a new site due to space constraints at HH	No	This does not meet the locational suitability of HH. Does represent value for money. All departments require clinical adjacencies with other services provided at HH. **Reject.**
		7	Deliver additional activity resulting from SaHF from other sites	Identify other Trusts in the area who could accommodate additional maternity, acute and blue light activity arising from SaHF	No	SaHF has already reviewed the locations and suitability of all the hospitals in NW London as detailed in the DMBC and identified HH as a suitable location for service provision. Does not provide patients in the Hillingdon area with clinical care close to home. Does not address issues relating to the quality of accommodation on the site. **Reject.**

ACUTE TRUST LONG LIST OPTIONS

Trust	Site	Option		Description	Shortlisted?	Reason for Decision
LNWHT	Ealing	1	Do Nothing	This option would see the Trust continue with the 'status quo' and therefore not implement the proposed Local Hospital Model and consequently the requirements of the SaHF programme.	Yes	This option was ruled out given it failed to meet the Trust and SaHF objectives. For completeness however, this option was carried through to the short-list as required by TDA and NHSE guidance for comparative assessment purposes.
		2	DMBC Option	This option would see the Trust adopt and implement the Local hospital Model proposed within the DMBC, with a narrow set of services and 3,300m2 new build.	No	The DMBC Option was ruled out prior to scoring. JCPCT requested that the wider set of options for Ealing be explored.
		3	Refurbishment	This option retains the existing Ealing Hospital podium and tower and modernise the facility to accommodate the proposed activity for the Local Hospital within the lower floors of the tower with the remaining space either mothballed or utilised for other purposes. Various sub options around the scale of refurbishment (from minimal to full) were considered. In all variations, the refurbishment programme would be managed to ensure existing services remain operational through the use of decant and phased refurbishment of the various areas.	Yes	These options scored moderately well against the criteria in terms of acceptability, retaining accessibility, achieving optimum clinical adjacencies and deliverability. From a financial perspective this option was considered broadly affordable and cost effective.
		4	Part Refurbishment / New Build	This option would locate the Local Hospital, at the back of the site, utilizing the existing maternity building along with the surrounding space/ buildings. This option would use and refurbish the shell of the current maternity wing with the surrounding space and buildings around the Maternity wing to be demolished and used for the new build elements of the Local Hospital.	Yes	This option scored well against most of the qualitative criteria. From a financial perspective this option was not as cost effective or affordable as option 3. However this option was carried through to the short list for comparative purposes.
		5	New build only option	This option would result in a new build of the Local Hospital on the existing Ealing site along with demolition of the existing hospital and sale of excess land. Under this option Clayponds would have closed with the bedded care relocated into the Local Hospital, in some form.	No	This scored highly against the majority of the criteria however from a financial perspective was unaffordable. As a result this option was ruled out.
	CMH	1	Do Nothing	Services to remain as currently delivered (as required for the purposes of comparing against the status quo). Only high and significant risk backlog maintenance is performed of which the differential is reflected in the comparator.	Yes	A set of hurdle criteria, were used to narrow down these proposals. All 14 services were subsequently reviewed against the appropriate hurdles associated with each service area. These included: a. Be Safe b. Potential for material financial impact c. Implementable in a reasonable period d. Fit with commissioning strategy e. Provider/Market interest
		2	Do minimal	CMH disposal and dispersal of services	Yes	
		3	Lower Capital Option	Develop CMH to include the additional activity : a. Development of the Health & Wellbeing Centre (including GP practice) b. Relocation of the Regional Genetics Service from Northwick Park to CMH c. Relocation of Willesden community beds. d. Expansion of existing theatre and supporting recovery capacity	Yes	
	NPH	1	Do nothing	-	Yes	NPH shortlisted all three options from their long list
		2	Updated 2016 Do Minimum:	This option would see a new build extension to ITU in order to provide a total of 32 high acuity beds (including HDU) Post reconfiguration NPH will have 42 of the 44 Trust critical care bed capacity (Currently NPH has 29 beds out of 45 Trust wide beds). Subsequently the existing ITU/HDU space would be reconfigured into an additional 12 recovery bays (resulting in a total 24 recovery bays). Pharmacy automation would be implemented so as to support efficient patient discharge and safety, as well as the MRI being relocated in order to support a) the new critical care build and improved imaging access	Yes	
		3	Original 2014 Do Minimum:	A new build extension to ITU to provide a total of 28 high acuity beds in total (including HDU). Subsequently reconfigure the existing ITU/HDU space into an additional 12 recovery bays (total 24). Implement pharmacy automation to support efficient discharge and safety. MRI relocation to support imaging access. Implement robotics and phased conversion of space in pharmacy.	Yes	

ACUTE TRUST LONG LIST OPTIONS

Trust	Site	Option		Description	Shortlisted?	Reason for Decision
CW	WM	1	Do nothing	Continuing to deliver the existing level of activity and no changes to estates or facilities.	Yes	The Do Nothing option cannot deliver the activity transfers proposed by SAHF but has been kept as a benchmark.
		2	A - Lowest Cost	ED - ED layout A (lowest cost): This option includes a reconfiguration of the current ED footprint so that it meets all activity requirements and space standards. There will be a total of 25 'majors' adult cubicles and eight paediatric cubicles. - This option includes adding a new resus area that will include an additional four resus cubicles (one of which is paediatric) and an ambulance handover area. It also involved displacement of the existing office space into the new build area in order to expand paediatric space in the department and converting existing adult space into one enlarged ED 'majors' area rather than the current split configuration. This option will include a link from UCC to imaging. Adult Inpatients - Reconfigure to add 72 beds (lowest capital cost): This option was developed to maximise the use of any existing clinical areas. This option involves utilising the existing footprint in East Wing and Marjory Warren. ITU / HDU (critical care) - ITU/HDU + 7 beds (lowest capital cost): Following consultation with clinicians working in critical care and allied healthcare services it was proposed that an additional seven ITU beds were required and space has been identified within the existing footprint to locate the additional beds. Paediatrics - Existing + 5 beds 2. WCU (lowest capital option): Adding 5 additional paediatrics inpatient beds within the current paediatric footprint on the 3rd floor. This approach will also allow for more efficient ways of working.	Yes	
		3	Other options	CW (WM) considered a number of options for each individual component of the SaHF capital spend; the preferred option for each component then being aggregated into A - lowest Cost option above. A summary of the individual options by area is provided below. **ED:** Three options were considered, these were as follows: Do nothing, ED layout A (lowest cost) and ED layout B. **Adult inpatients: Four options were considered, these were as follows:** Do Nothing, 1.Reconfigure to add 72 beds (lowest capital cost), 2. New build 84 beds (3 wards) and 1b.WCU. **Paediatrics: Two options were considered, these were as follows:** Do Nothing and 1. Existing + 5 beds 2. WCU (lowest capital option) **ITU / HDU (critical care):** Two options were considered, these were as follows: Do	No	

J EQUIVALENT ANNUAL COST PER STANDARDISED BENEFIT POINT

EQUIVALENT ANNUAL COST PER STANDARDISED BENEFIT POINT ANALYSIS

The EAC analysis bringing together the component elements are summarised below.

Table 29: Summary of costs and quantified benefits

£m	EAC		
	Comparator EAC	SaHF EAC	Annual Impact EAC
CWWM	566	590	24
THH	235	244	9
LNWHT	587	539	(48)
Total Outer Acute	**1,387**	**1,373**	**(15)**
Total Hubs	**93**	**65**	**(29)**
Total NWL	**1,481**	**1,438**	**(43)**
1. Wider economic benefits Acute		(29)	(29)
2. Wider economic benfits Hubs	(1)	(17)	(15)
3. Health benefits		(94)	(94)
Grand total	**1,480**	**1,298**	**(181)**

The programme level EAC per indexed benefit point brings together the EAC above (excluding wider economic benefits and health benefits), with the non-quantifiable benefits (detailed below).

a) Non-quantifiable benefits

Hubs - non-quantifiable benefits

The non-quantifiable benefits are based on the quality scoring system used in the individual out-of-hospital OBCs.

Evaluation criteria for investment in the out-of-hospital estate across NHS NW London were agreed at the NWL Collaboration Board, compromising all CCG Chairs, AOs and CFOs, in December 2013. These were based on a number of principles agreed at Collaboration Board in September 2013.

The benefit score used for the option appraisal are from the Heston Business case. For the Comparator option scores were 1.5 and the preferred option scores were 9.2 and 9.3 (all scores are out of 10). Based on these results, we assume within this SOC that any individual hub site OBC would score an average of 2 out of 10 for the Comparator option, and 9 out of 10 for the preferred hub site option.

The criteria used to make this assessment are shown below.

Table 30: Summary of costs and quantified benefits

Critical success factor type		Critical success factor	Weighting	Comparator	Deliver out-of-hospital approach
Quality	1	Catchment area meets minimum threshold			
	2	Plans for estate make maximum use of spare capacity			
	3	Estate meets, or can be improved to meet, minimum standards			
	4	When expanding or building new, proposed estate can accommodate new services			
	5	Plans that make a larger contribution to the delivery of the out-of-hospital strategy will be prioritised	70%	Weighted aggregated score: 2	Weighted aggregated score: 9
	6	Plans offer good value for money			
	7	Sites are accessible			
	8	Plans represent flexible estates solutions			
	9	Plans improve the overall suitability of the borough estate			
	10	The maximum number of people are affected			
	11	Areas with higher deprivation are prioritised			
Risk	12	Risks to patient / users; legal, political, financial risks; risks to partners and staff; building and operational risks	30%		

The critical success factors have been designed to ensure that options align with making care more:

- Accessible: care that is responsive to patients' needs and preferences, timely and accessible.
- Proactive: proactive planned care that is easy to access, convenient and able to utilise specialist skills where appropriate.
- Co-ordinated (including rapid response and supported discharge): care that is patient-centred, co-ordinated and offers continuity of care to high need patients.

Acute - Non-quantifiable benefits

The non-quantifiable benefit assessment has been undertaken by each individual trust and relates to benefits that each trust has assessed, but to which a monetary value cannot be attached. The relative benefit was therefore appraised by each trust and a total benefit score created for each option.

The criteria used to make this assessment by Trusts are shown below.

Table 31: Non-quantifiable benefits - Acute: Benefit scoring approach

	Categories	Weighting	Scoring
CW (WM)	Quality of environment	68%	1-10 (10 being highest)
	Strategic fit	8%	
	Deliverbaility	3%	
	Value for money	21%	
	Total	**100%**	
LNWH (all sites)	Strategic Fit	15%	1-10 (10 being highest)
	Quality of Care	20%	
	Quality of Environment	25%	
	Deliverability	30%	
	Future Flexibility	10%	
	Total	**100%**	
THH	Strategic Fit	20%	1-10 (10 being highest)
	Deliverability	5%	
	Quality of Environment	20%	
	Feasibility / capacity / access	10%	
	Sustainability	15%	
	Quality of Care	30%	
	Total	**100%**	

To allow aggregation across the programme, each trust's non-quantifiable benefit scores have been standardised and weighted.

The standardised scores for the OOH hubs and the acute reconfiguration are shown below in Table 32.

Table 32: Trust and OOH – Risk adjusted EAC (excluding wider economic and health benefits) per standardised benefit point

	Trust options	Risk adjusted EAC £m	Benefits Points	Risk adusted EAC per benefit point £m	Standardised benefit points	Risk adjusted EAC per standardised benefit point
Hubs	Comparator	93	2	46.7	100	0.9
	SaHF	65	9	7.2	450	0.1
CWWMH	Comparator	566	72	7.9	100	5.7
	SaHF	590	125	4.7	174	3.4
THH	Comparator	235	290	0.8	100	2.3
	SaHF	244	600	0.4	207	1.2
LNWHT	Comparator	587	1,545	0.4	100	5.9
	SaHF	539	2,055	0.3	133	4.1

Total Comparator	1,481	400
Total SaHF	1,438	964
Variance	**(43)**	**564**

To allow aggregation across the programme, the non-quantifiable benefit scores have been standardised such that the Comparator has a benefit point value of 100.

The scores for each Trust have then been weighted according to their relative EAC size. The total standardised benefit points, both un-weighted and weighted, are shown Table 33.

Table 33: Standardised benefit points for Hubs and Trusts combined

Option	Unweighted	Weighted
Comparator	400	400
SaHF	964	706

The programme level EAC per weighted (standardised) benefit point is shown below in Table 34.

Table 34: Programme level EAC (including wider economic and health benefits) per weighted standardised benefit point

	Programme level EAC £m's	Weighted benefit points (from above)	Programme level EAC per weighted benefit point £m's
Comparator	1,480	400	3.7
SaHF	1,298	706	1.8
Difference between SaHF and Comparator	(181)	306	(1.9)
% Difference	(12%)	77%	(50%)

This analysis shows that the SaHF Option has a 12% better EAC, 77% better weighted benefit point and 50% better programme level EAC per weighted benefit point.

The above analysis has been replicated excluding the wider economic and health benefits to assess the impact of the programme excluding these. This is shown in Table 35 below.

Table 35: Programme level EAC (excluding wider economic and health benefits) per weighted standardised benefit point

	Programme level EAC £m's	Weighted benefit points (from above)	Programme level EAC per weighted benefit point £m's
Comparator	1,481	400	3.7
SaHF	1,438	706	2.0
Difference between SaHF and Comparator	(43)	306	(1.7)
% Difference	(3%)	77%	(45%)

Excluding the wider economic and health benefits, the SaHF Option continues to have a positive programme level EAC, weighted benefit points remain 77% better and a 45% better programme level EAC per weighted benefit point.

K KEY PLANNING ASSUMPTIONS CCGs AND ACUTE TRUSTS

Table 36: CCG Assumptions

CCG	Assumption	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Hillingdon	Allocation uplift	5.8%	2.6%	2.9%	3.1%	4.8%	3.1%	3.1%	3.1%	3.1%	3.1%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	3.5%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%
	Demographic Growth	1.6%	1.4%	1.4%	1.4%	1.3%	1.25%	1.3%	1.3%	1.3%	1.3%
	Non Demographic Growth	2.1%	2.5%	2.7%	2.7%	2.7%	3.0%	2.0%	2.0%	3.0%	2.0%
Harrow	Allocation uplift	9.9%	1.0%	2.8%	2.9%	4.7%	3.0%	3.1%	3.1%	3.1%	3.1%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%
	Demographic Growth	1.2%	1.1%	1.1%	1.0%	1.0%	1.10%	1.1%	1.1%	1.1%	1.1%
	Non Demographic Growth	1.9%	2.4%	2.4%	2.4%	2.4%	3.1%	2.0%	2.0%	2.5%	2.5%
Brent	Allocation uplift	4.8%	2.0%	2.1%	2.1%	3.6%	2.2%	2.2%	2.2%	2.2%	2.2%
	Provider Efficency	(2.0%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)	(2.5%)
	Price Inflation	3.9%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%
	Demographic Growth	0.9%	0.9%	0.9%	0.8%	0.8%	0.79%	0.8%	0.8%	0.8%	0.8%
	Non Demographic Growth	3.2%	2.9%	2.1%	2.1%	2.1%	2.3%	2.3%	2.3%	2.3%	2.3%
Central	Allocation uplift	1.4%	0.2%	0.1%	0.0%	1.5%	0.5%	0.7%	1.2%	1.3%	1.3%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	4.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Demographic Growth	1.5%	1.4%	1.4%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
	Non Demographic Growth	2.4%	2.4%	2.3%	2.2%	2.2%	1.8%	1.8%	1.8%	1.8%	1.8%
West	Allocation uplift	1.4%	0.2%	0.1%	0.0%	1.5%	0.4%	0.6%	1.0%	1.1%	1.0%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	4.8%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Demographic Growth	0.4%	0.4%	0.4%	0.3%	0.8%	0.4%	0.4%	0.7%	0.7%	0.6%
	Non Demographic Growth	2.3%	2.3%	2.2%	2.2%	2.2%	1.8%	1.8%	1.8%	1.8%	1.8%
H&F	Allocation uplift	1.5%	0.7%	1.1%	1.4%	3.1%	5.8%	5.7%	5.6%	5.4%	5.4%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	5.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Demographic Growth	1.2%	1.1%	1.1%	1.0%	0.7%	5.3%	5.0%	4.8%	4.5%	4.4%
	Non Demographic Growth	2.4%	2.4%	2.4%	2.3%	2.3%	1.9%	1.9%	1.9%	1.9%	1.9%
Hounslow	Allocation uplift	8.6%	2.6%	2.8%	2.9%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	3.7%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Demographic Growth	1.5%	1.5%	1.4%	1.3%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%
	Non Demographic Growth	2.5%	2.5%	2.4%	2.4%	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%
Ealing	Allocation uplift	3.1%	2.1%	2.2%	2.3%	4.0%	1.5%	1.5%	1.4%	1.4%	1.4%
	Provider Efficency	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
	Price Inflation	4.1%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Demographic Growth	1.0%	1.0%	1.0%	0.9%	0.9%	1.5%	1.5%	1.4%	1.4%	1.4%
	Non Demographic Growth	2.5%	2.6%	2.5%	2.5%	2.5%	2.4%	2.4%	2.4%	2.4%	2.4%

Allocation uplifts for 2016/2017 to 2020/21 are in line with published allocations and national guidance for the Sustainability and Transformation Plans. Projections for 2021/22 to 2025/26 are based on projected population growth and individual CCG Distances from Target.

Table 37: Acute Planning Assumptions

CW/WM	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Employee Benefit Expenses	2.0%	1.6%	1.6%	2.9%	1.6%	1.6%	1.6%	1.6%
Drugs	4.6%	3.6%	3.6%	4.1%	4.1%	4.1%	4.1%	4.1%
Clinical Supplies and Services	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Other Expenses	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Unitary Charge Inflation	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
Capex Inflation	2.4%	3.0%	3.0%	2.7%	3.0%	2.6%	3.2%	3.2%
Tariff income inflation	0.3%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%

LNWH	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Employee Benefit Expenses	1.0%	0.6%	0.6%	1.9%	0.6%	0.6%	0.6%	0.6%
Drugs	4.6%	3.6%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
Clinical Supplies and Services	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Other Expenses	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Unitary Charge Inflation	3.0%	3.3%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Capex Inflation	3.0%	3.3%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Tariff inflation	0.3%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%

THH	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Employee Benefit Expenses	2.0%	1.6%	1.6%	2.9%	1.6%	1.6%	1.6%	1.6%
Drugs	4.6%	3.6%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
Clinical Supplies and Services	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Other Expenses	1.8%	2.1%	1.9%	2.0%	1.9%	1.9%	1.9%	1.9%
Unitary Charge Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Capex Inflation	1.7%	2.3%	2.8%	2.8%	2.8%	2.6%	2.7%	2.6%
Tariff inflation	1.1%	0.4%	0.5%	2.4%	0.6%	0.6%	0.6%	0.7%

L COMPARISON OF TRUST INCOME ASSUMPTIONS AGAINST COMMISSIONER PROJECTIONS

Comparing trust income assumptions against commissioner projections (Triangulation)

Trusts developed their LTFMs through bottom-up analysis of income, activity and bed projections. The trust projections have been compared to commissioner projections, for both CCG and NHSE. The results are shown below:

Table 38: Income variance categories

Income triangulation - CCGs

	Income (£m)	16/17	20/21	24/25
CCG triangulation	Income per outer Trusts	611.8	604.1	635.4
	Income per CCGs	610.8	598.9	629.7
	Variation	1.0	5.2	5.7

Income triangulation - NHSE

	Income (£m)	16/17	20/21	24/25
NHSE triangulation	Income per outer Trusts	200.4	232.2	250.4
	Income per NHSE	199.9	216.0	237.4
	Variation	0.5	16.2	13.0

The conclusion is that spend/income between commissioner (both CCGs and NHSE) and Trust plans is materially triangulated.

An immaterial inconsistency in activity/bed assumptions at Chelwest/Westmid relating to transferring activity (circa £3m) was identified as part of the triangulation. This will be corrected in the OBC.

M TRUST I&E AND BALANCE SHEET – UNDER SAHF SCENARIO

Table 39: Acute I&E by trust

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
ChelWest / West Mid	Clinical income	499	510	525	540	552	564	569	574	579	623
	Other income	76	87	89	91	81	56	52	50	52	49
	Total income	**576**	**597**	**615**	**631**	**634**	**620**	**621**	**624**	**631**	**672**
	Employee Benefit Expenses	(312)	(323)	(328)	(326)	(322)	(328)	(326)	(325)	(324)	(343)
	Drug expenses	(77)	(94)	(98)	(102)	(105)	(108)	(111)	(115)	(118)	(125)
	Clinical supplies and services expenses	(63)	(58)	(58)	(59)	(59)	(59)	(59)	(59)	(58)	(66)
	Other	(100)	(79)	(87)	(87)	(81)	(80)	(76)	(74)	(76)	(73)
	Opearting costs	**(552)**	**(554)**	**(571)**	**(575)**	**(567)**	**(575)**	**(572)**	**(572)**	**(576)**	**(608)**
	Non-EBITDA	(39)	(39)	(40)	(43)	(44)	(46)	(48)	(51)	(52)	(52)
	Surplus / (deficit)	**(15)**	**4**	**3**	**13**	**22**	**(1)**	**1**	**0**	**3**	**13**
	Normalising adjustments	(4)	(29)	(20)	(22)	(18)	5	5	5	5	4
	Normalised surplus / (deficit)	**(19)**	**(25)**	**(17)**	**(9)**	**4**	**4**	**5**	**5**	**8**	**17**

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
LNWH	Clinical income	594	572	581	578	574	576	589	594	565	569
	Other income	70	98	84	75	82	76	81	88	54	51
	Total income	**665**	**670**	**665**	**653**	**656**	**652**	**670**	**682**	**619**	**621**
	Employee Benefit Expenses	(474)	(449)	(436)	(419)	(406)	(401)	(406)	(404)	(340)	(338)
	Drug expenses	(65)	(66)	(67)	(68)	(70)	(71)	(75)	(78)	(73)	(76)
	Clinical supplies and services expenses	(83)	(80)	(78)	(76)	(74)	(73)	(73)	(73)	(65)	(65)
	Other	(103)	(108)	(110)	(100)	(106)	(100)	(105)	(113)	(97)	(96)
	Opearting costs	**(724)**	**(702)**	**(692)**	**(663)**	**(656)**	**(645)**	**(659)**	**(668)**	**(576)**	**(575)**
	Non-EBITDA	(39)	(31)	(30)	(32)	(35)	(38)	(42)	(41)	(37)	(90)
	Surplus / (deficit)	**(99)**	**(63)**	**(57)**	**(43)**	**(35)**	**(31)**	**(31)**	**(27)**	**6**	**(44)**
	Normalising adjustments	(2)	(35)	(12)	(13)	(13)	(13)	(7)	(11)	(2)	48
	Normalised surplus / (deficit)	**(101)**	**(97)**	**(69)**	**(56)**	**(48)**	**(45)**	**(38)**	**(39)**	**4**	**5**

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
THH	Clinical income	194	206	204	202	200	200	201	201	201	219
	Other income	45	36	30	31	31	32	32	32	33	33
	Total income	**239**	**242**	**235**	**233**	**232**	**232**	**233**	**233**	**233**	**252**
	Employee Benefit Expenses	(155)	(157)	(156)	(153)	(150)	(148)	(146)	(144)	(142)	(152)
	Drug expenses	(18)	(19)	(20)	(20)	(21)	(21)	(22)	(23)	(23)	(24)
	Clinical supplies and services expenses	(24)	(24)	(23)	(23)	(22)	(22)	(21)	(21)	(21)	(22)
	Other	(28)	(28)	(27)	(26)	(26)	(26)	(26)	(27)	(27)	(27)
	Opearting costs	**(225)**	**(228)**	**(225)**	**(222)**	**(219)**	**(218)**	**(216)**	**(215)**	**(213)**	**(226)**
	Non-EBITDA	(16)	(16)	(17)	(17)	(18)	(18)	(17)	(19)	(59)	(20)
	Surplus / (deficit)	**(1)**	**(2)**	**(7)**	**(6)**	**(5)**	**(3)**	**(1)**	**(1)**	**(39)**	**6**
	Normalising adjustments	(11)	(6)	(0)	0	0	0	(0)	(0)	39	0
	Normalised surplus / (deficit)	**(12)**	**(8)**	**(8)**	**(6)**	**(5)**	**(3)**	**(1)**	**(1)**	**0**	**6**

Note: The Chelwest I&E includes the full Chelwest/Westmid I&E. The income therefore includes the Chelwest site activity.

Table 40: Acute BS by trust

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
ChelWest / West Mid	Property, Plant and Equipment and inta	475	495	512	526	524	526	539	562	581	576
	Property, plant & equipment (PFI)	32	31	31	31	31	31	30	30	30	30
	Investments, Non-Current	2	2	2	2	2	2	2	2	2	2
	Assets, Non-Current, Total	**509**	**527**	**544**	**559**	**556**	**558**	**572**	**595**	**613**	**608**
	Inventories	6	5	6	6	6	6	6	6	6	6
	NHS Trade Receivables, Current	16	13	14	26	27	27	27	28	28	30
	Non NHS Trade Receivables, Current	6	5	5	11	11	9	8	8	8	8
	Other Receivables, Current	4	4	4	4	4	4	4	4	4	4
	Other Financial Assets, Current (e.g. a	6	6	8	8	8	8	8	8	8	8
	Prepayments, Current, non-PFI related	6	6	6	6	6	6	6	6	6	6
	Cash and Cash Equivalents	38	37	32	17	36	29	27	19	19	27
	Assets, Current, Total	**80**	**76**	**75**	**78**	**97**	**89**	**87**	**79**	**79**	**90**
	ASSETS TOTAL	**589**	**603**	**620**	**637**	**653**	**648**	**658**	**674**	**693**	**698**
	Interest-Bearing Borrowings , Current (	(4)	(4)	(3)	(4)	(4)	(5)	(6)	(7)	(7)	(7)
	Deferred Income, Current	(3)	(3)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)
	Provisions, Current	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
	Trade Payables, Current	(16)	(16)	(16)	(21)	(20)	(21)	(20)	(21)	(21)	(22)
	Other Payables, Current	(11)	(11)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)
	Capital Payables, Current	(2)	(2)	2	2	2	2	2	2	2	2
	Accruals, Current	(23)	(23)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)
	Finance Leases, Current	-	-	0	0	1	1	1	1	1	(0)
	Other Liabilities, Current	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	-
	Liabilities, Current, Total	**(62)**	**(62)**	**(62)**	**(68)**	**(67)**	**(68)**	**(69)**	**(70)**	**(71)**	**(71)**
	NET CURRENT ASSETS (LIABILITIES	**18**	**14**	**13**	**10**	**30**	**21**	**18**	**9**	**9**	**19**
	Interest-Bearing Borrowings, Non-Curr	(59)	(60)	(59)	(59)	(55)	(51)	(62)	(77)	(94)	(87)
	Provisions, Non-Current	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
	Finance Leases, Non-current	-	-	-	-	-	-	-	-	-	1
	Other Liabilities, Non-Current	(35)	(34)	(33)	(32)	(31)	(29)	(28)	(27)	(26)	(26)
	Liabilities, Non-Current, Total	**(94)**	**(95)**	**(94)**	**(92)**	**(87)**	**(81)**	**(90)**	**(104)**	**(120)**	**(113)**
	TOTAL ASSETS EMPLOYED	**432**	**446**	**464**	**477**	**499**	**498**	**499**	**499**	**502**	**515**
	TOTAL TAXPAYERS EQUITY	**432**	**446**	**464**	**477**	**499**	**498**	**499**	**499**	**502**	**515**

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
LNWH	Property, Plant and Equipment and inta	363	372	373	376	388	437	497	542	565	517
	Property, plant & equipment (PFI)	70	70	71	72	72	74	76	77	78	79
	Assets, Non-Current, Total	**433**	**442**	**444**	**448**	**460**	**511**	**572**	**618**	**643**	**596**
	Inventories	9	9	9	9	9	9	9	9	8	8
	NHS Trade Receivables, Current	17	16	16	16	16	16	16	16	16	16
	Non NHS Trade Receivables, Current	10	9	9	9	10	9	10	10	6	6
	Other Receivables, Current	5	4	4	3	3	3	3	3	3	3
	Other Financial Assets, Current (e.g. a	1	1	1	1	1	1	1	1	1	1
	Prepayments, Current, non-PFI related	2	2	2	2	2	2	2	2	2	2
	Cash and Cash Equivalents	3	2	1	0	1	4	4	(0)	(6)	(18)
	Assets, Current, Total	**48**	**44**	**41**	**41**	**42**	**44**	**45**	**42**	**30**	**18**
	ASSETS TOTAL	**481**	**486**	**486**	**488**	**502**	**555**	**617**	**660**	**673**	**614**
	Interest-Bearing Borrowings , Current (	(62)	(52)	(90)	(91)	(72)	(59)	(52)	(45)	(40)	(44)
	Deferred Income, Current	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
	Provisions, Current	(1)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
	Trade Payables, Current	(22)	(24)	(24)	(23)	(24)	(23)	(24)	(25)	(26)	(26)
	Other Payables, Current	(18)	(18)	(18)	(17)	(17)	(17)	(17)	(17)	(17)	(17)
	Capital Payables, Current	(7)	(3)	(1)	(2)	(2)	(6)	(9)	(8)	(6)	(3)
	Accruals, Current	(31)	(30)	(30)	(29)	(29)	(28)	(28)	(28)	(27)	(27)
	Finance Leases, Current	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0	0	0
	Other Liabilities, Current	(2)	(1)	(2)	(2)	(2)	(1)	(2)	(2)	(2)	(2)
	Liabilities, Current, Total	**(150)**	**(137)**	**(173)**	**(173)**	**(153)**	**(143)**	**(140)**	**(134)**	**(127)**	**(127)**
	NET CURRENT ASSETS (LIABILITIES	**(102)**	**(93)**	**(132)**	**(132)**	**(112)**	**(98)**	**(95)**	**(92)**	**(96)**	**(109)**
	Interest-Bearing Borrowings, Non-Curr	(38)	(121)	(143)	(115)	(106)	(143)	(194)	(235)	(217)	(175)
	Deferred Income, Non-Current	-	-	-	-	-	-	-	-	-	-
	Provisions, Non-Current	(5)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)
	Finance Leases, Non-current	(1)	(1)	(1)	(1)	(0)	(0)	-	-	-	-
	Other Liabilities, Non-Current	(55)	(53)	(52)	(50)	(48)	(47)	(45)	(42)	(40)	(38)
	Liabilities, Non-Current, Total	**(98)**	**(180)**	**(200)**	**(170)**	**(159)**	**(195)**	**(243)**	**(282)**	**(262)**	**(217)**
	TOTAL ASSETS EMPLOYED	**232**	**169**	**112**	**146**	**189**	**218**	**234**	**245**	**285**	**270**
	TOTAL TAXPAYERS EQUITY	**232**	**169**	**112**	**146**	**189**	**218**	**234**	**245**	**285**	**270**

TRUST I&E AND BALANCE SHEET – UNDER SAHF SCENARIO

	£'m	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
THH	Property, Plant and Equipment and intangible a	159	168	172	167	185	165	183	189	183	186
	Trade and Other Receivables, Net, Non-Current	1	1	1	1	1	1	1	1	1	1
	Assets, Non-Current, Total	**160**	**169**	**173**	**168**	**186**	**166**	**183**	**190**	**184**	**187**
	Inventories	3	3	3	3	3	3	3	3	3	3
	NHS Trade Receivables, Current	13	13	13	10	9	9	9	9	9	10
	Non NHS Trade Receivables, Current	-	-	-	5	-	-	-	-	-	-
	Other Receivables, Current	2	2	2	2	2	2	2	2	2	2
	Prepayments, Current, non-PFI related	2	2	2	2	2	2	2	2	2	2
	Cash and Cash Equivalents	3	6	6	6	6	5	5	3	0	2
	Assets, Current, Total	**23**	**26**	**26**	**28**	**22**	**21**	**21**	**19**	**16**	**20**
	ASSETS TOTAL	**183**	**195**	**199**	**196**	**208**	**187**	**204**	**209**	**200**	**207**
	Interest-Bearing Borrowings , Current (including	(1)	(1)	(1)	(2)	(2)	(2)	(2)	(4)	(7)	(5)
	Provisions, Current	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
	Trade Payables, Current	(9)	(9)	(9)	(14)	(14)	(14)	(14)	(14)	(14)	(15)
	Other Payables, Current	(6)	(10)	(8)	(9)	(3)	(3)	(3)	(3)	(2)	(4)
	Capital Payables, Current	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
	Accruals, Current	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
	Finance Leases, Current	(0)	(0)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
	PDC dividend payable, Current	(2)	(3)	(3)	-	-	-	-	-	-	-
	Other Liabilities, Current	-	-	(1)	-	-	-	-	-	-	-
	Liabilities, Current, Total	**(28)**	**(34)**	**(34)**	**(36)**	**(30)**	**(30)**	**(30)**	**(32)**	**(35)**	**(35)**
	NET CURRENT ASSETS (LIABILITIES)	**(5)**	**(8)**	**(8)**	**(8)**	**(8)**	**(9)**	**(10)**	**(13)**	**(18)**	**(16)**
	Interest-Bearing Borrowings, Non-Current	(14)	(12)	(19)	(25)	(28)	(29)	(28)	(63)	(96)	(91)
	Trade and Other Payables, Non-Current	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
	Finance Leases, Non-current	(4)	(4)	(4)	(4)	(4)	(5)	(5)	(5)	(5)	(5)
	Other Liabilities, Non-Current	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)
	Liabilities, Non-Current, Total	**(32)**	**(31)**	**(38)**	**(43)**	**(46)**	**(48)**	**(47)**	**(82)**	**(115)**	**(110)**
	TOTAL ASSETS EMPLOYED	**123**	**131**	**127**	**117**	**131**	**109**	**127**	**94**	**50**	**61**
	TOTAL TAXPAYERS EQUITY	**123**	**131**	**127**	**117**	**131**	**109**	**127**	**94**	**50**	**61**

N ABBREVIATIONS

A&E	Accident and Emergency
ADASS	Association of Directors of Adult Social Services
BCF	Better Care Fund
BHH	Brent, Harrow, Hillingdon
BME	Black and Minority Ethnic
C&W	Chelsea and Westminster
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CHP	Community Health Partnerships
CIG	Clinical Implementation Group
CIP	Cost Improvement Programme
CLCH	Central London Community Healthcare
CMH	Central Middlesex Hospital
COPD	Chronic Obstructive Pulmonary Disease
COSOP	Cabinet Office Statement of Practice
CQC	Care Quality Commission
CSF	Critical Success Factor
CSR	Comprehensive Spending Review
CT	Computerised Tomography
CWG	Clinical Working Group
CWHHE	Central London, West London, Hammersmith & Fulham, Hounslow, Ealing
CX	Charing Cross
DGH	District General Hospital
DH	Department of Health
DMBC	Decision Making Business Case
DNA	Did Not Attend
EAC	Equivalent Annual Cost
EH	Ealing Hospital
FAM	Finance & Activity Modelling
FBC	Full Business Case
FIAC	Funding and Investment Assurance Committee
FIC	Finance and Investment Committee

FIPA	Finance, Investment, Procurement and Audit Committee
FM	Facilities Management
FRI	Full Repairing and Insuring
FT	Foundation Trust
FYFV	Five Year Forward View
GMP	Guaranteed Maximum Price
GP	General Practitioner
GPU	Government Property Unit
H&F	Hammersmith & Fulham
HAC	Heart Attack Centre
HASU	Hyper-Acute Stroke Unit
HDU	High Dependency Unit
HENWL	Health Education North West London
HMT	Her Majesty's Treasury
HRCH	Hounslow and Richmond Community Healthcare
IAPT	Improving Access to Psychological Therapies
ICHT	Imperial College Healthcare NHS Trust
ICP	Integrated Care Pilot
ICU	Intensive Care Unit
ImBC	Implementation Business Case
IRP	Independent Reconfiguration Panel
ITFF	Independent Trust Finance Facility
ITU	Intensive Therapy Unit
JCPCT	Joint Committee of Primary Care Trusts
JCT	Joint Contracts Tribunal
JSNA	Joint Strategic Needs Assessments
LETB	Local Education and Training Board
LHP	London Health Programmes
LIFT	Local Improvement Finance Trust
LOS	Length of Stay
LSOA	Lower Super Output Area
LTC	Long Term Condition
LTFM	**Long Term Financial Model**
MCP	Multispecialty Community Provider
MDT	Multidisciplinary Team
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRSA	Methicillin- resistant Staphylococcus aereus
MTC	Major Trauma Centres
NCAT	National Clinical Advisory Team
NEC	New Engineering Contract
NHS	National Health Service
NHS HEE	NHS Health Education England
NHS IQ	NHS Improving Quality
NHS PS	NHS Property Services
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NPH	Northwick Park Hospital
NPV	Net Present Value
NW	North West
OBC	Outline Business Case
OJEU	Official Journal of the European Union
ONS	Office of National Statistics
OOH	Out-of-Hospital
PACS	Primary and Acute Care System
PAM	Property Asset Management
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PHE	Public Health England
PID	Project Initiation Document
PMO	Programme Management Office
PPRG	Patient and Public Representation Group
PSCP	Principal Supply Chain Partner
QEQM	Queen Elizabeth the Queen Mother
QIPP	Quality, Innovation, Productivity and Prevention
QMMU	Queen Mary Maternity Unit
QOF	Quality and Outcomes Framework
RAG	Red Amber Green
RNOH	Royal National Orthopaedic Hospital
SaHF	Shaping a healthier future
SAU	Surgical Assessment Unit

SCF	Strategic Commissioning Framework
SCIE	Social Care Institute for Excellence
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
SSDP	Strategic Service Delivery Plan (for out-of-hospital)
STP	Sustainability and Transformation Plan
TDA	Trust Development Authority
THH	The Hillingdon Hospitals NHS Foundation Trust
TLAP	Think Local Act Personnel
TUPE	Transfer of Undertakings (Protection of Employment)
UCC	Urgent Care Centres
WCC	Westminster City Council
WMUH	West Middlesex University Hospital
WSIC	Whole Systems Integrated Care