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.

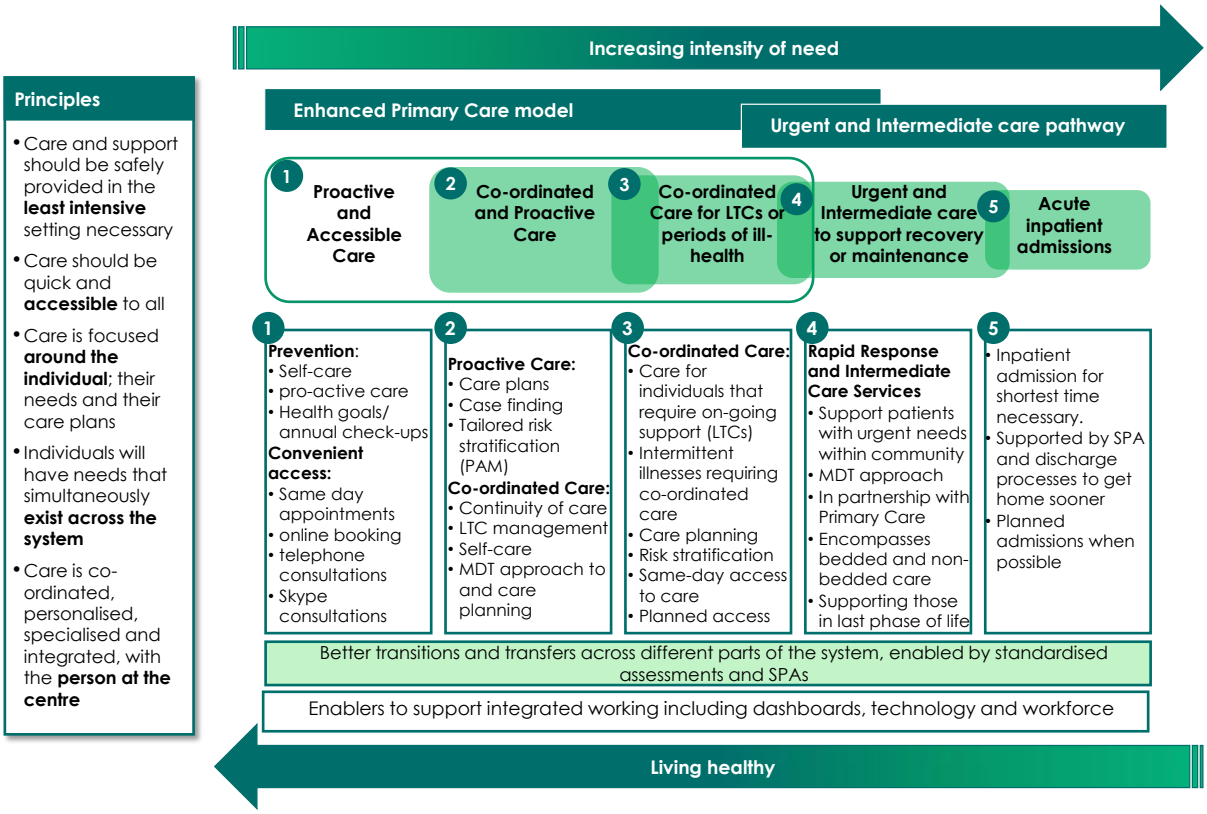
Personalised, localised, coordinated and specialised: this is our proposed solution

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.

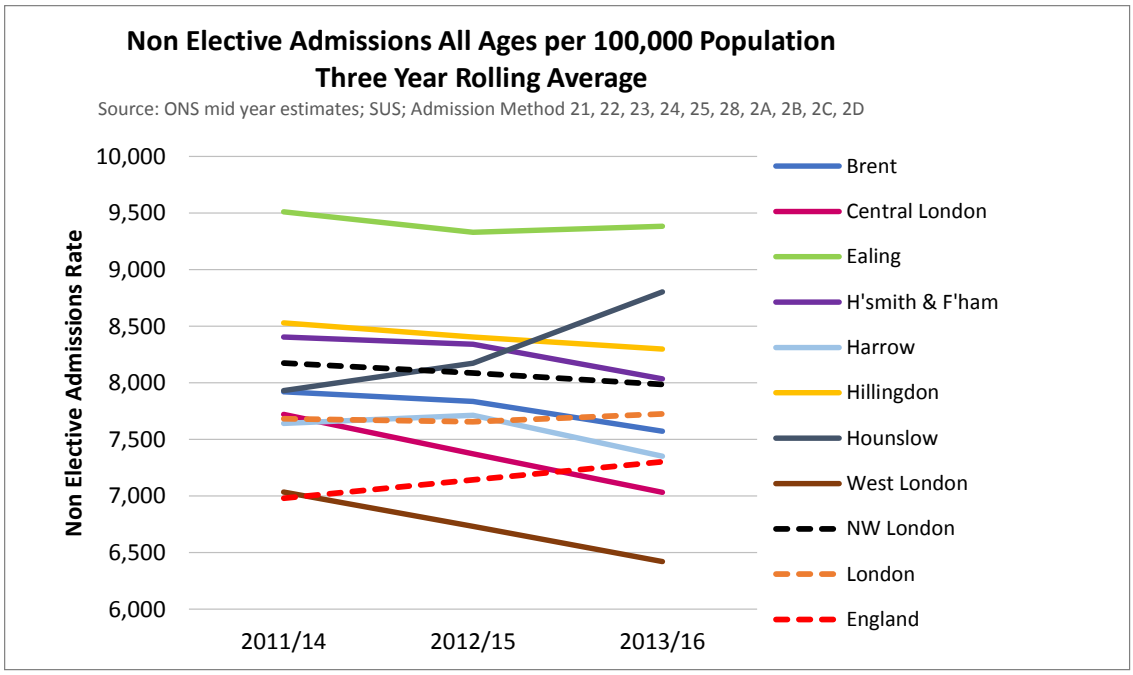
We also know that we currently have an unacceptable level of variation in care processes, especially for people with long term conditions who often experience fragmented, poorly-co-ordinated care. This may in part explain our observed variation in non-elective bed days per person over 65years per general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



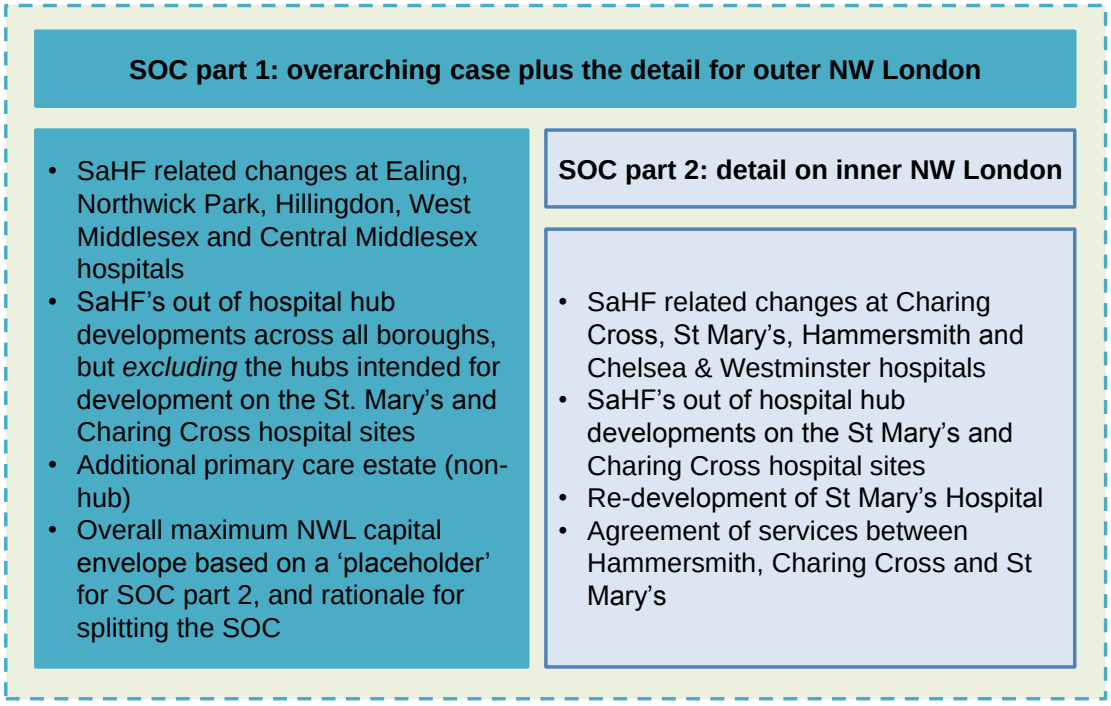
The data on non-elective admissions and bed days for all our commissioned care with all acute providers shows there is clear evidence that in NW London, we can and are delivering our strategy and realising benefits. However, to maintain this progress, make it universal for all our population in all our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



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.