The Hillingdon Hospitals NHS
NHS Foundation Trust

Strategic Plan Document for 2014-19

cares
communication attitude
responsibility equity safety

1. Trust Vision, Mission & Strategy

The Trust vision is: *To put compassionate care, safety and quality at the heart of everything we do*.

Beneath that vision sits the mission: *To be the preferred, integrated provider of healthcare for Hillingdon and the surrounding population, with a major acute hospital as a hub.*

Our strategy sets out the Trust's ambition for the next 5 years through 4 key pillars, known as our strategic priorities, and supporting strategic objectives. Underneath sit actions and measures of success which are agreed each year by the Board. The actions and measures of success flow down into divisional business plans and from there into individual's personal development plans, to ensure a 'golden thread' running down the organisation from the board to ward.

The Trust strategy in the form of the priorities, objectives, actions and measures of success are captured each year within a single page document known as Strategy on a Page, which is widely distributed throughout the organisation.

STRATEGIC PRIORITIES	STRATEGIC OBJECTIVES
To create a patient centred organisation to deliver improvements in patient experience and the quality of care we provide	1. Fully comply with licence to operate/ regulators 2. Improve the quality of care and clinical effectiveness 3. Improve patient and carer experience 4. Improve patient safety
A clinically led service strategy that responds to the needs of patients and other health and social care partners	5. Work with CCG collaboratively to improve services within available resources 6. Improve Patient & Public involvement 7. Engage clinicians to develop innovation and expansion of services
To deliver high quality care in the most efficient way	8. Deliver healthcare more efficiently 9. Improve and invest in IT to support service improvement 10. Modernise & reconfigure the Estate & Facilities to meet the needs of our clinical services 11. Maximise staff contribution to transforming the way we deliver our services
To develop sufficient sustainable scale to enable us to improve and grow healthcare services for our communities	12. Develop a service plan in response to SaHF 13. Develop strategic alliances with appropriate partners

2. Market analysis and context

2.1 Context in North West London

The population of NW London is growing and life expectancy is improving: population is forecast to increase by approximately 141,000 people from 2 million to 2.15 million over the period to 2018. Life expectancy has grown by an average of 3 years over the last 10 years, particularly due to early diagnosis and improved treatments resulting in fewer people dying prematurely from diseases such as cancer, heart disease and stroke.

There is currently a difference of up to 17 years in life expectancy in different wards in NW London (NWL). This difference is heavily correlated with deprivation and is caused by a number of factors including: living conditions, diet, levels of smoking and drinking, access to sport and leisure activities, social and support networks, as well as barriers to healthcare such as language and literacy.

Some 300,000 people in NWL have diabetes, asthma, coronary heart disease, chronic obstructive pulmonary disease or cystic fibrosis. More needs to be done to prevent ill health and to improve access to GP and community care. Much can be done through successful promotion of public health information and

campaigns that assist people to take personal responsibility for their own health. Also, more proactive primary care and better integrated working needs is required so that the health and social care system works seamlessly to support everyone to lead healthier lives. There have been vastly different levels of funding across the sector for different settings of care and on long term conditions, with Hillingdon significantly below the average for both.

Patient experience across NWL is low compared to other regions. Mortality rates vary significantly between trusts, and weekday vs weekend, and readmission rates vary considerably from one hospital to another. There is considerable variation in the availability of senior experienced staff to care for patients between hospitals and from weekday to weekend, and particularly for specialist services. It is increasingly difficult to provide a broad range of services 24/7 across 9 acute hospital sites: 4 NWL hospitals have a smaller than average catchment population, and all but one are smaller than the Royal College of Surgeon's preferred catchment size.

The Royal Colleges have recommended increased consultant presence, in particular to cover emergency and maternity services. Achieving such increased coverage is a huge challenge nationally as well as in NW London:

- Units need to serve a sufficiently large population so that they are busy enough out-of-hours for staff to maintain their skills in dealing with complications. This is a particular issue for senior staff who must also spend time fulfilling other responsibilities
- Only larger units can afford to employ an increased number of senior staff, with many smaller units already being on the margins of economic viability due to junior doctors now working fewer hours
- There are insufficient staff available to provide such increased cover across all units, even if it could be afforded and skills could be maintained.

Three overarching principles form NHS NWL's vision for care: that health services need to be: localised where possible; centralised where necessary; and in all settings, integrated across health, social care and local authority providers to ensure seamless patient care. Local clinicians have developed visions for emergency and urgent care, maternity and paediatrics. These include quick access to high quality care, 24/7, and expectant mothers having the choice to deliver at home if appropriate, or with immediate access to supporting services if needed.

The 8 NWL CCGs have agreed a vision to transform out-of-hospital care which will centre on the patient and ensure people receive the right care, in the right place, at the right time. The Shaping a Healthier Future (SaHF) programme was established in Nov 2011 and builds on significant work by clinicians to develop suitable models of care. In February 2013 the NW London Joint Committee of Primary Care Trusts agreed the following recommendations for service change:

- To adopt the NW London acute and out of hospital standards, service models and clinical specialty interdependencies for major, local, elective and specialist hospitals
- To adopt the model of care based on five major acute hospitals
- To coordinate implementation of out of hospital strategies in conjunction with the above changes

2.2 Hillingdon Healthcare Needs

It is estimated that there are 273,900 people living in Hillingdon, 19.5% are under 15 years of age and 12.9% are over 65. This compares with 18.7% under 15's and 11.1% over 65's in London. From Sub National Population Projection figures the population of Hillingdon is expected to rise linearly by approximately 4,500 each year for the next 10 years. According to the 2011 Census in Hillingdon, 52% of the population were White British, 8% were White Other and 40% were from black and minority ethnic (BME) groups including 25% of the population that are Asian (figures sourced from 2013 Joint Strategic Needs Assessment, Hillingdon Clinical Commissioning Group (CCG)).

There are around 4,200 births to Hillingdon residents each year. Over 80% of these babies are delivered at the Trust. This is a significantly higher birth rate than in England as a whole. The rate of women smoking during pregnancy in Hillingdon is significantly higher than the London average with 10% of pregnant women in the borough smoking at the time of delivery. There is a significantly higher rate of emergency caesarean sections in Hillingdon compared to England The proportion of babies born with low birth weight is significantly higher than the national average.

Current estimates suggest that there are currently 36,200 people aged over 65 living in Hillingdon. This figure is projected to increase by 13.3% by 2020 to 38,600. The numbers of people aged 85 and over is expected to increase by 10% to 5,400 within this period. There are estimated to be 4,778 frail elderly households living in the borough and nearly a quarter of these are thought to be living in unsuitable housing.

Stroke is a condition that mainly affects older people and is one of the main causes of disability. In 2008/9 (the last year for which validated data is available) 3,209 people were reported by GPs as living with stroke. This is projected to increase to 4,351 by 2015.

The number of adults aged 18 to 64 with a serious visual impairment is projected to increase by 3.5% by 2015 to 114. The majority of people with a moderate to severe sight impairment are in the over 75 age group and the number is projected to increase by 6.6% by 2015 to 2,244. The number in the 65 to 74 age group is expected to increase by 8.9% to 1,075. These figures are significant because of the linkages between sight loss and a loss of independence arising injuries sustained as a result of falls. There are also projected to be significant increases in the number of people with a moderate to severe hearing impairment. As expected, the largest concentration is amongst the 65+ age group, which is projected to increase by 8.2% to 16,164.

There are currently an estimated 15,176 diabetics in Hillingdon. The rising prevalence of diabetes is due to an ageing population and unhealthy lifestyles leading to obesity. The number of people with diabetes is expected to increase in Hillingdon to 18,974 by 2020. A major challenge for health service is improvement in prevention and early detection of diabetes.

Other lifestyle factors and risky behaviours contribute enormously to long-term (and short-term) health. The most significant of these in the Hillingdon area are:

- **Obesity** In Hillingdon, 23% of adult population is estimated to be obese, which is the same as London but slightly lower than England (24%).
- **Physical activity r**ates of physical activity are worse than the England, London and Northwest London rates.
- **Smoking** the estimated 2011/12 prevalence of smoking in Hillingdon (17.6%) is lower than the estimated proportions for England (20.0%) and London (18.9%).
- **Alcohol** attributable hospital admissions and alcohol-related recorded crimes are worse (higher) than the England average.

2.3 Integrated Care

North West London (NWL) has had Integrated Care pilots (ICPs) running for a number of years and a Whole Systems Integrated Care Programme is viewed as the next stage in the journey to provide a seamless model of health and social care. Much of the work to date has involved looking at condition specific issues such as diabetes and care of the elderly given the respective challenges they present. This has had significant involvement from our clinicians in each of these specialties but as the model evolves, there is a movement away from condition specific pathways to a more holistic whole patient approach, although still underpinned by the input of specialist expertise. The Whole Systems Vision is underpinned by 3 principles:

i. People will be empowered to direct their care and support and to receive care they need in their homes or local community
ii. GPs will be at the centre of organising and coordinating peoples care
iii. Our systems will enable and not hinder the provision of integrated care.

Hillingdon CCG submitted an expression of interest (EOI) supported in principle by CNWL, THHFT, GP's and third sector, initially planning to support the elderly and frail population in Hillingdon.

The integrated model is expected to include:

- The GP as the professional, with overall responsibility for the patient including approval of MDT care plans
- Multi-Disciplinary Teams (MDTs), drawn from the Provider Network, to deliver care and the use of care coordinators to support delivery of desired outcomes. The GP as the lead MDT professional will

draw in whatever additional support (consultant, social care etc.) is needed from the Provider Network to ensure care plan outcomes are delivered

- A focus on supporting self-care and independence
- The use of capitated budgets and longer term contracts to increase incentives for primary and secondary prevention
- Through the Better Care Fund, pooling commissioning budgets relating to services commissioned for older people and exploring further pooling as part of this initiative
- Risk stratification
- Embedding ICP and its functions into the network

The most important next step will be to co-create the new model of care in detail and to consider the related implications. Hillingdon's CCG Chair is currently arranging local meetings to clarify and to begin to develop a shared commissioner/provider vision on how Hillingdon healthcare might look in the future. Public Health will also join this group.

The NWL ICP enters into a transition phase going into 14/15, dovetailing into the whole systems Integration programme within Hillingdon. Commissioners are currently putting a detailed service specification together which also sees some of the projects evolving into substantive models of care with a focus on outcomes monitoring. Some projects have been mainstreamed going forward; one example is the Falls Assisted Discharge Service and Falls Outpatient Clinic. Both services are set to continue, the assisted discharge is being incorporated into the Trust's early supported discharge model known as Home Safe (section 3.4.4) and the falls outpatient clinic is being commissioned separately by the CCG .

2.4 Capacity Analysis

The SaHF programme used 7 criteria to establish the appropriate number of major hospitals in NW London, to ensure appropriate capacity, quality of care, patient access and safety:

i. **The correct care setting model to deliver high quality care**: clinicians agreed that clinical standards could not be met if the 9 current acute sites became major hospitals, due to lack of staff with sufficient skills & experience, and the costs involved in providing staff on a 12-24/7 basis.
ii. **Consider the 9 existing major hospitals only** rather than new sites, due to capital build costs and timescales
iii. **There should be enough major hospitals to support the population of NW London**: clinicians considered evidence about the factors contributing to high quality care, including senior staff presence, patient volumes to ensure staff build and maintain skills, technology requirements, and interdependencies between acute services and the required clinical support. The resulting decision was that there should be no more than five major hospitals
iv. **The number of major hospitals must be viable in the medium term**: it was agreed that having less than 5 major acutes would require a large number of service moves simultaneously across the region, increasing the likelihood of a long implementation timeframe and large capital investment requirements. No existing sites had the capacity to deliver the volumes of activity in an option with less than 5 major acutes.
v. **Ensure a good geographical spread** of major hospitals across NW London: travel analysis showed the volumes of patients who would experience an increase in travel times, if residents there had to go to their 'next nearest' hospital.
vi. **Use sites currently delivering high quality major hospital services** to determine major hospital sites.
vii. **Geographic distribution of the remaining sites** is proposed to minimise the impact of changes on local residents

As part of this programme evaluation, an income and expenditure, activity and beds forecast was produced, taking into account planned service changes from hospitals changing from acute hospitals to local hospitals, most notably from the Trust's perspective, Ealing hospital. The table below shows the prediction of underlying changes required to deliver reconfigured service levels at Hillingdon.

	13/14 activity	14/15 Activity	15/16 Activity	16/17 Activity	17/18 Activity	Post Reconfiguration Activity	Movement - 13/14 to 17/18
A&E	54,112	55,137	56,222	57,353	58,510	61,887	7,775
Critical Care	4,028	4,184	4,347	4,516	4,691	5,165	1,137
Elective	16,456	16,670	16,891	17,118	17,346	21,032	4,576
Maternity (births)	4,033	4,193	4,359	4,532	4,711	6,020	1,987
Non Elective	23,724	22,720	21,702	20,637	19,498	22,039	-1,685
Outpatient	295,174	275,090	254,390	232,758	209,706	211,724	-83,450
	397,527	377,994	357,911	336,913	314,463	327,867	-69,660

An Outline Business Case for Maternity, Theatres, Critical Care, A&E and backlog maintenance has been developed by the Trust to meet the strategic requirements of the SaHF programme. Delivery should ensure that Hillingdon Hospital is able to manage projected future patient demand of both its traditional population base and the expected patient flows from maternity and non-elective services at Ealing Hospital.

2.4.1 Workforce assumptions

The proposed re-shaping of Ealing Hospital through the SaHF programme will have significant implications for the both the Maternity and Accident and Emergency departments in terms of numbers and skill mix with an increased need for paediatricians, midwives, maternity support workers, nurses and A&E consultants. This programme together with the development of more integrated pathways of care across acute and community settings will require significant changes to our workforce configuration.

A detailed plan is currently being developed to ensure that the workforce is of the requisite size, meets quality standards and is equipped with the necessary skills to deliver the revised pathways of care. Two new A&E consultants have already been appointed to meet some of the new Emergency Care standards. Based on the activity assumptions contained within the Outline Business Case, modelling of the workforce has been undertaken for maternity staffing. Further work is currently being undertaken to determine the impact upon other specialties.

<u>Workforce Risks</u>

As with most other acute providers, the Trust faces recruitment and retention risks related to a number of staffing groups. This most obviously applies to qualified nurses as our biggest cohort of staff, particularly in light of the Francis and Keogh reviews which has seen demand for these posts rise significantly. Whilst we have been fortunate to date in attracting additional A&E consultant staff, we are clear that this presents a challenging area for future recruitment and retention. Other challenged medical specialties include paediatrics, anaesthetics, obstetrics, acute medicine and care of the elderly. The development of our workforce strategy looks to mitigate many of these risks through structured recruitment and retention plans, work with Health Education North West London (HENWL) regarding education and training and creating stronger links with education and health organisations.

<u>Out of Hospital Care</u>

The drive to provide care closer to home will undoubtedly impact on the delivery of services and the staff who deliver those services. The majority of changes in terms of enhanced skills are for those currently delivering care in the community setting; GPs, community and practice nurses and work is currently underway through HENWL to develop those skills. However, the envisaged changes to patient pathways and integrated care will undoubtedly mean that our clinical and medical workforce will need to be increasingly mobile, work in multi-disciplinary teams and be more IT literate to deliver care in an out of hospital setting. Care Co-ordinators have recently been appointed to support the drive towards patient centred care delivered in an OOH setting.

The Trust has also recently introduced the Home Safe – Early Supported Discharge programme which has already seen some changes to the shape and locality of patient care e.g. therapists visiting patients in a home setting. Increasingly clinics are being delivered in an OOH setting e.g. dermatology, ophthalmology, diabetes and antenatal clinics. These will undoubtedly continue to expand.

New Quality Standards and 7 Day Working

The drive towards providing Seven Day Services including 16 hour/7 day a week consultant cover (24/7 in maternity) together with a requirement for a consultant assessment within 12 hours and the other emerging standards of care) present the Trust with significant challenges. Where possible job plans are being reviewed to meet the additional requirements and funding has already been provided from the quality fund to increase consultant presence in A&E and paediatrics. An analysis of how the trust meets the London Quality Standards and residual gaps has been undertaken and further work is currently being undertaken to prioritise how and where the gaps can be closed. Work is also starting to take place around how network solutions with other providers can help to meet quality standards in an efficient and sustainable way.

Following the Cavendish review and the resultant Safer Staffing initiative, a review was undertaken of the nursing and midwifery staffing levels across the Trust. Several areas were identified as having insufficient levels of staffing and additional funding has been made available through the Quality Fund to provide additional staff. However, an overall reduction in the pay bill needs to be achieved. A number of QIPP programmes have been implemented which include a review of non-clinical support workers; benchmarking exercises have indicated that the Trust is an outlier in terms of the number of staff at bands 7 and above and work has commenced to streamline and rationalise these roles wherever possible.

Workforce Plan

Early in 2014 the Trust submitted an outline Workforce Development and Education Plan to HENWL to meet, where possible, the Health Education England and HENWL key priorities of:

- Emergency Care and Urgent Care Pathways
- The OOH/primary care and community workforce
- Developing community education provider networks
- Bands 1-4 staff
- End of Life and cancer pathways

The key Organisational Development (OD) deliverables that will be encompassed within the Trust's workforce plan are as follows:

- Manage the development and implementation of relevant programmes to engage staff through a culture that promotes involvement, capability and quality in all areas of the Trust's work.
- Develop, implement and sustain the Trust Culture, values and behaviours through the integration of the CARES framework into all Trust processes and initiatives
- Contribute to the development of a learning organisation through appropriate OD interventions that encourage personal and organisational growth, reflection, innovation and team building
- Oversee the annual staff survey and use the results to inform and transform the level of engagement of staff, by developing corporate and local improvement plans
- Manage the human dimensions of organisational change, whether this is a small departmental change or a big divisional re-organisation so that it is seen as a positive experience.

2.5 Scenario Modelling

The scenario modelling set out below illustrates our chosen strategic option (1a), which is aligned to the agreed sector wide reconfiguration (SaHF) and is principally supported by our local commissioner through the alignment of our shared long term financial model. The different scenarios describe variations to assumptions that impact our key service lines, and demonstrate a clear understanding of the key sensitivities that ultimately impact our declaration of sustainability.

In light of the above analysis and specifically the planned Shaping Healthier Future initiative in NW London, the Trust have included the following possible scenarios in the financial model.

- Scenario 1: SaHF programme delivers in full, with £40m Public Dividend Capital (PDC) funded capital
- Scenario 1a: SaHF programme delivers in full, with £80m PDC funded capital
- Scenario 2: SaHF programme only delivers partially, with no associated capital funding available

The Trust does not consider that a pure "do nothing" scenario is applicable in the context of SaHF and the changes at Ealing Hospital Trust.

2.5.1 Scenario 1: SaHF Programme delivers in full with £40m PDC

The base strategy assumes SaHF will be implemented by 2017/18. Until this point the Trust will lose significant activity and associated revenue that is planned to be moved out-of-hospital by commissioners. In 2017/18 SaHF plans for the Trust to gain sufficient activity and revenue from Ealing Hospital to replace what is lost in the intervening years. During this SaHF implementation period the Trust will require £29.6m of fixed cost transitional support from top-sliced NWL commissioners' funds to be able to remain financially viable. This builds on the process that commenced in 2013/14 when the Trust received £3m non-recurrent transitional financial support from the outer-cluster CCGs and continued in 2014/15 with a further agreed package of £5.5 m.

Funding for quality investments is built into the financial strategy at £2.1m per annum until 2018/19 when it reduces to match the national tariff assumptions for the Trust of £0.5m.

Capital Funding

In addition to £45m of ongoing investment the strategy, also incorporates an additional £40m PDC capital required to deliver the SaHF programme. The SaHF investment in backlog maintenance (BLM) is estimated as £18m and includes the Trust's prioritised High and Significant BLM and Infrastructure works. This will make a material difference to the Trust's immediate needs to improve its estate over the next two to three years. It does not however create a sustainable maintainable position for the largest component of the Trust's retained estate in the longer term beyond five years.

Although capital works undertaken within the Trust's capital programme has been able to mitigate the consequential impact of the deteriorating estate, the Trust are becoming increasingly concerned at its continuing ability to manage the estate on a "sticking plaster" approach. The Trust's long- term sustainability is affected by the lack of capital to address the Tower and Podium as an increasing proportion of its capital programme has to be used to reactively respond to infrastructure failures and other high risk works.

Risk Rating

Overall, the financial strategy as set out will only achieve modest financial surpluses of less than 1% in each financial year as a direct result of the Trust being in planned receipt of SaHF transition support funding. It will however, maintain a continuity of services risk rating of 3 (2.5) throughout the entire strategic planning period.

	14/15 £'000	**15/16 £'000**	**16/17 £'000**	**17/18 £'000**	**18/19 £'000**
Surplus/(Deficit) before Exceptionals	66	324	345	208	1,823
Surplus/(Deficit) after Exceptionals	(8,055)	324	(19,655)	208	1,823
	14/15	**15/16**	**16/17**	**17/18**	**18/19**
Continuity of Service Risk Rating	3	3	3	3	3

2.5.2 Scenario 1a: SaHF programme delivers in full, with £80m PDC funded capital

The Trust is also continuing to explore under the scenario set out above, how it can access a further £40m of capital investment required to keep physical infrastructure fit for purpose. Assuming PDC can be accessed, this would be possible within the constraints of the financial strategy whilst still maintaining a continuity of services risk rating of 3 (2.5) in each year.

	14/15 £'000	**15/16 £'000**	**16/17 £'000**	**17/18 £'000**	**18/19 £'000**
Surplus/(Deficit) before Exceptionals	66	324	345	(302)	663
Surplus/(Deficit) after Exceptionals	(8,055)	324	(19,655)	(302)	663
	14/15	**15/16**	**16/17**	**17/18**	**18/19**
Continuity of Service Risk Rating	3	3	3	3	3

The most recent Estate condition survey was produced by Ove Arup & Partners Ltd (Arup) in February 2013. As a consequence of concerns raised in areas of the estate and infrastructure that were not readily visible to survey, a series of more detailed reports were additionally commissioned to produce a more rounded account of the works required on the Hillingdon site. The additional reports included:

- Electrical Distribution - Capacity and resilience.
- Medical Gases - Capacity and resilience.
- Upgrading theatre ventilation systems
- Tower & Podium structural, fenestration and facade works

It was clear to the Trust that a large proportion of remedial works required were outside of what would be traditionally identified as backlog maintenance. Based on the indicative costs produced as a by-product of the Arup survey and the costs included in the above reports, the estimated investment required to raise the condition of the Hillingdon estate to an acceptable condition is circa £40m on top of the £17.69m identified under SAHF.

2.5.3 Scenario 2: SaHF programme only delivers partially, with no associated capital funding available

The Trust has developed a separate financial strategy to address the likely downside scenario that would result should the SaHF programme not be fully realised. Due to the interlinked nature of the commissioners' out-of-hospital strategy aligned to SaHF this scenario is based on only 75% of the related QIPP being delivered but also that the Trust will not receive any further fixed cost transitional funding beyond what has already been agreed for 2014/15.

It also assumes even though the SaHF programme does not continue the planned changes in relation to Ealing Hospital's Maternity and A&E service reconfigurations will happen in full regardless given how advanced these are. For the other SaHF programme changes it has been assumed that only 30% of the planned activity from A&E and non-elective services will transfer to the Trust.

In addition, the Trust has not included the £40m SaHF related additional capital investment and its associated revenue statement costs. Therefore, only the £45m ongoing capital investment will be planned.

Risk Rating

In order to mitigate the downside scenario the Trust would need to reduce our contingency in 2018/19 to 1%, a reduction of £1m, defer £1.0m of quality investment from 2017/18 to 2018/19, and further reduce quality investment planned for 2017/18 by £0.5m. During 2015/16 and 2016/17 our continuity of services risk rating will fall to a 1 before recovering to 2 in 2017/18. Without an injection of cash (PDC) however, it will not be able to restore the rating to a 3 in the foreseeable future.

2.6 Alignment of findings with LHE partners

The 5-year financial strategy of the Trust has been based on the joint health economy financial planning work that was undertaken with external consultancy support. This aligned Trust and local Commissioner financial plans with the strategic commissioning North West London (NWL) Sector acute reconfiguration intentions of 'Shaping a Healthier Future' (SaHF). This incorporates both revenue and capital assumptions and is consistent with the Outline Business Case submitted for review to the SaHF project team.

Scenario 2 is set within a different context than the agreed alignment with health economy partners around SaHF. Therefore, not all the principles of the base case will apply. This will have financial implications on all local health economy partners, especially in relation to out of hospital strategies and the extent of commissioner QIPP that can be realistically achieved.

More specifically, HCCG's relatively aggressive QIPP was a function of their underlying financial position. All other factors being equal achieving a lower level of QIPP delivery would therefore put a strain on the overall resources available for the commissioner unless replacement QIPP initiatives could be developed, agreed and implemented. However, since their out of hospital strategy was put in place HCCG's resource allocation has been significantly increased and as a consequence they will have additional financial headroom that can be utilised to mitigate the financial impact of lower QIPP and the resultant higher than planned provider spend. The CCG have also agreed a more formalised collaborative approach with the other 7 CCGs in the sector to pool financial risk across the North West London health economy. This in turn

should provide further assurance around HCCG's ability to support both its own and the Trust's financial requirements given the net surpluses that the 8 CCGs generate as region.

3. Risk to sustainability and strategic options

3.1 Estate Development and Rationalisation

The Trust estate strategy is to continue to deliver services from its two existing hospital sites but also to develop its outreach community facilities in locations in Hillingdon and surrounding boroughs. The Hillingdon Hospital will continue to be the acute medical site and Mount Vernon will serve as the elective treatment centre with the addition of some medical rehabilitation wards and a skin centre.

In recent years the hospital premises have suffered from serious infrastructure underinvestment arising from historic decision making about the failed PFI build. The Trust seeks to use the SAHF funding to rectify this to the greatest extent possible, however as noted in section 2.5, additional capital sums of £40m are being sought to create a sustainable hospital environment that is fit for patient care in the longer term.

3.1.1 Scenario 1: SaHF programme delivers in full

The Hillingdon Hospital Site

The Trust has developed a master plan for the Hillingdon site, consistent with SAHF plans, which will see patient accommodation progressively move out from the old annex corridor wards into the tower block. This will be achieved by the reduction in overall bed requirements arising from the out of hospital strategy plus the transfer of some acute medical patients from the tower to the new Acute Medical Unit. SAHF plans will also see the development of an extension to the maternity building, A&E and ICU.

Mount Vernon Site

The Trust serves as landlord on the Mount Vernon site to a number of tenants, most notably the Mount Vernon Cancer Centre run by East and North Hertfordshire NHS Trust. In a number of cases the tenancy is not formalised with lease arrangements. The strategy for the site is to rationalise the estate so that the Trust can focus on running its clinical services from two principal buildings, the modern 2011 Treatment Centre and the Medical Block. An associated objective is to provide East and North Hertfordshire with their own area of land on a proper leased basis so they can invest and develop their objectives for the Mount Vernon Cancer centre. The Mount Vernon site will not be affected to any material degree by SAHF.

Community Locations

The Trust already runs outpatient services for some specialties such as ophthalmology and dermatology from out of hospital locations using premises rented from GP practices. In addition, antenatal clinics are run from a number of different Children's Centres across the borough.

The strategy, consistent with SAHF, is to increase the number of services provided from community locations. In this respect the Trust will plan to make appropriate use of the three proposed CCG community hubs but may also develop further community locations in Hillingdon. The Trust will also specifically seek to develop community premises in the west of Ealing.

3.1.2 Scenario 2: SaHF programme only delivers partially, no capital funding

The Hillingdon Hospital Site

In the scenario where SAHF is only partially implemented the Trust will accommodate the smaller amount of additional maternity activity by reconfiguration of existing estates footprint.

If the out of hospital strategy fails or is only partially successful then it will only be possible to partially implement the site Master plan to exit the old annex corridor wards.

The absence of capital funding under this scenario will mean that backlog maintenance will continue to be underfunded. The hospital estate will continue to deteriorate and although this will not affect sustainability over the 5 year time horizon it will create a very significant problem for the longer term.

Mount Vernon Site

There will be no material difference to plans for the Mount Vernon site under this scenario however the lack of capital funding will again affect the ability to carry out appropriate back log maintenance.

Community Locations

If the out of hospital strategy fails and the Hillingdon CCG does not develop community hub premises then the Trust will seek to identify its own community healthcare locations in Hillingdon and Ealing in particular.

3.2 Transformation Programme

This year the Trust has endeavoured to develop and drive a longer term transformation programme which has greater engagement and leadership of clinical teams. Tactical opportunities are now limited and in the coming years the focus needs to be very much on internal transformation programmes, with a growing emphasis on health economy opportunities specifically around integrated care. The 14/15 programme is a £7.5m programme made up of both single year schemes and larger transformational schemes which are planned to deliver over 2-3 years.

Over the past 3 years QIPP achievement has increased from £4.5m in 11/12 to £6.3m in 12/13 and £8.2m in £13/14. The plan for future years is to continue to achieve £7.5m year on year. This will be very challenging and will need a different approach to that which has been used in previous years. The 3-5 year Transformation programme for Hillingdon starts to build on the longer term trustwide schemes already being taken forward and incorporates potential system wide improvements around SaHF and integrated care which will support the delivery of longer term savings across the system.

In 13/14 the Trust invested in a Programme Management Office which has both supported the assurance of the QIPP programme and also provided significant delivery support such as identification, planning, driving and tracking of schemes and change programmes. The future, more complex, transformation programme will require this to continue alongside a new approach which begins to upskill local teams in their ability to plan and drive programmes of work. This skills transfer and cultural change has started but there will be a greater emphasis on this in 14/15 and future years. Engagement will also be key: all projects this year have a clinical lead but clinical champions will be identified to drive forward complex programmes of work. The transformation strategy which is in development begins to review the workforce requirements in terms of skills, capacity, capability and clinical leaders/champions that will be required in coming years to drive and deliver this challenging agenda.

3.3 Key service lines strategies underpinning 'Major Acute' status

Under the Shaping a Healthier Future model, the Trust is one of the five major acute hospitals in NW London and as such will continue to provide a full range of acute clinical services. Major Hospitals must 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 must 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. In NW London each major hospital will also provide local hospital services, with specialist staff and equipment to support the networks of GP practices where much care in the future will be delivered.

For other service lines, the strategy differs somewhat between planned and unplanned care. For planned care (includes outpatients, direct access diagnostics, elective daycase and inpatient care, and rehabilitation) the strategy is for growth, both organic and inorganic where clinically appropriate and profitable. The Trust will aim to grow Hillingdon market share through repatriation of activity from other providers and expand in key co-located boroughs. We will ensure that we streamline pathways to make them value for money to commissioners (including movement of unplanned activities to planned activities).

For unplanned care (A&E attendances, ambulatory care, 'hot clinics' or rapid access services, non-elective admissions and critical care), THHFT will look to lead the appropriate prevention of unplanned attendances or admissions, and become a leading provider of ambulatory models of care. We will support the provision of high quality clinical care delivered in the most appropriate clinical setting, first time. Growth should only be inorganic through planned service reconfiguration.

For all service lines, planned service developments will need to satisfy the following criteria:

1. Can we provide this service safely and to a high quality?
2. Will the service make a positive contribution or defend our market position (where the alternative is a greater loss to the organisation)?
3. Will the service development either support the expansion of us as a community or integrated service provider, or help our position as a major acute hospital under SaHF?
4. Can we deliver this for ourselves or do we need a partner to support this development?

For both planned and unplanned care, THHFT will provide high quality, safe services with clear measurable outcomes, resulting in excellent staff and patient feedback. We will provide easy efficient access in the most appropriate clinical setting (including community or acute sites), and will work with partners to integrate health and social care and align commissioner and Trust strategies wherever possible. The Trust will seek to improve its brand development and increase market reach through planned networks and strategic collaborations.

3.4 Scenario modelling – key service line evaluations

Two scenarios (1 and 2) as described in para 2.5 above are considered in light of the key service lines below.

3.4.1 Scenario modelling for Maternity Services

i) Scenario 1: SaHF programme delivers in full

A business case is currently being developed to support the expansion of maternity services from 4,200 to 6,000 births, as a result of the reduction in the number of maternity units in NW London and demographic change, in line with the SaHF DMBC assumptions.

21 standards were identified in the DMBC. Those relating to quantifiable changes are as follows:

1	168 hours (24/7) of obstetric consultant presence on the labour ward
2	Midwifery staffing ratios to achieve a minimum of one midwife to 30 births.
3	One consultant midwife for every 900 expected normal births.
4	1:1 care during established labour from a midwife.
10	Consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours a week. Units with > 5,000 deliveries a year, an epidural rate >35%, or a caesarean section rate >25%, to provide extra consultant anaesthetist cover during periods of heavy workload.
11	24/7 access to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.
14	All labour wards to have onsite access to a monitored and nursed facility with appropriately trained staff.

The intention is to create additional capacity throughout all maternity services which will include both consultant and midwifery led environments. Women will be risk assessed to identify those suitable for the delivery at the Midwifery Led Unit (MLU). The additional capacity both in estate and staffing will enable a flexible service enabling women and families to have greater choice of the maternity care and place of delivery.

By creating a MLU, the model of care will change provision from a transitional ward concept to a Labour/Delivery/Recovery/Postnatal (LDRP) model where women will be admitted to rooms and remain there until discharge. Partners will be encouraged to stay throughout. LDRP rooms should be as non-clinical as possible with comfortable home-style ambience and should enable self-management in privacy wherever possible.

The preferred option would create a new MLU and transitional care environment and would also include a significant refurbishment of the existing unit with the introduction of a HDU facility on Labour Ward and an increase in recovery space to meet modern health building standards. In addition this would include a new environment for Triage to improve privacy and dignity.

Scenario 2: SaHF programme only delivers partially, no capital funding

Under this scenario the services continue to operate from the existing facilities and would accommodate an increase of up to a maximum of 4,800 deliveries. Minor capital works to achieve this level of births have

been identified for the transitional period. The Trust would be unable to spend significantly on necessary backlog maintenance to remove a substantial proportion of the known historical backlog.

There would be no strategic expansion of the facility in terms of added capacity to cope with future increased demand. The Trust would not be able to improve patient choice and would be the only Trust in NWL without a midwifery unit. Whereas it is feasible for the unit to continue to provide a good quality service at these levels of activity, the way in which the facility is set out will always be sub-optimal in terms of current best practice.

3.4.2 Scenario modelling for Specialist Rehabilitation

Under both scenarios the plan is the same, as it is based on a gap analysis in the market that is applicable in both instances.

The Hillingdon Alderbourne Rehabilitation Unit (ARU) has been designated as a level 2b unit providing care for category A and B patients to a population of approximately 350,000. A The ARU catchment area is predominantly Hillingdon borough, but as the reputation of the unit has grown over the past several years as a competent provider of specialist rehabilitation, referrals have been increasing from Harrow, Hounslow, Ealing and Berkshire. In addition, the unit has close links with Neurology and Neurosurgery at Charing Cross which has resulted in an increasing number of referrals from West London, not only for its inpatient rehabilitation beds but also for its specialist outpatient activity.

The clinical teams provide multi-disciplinary, goal orientated rehabilitation for patients with predominantly, though not exclusively, complex neurological conditions. Areas for additional expansion include complex musculoskeletal rehabilitation including polytrauma and amputee rehabilitation. The ARU admits patients over the age of 18, with no upper age limit; however the patient must have needs or goals which can be met through specialist rehabilitation.

There is clear evidence of under provision of specialist rehabilitation in London and adjoining areas with specialist rehabilitation beds in the region oversubscribed by a ratio of 5:1 to 3:1. The reported ratio of unmet need is commensurate with the steadily increasing number of referrals and is demonstrated by the current over subscription of referrals to ARU by 100%. The ARU currently has over 200 referrals per year for 20 beds and is able to admit in the region of 110 patients per year. In addition to the opportunities provided by under provision in the capital, the geographic location of Hillingdon and Mount Vernon Hospitals mean that THHFT is ideally located to draw in activity from the surrounding counties of Buckinghamshire, Hertfordshire and Berkshire. The next (westerly) significant specialist rehabilitation unit is situated at Stoke Mandeville Hospital, approximately 30 miles from THHFT.

In winter 2013/14, in order to scope potential demand the ARU clinical team worked with other rehabilitation providers and trusts requiring rehabilitation services to improve local networks and pathways. This included:

- Increasing links with the Major Trauma unit at St Mary's hospital through the NWL Major Trauma rehabilitation group and through shadowing opportunities for therapy staff. Following discussions with St Mary's it is anticipated that transfers to Mount Vernon will require the use of 4 beds.
- Discussions with the RNOH to develop a hub and spoke service for non-complex SCI patients with an anticipated requirement for 1-2 beds.
- The development of close working relations with neurological services at Charing Cross Hospital which will generate inpatient activity requiring 2 further beds.
- Development of clinical relationships with external trusts to raise awareness and build confidence in the service – anticipated requirement 3 beds.

A new 16 bed rehabilitation ward is planned to open on the Mount Vernon site in summer 2014; estates works are under way at the time of writing, as is recruitment. The expectation is that the number of referrals from Hillingdon CCG residents will remain at the current level but the Trust will be able to offer specialist rehabilitation to patients out of borough who are in need. This will be predominantly through increased links with St Mary's Hospital (Major Trauma Unit) and RNOH.

3.4.3 Scenario modelling for Radiology

Increases in demand and changes in standards are driving the need for the Trust to use network solutions to deliver Radiology out of hours reporting and Interventional Radiology. This will be the case in both scenario 1 (full SAHF) and scenario 2 (Partial SAHF). The only difference between the scenarios will be

that in scenario 2, the reduced amount of maternity activity will affect the requirements for the number of sonographers. A nominal sum has been included in the quality initiative fund to meet future requirements

Radiology Reporting

Radiology demand has been increasing continuously for the last 5 years and it is expected that the key drivers of demand (general population increase, over 60's, long term conditions) will remain unchanged for the next 5 years. This has created a pressure on reporting capacity.

In addition, the NHS operating framework (and the resulting London Health Programme service model) placed further pressure for faster turn-around times by specifying that all hospitals admitting medical and surgical emergencies should 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: Imaging and reporting within 24 hours.

A business case is currently being considered to increase resource through a quality investment at the Trust which would address current reporting performance, particularly during the 5 day week.

However, whilst extra capacity during 9am – 5pm weekdays can be achieved by recruiting additional local resource, the solution for out of hours reporting is best achieved using a network or outsourced arrangement. A number of outsource providers have been considered however the most economical solution will be to create an out of hours reporting network for North West London. This will be a strategic objective for the next 5 years and work is already underway to explore options with other potential partners.

Interventional Radiology

Interventional Radiology services are required on an emergency basis for several specialties including gastroenterology, renal, obstetrics and gynaecology. The Trust has only 2 IR consultants and like many acute hospitals cannot maintain an emergency rota in isolation. The reconfiguration of vascular services in North West London reduced the amount of local non-emergency work for interventional radiology providing further incentive to find a network solution for this service. This work will be taken forward as part of the SaHF reconfiguration with a plan to consider regional network solutions across acute providers.

3.4.4 Scenario modelling: Acute Medicine

The Trust is redesigning its emergency care facilities to support the delivery of a more integrated model of care, both within the acute setting, and more widely with other health and social care partners. A summary of some of the main principles that have been adopted for this programme are expressed below in the form of a measureable benefits:

- Patients should be seen by the right person in the right place, first time
- Reduced duplication of clinical input to patient pathways
- National clinical quality standards will be met
- The current Emergency Department targets would continue to be met
- Admission to hospital will be avoided wherever possible
- When admission is unavoidable, the aim will be for patient to be discharged in to a more appropriate care when clinically appropriate to do so
- The same standard of care will be available over an extended day 7 days a week

The main components of the new care model that are either new or materially redesigned are described below:

Acute Admissions Ward

A new 48-bedded Acute Admissions ward will be built and linked by a new corridor to be adjacent to the existing A&E, whilst also improving patient access to diagnostics. This will provide beds for the majority of emergency admissions, and will be the ward that the majority of patients who have a length of stay less than 72 hours will be admitted to and discharged from. The ward will have two side rooms which provide a negative pressure environment for nursing tuberculosis infected patients, the first of their kind in the Trust,

as well as a further six single rooms. The ward will also have a suite of 3 consulting rooms to house the ambulatory emergency care service.

As well as the general improvements set out above, further benefits will accrue as a consequence of this new facility such as:

- The co-location of patients will enable the acute physicians and surgeons to work more efficiently with the majority of acute admissions on one ward, stopping “safari ward rounds”.
- Reduction in the number of different medical staff who admit and review the same patient.
- Changes in the patient pathway to have direct admission of GP heralded patients to the new ward.
- Reduction in the number of times a patient moves on to different inpatient wards.
- Decommissioning of at least one inpatient ward and the relocation of two other wards on the annex corridor ward.
- Faster access to senior decision makers: there will also be a dedicated junior doctor ward team improving continuity of care for patients.
- The ambulatory emergency care service will allow GP’s to have access to consultant opinion; will provide an environment in which patients can have a clinical review and receive treatment; keeping the patient in the community; and will also reduce readmission rates.
- There will be a multidisciplinary approach to the care of the patients which will include social services, physiotherapy and occupational therapy and mental health services with the focus on safe efficient discharge.

The large majority of emergency admissions will be managed by acute physicians for the first 72 hours of their stay, with the clear philosophy of getting them fit for discharge as soon as possible. This has obvious quality and patient experience benefits such as to minimise the number of patient moves, increase continuity of care and reduce length of stay, which will translate to the potential closure of 18 beds. This will also be a lower cost model which will allow the Trust to reduce its operating revenue.

Majors & Clinical Decisions Unit (CDU)

Hillingdon CCG’s Commissioning Intensions 2013/14 identified the need to redirect patients from A&E to the UCC and to improve case management in the community of regular attenders. A&E attendances have risen year on year which has created capacity issues for the department, and the reduction in available space in the A&E caused by the creation of the UCC has resulted in an inadequately sized A&E. This, together with the lack of space for ambulance deliveries, has contributed to the Trust being financially penalised regularly for inability to achieve a satisfactory flow through the department.

A capacity model was prepared comparing activity to national norms, resulting in a requirement for 33 treatment spaces compared to the current 23 treatment spaces: a shortfall of 10 cubicles. The existing cubicles are also significantly below current space standards. The Trust has produced a case for additional A&E majors cubicles under the SaHF initiative.

There will also be, as part of the new Acute Medical Unit, a new assessment area known as Rapid Assessment and Triage” (RAT) which will facilitate a quicker clinical assessment, in which diagnostics can be ordered and the patient streamed to the appropriate area, with a target handover time of 15 minutes. In summary, the benefits that are projected to be delivered include:

- Earlier clinical assessment of patients.
- Reduced clinical risk and improved patient care and experience through the provision of an increased number of cubicles to provide assessment and treatment.
- Reduction in the number of patients waiting 3 hours for first assessment.
- The RAT service will allow diagnostics to be ordered and carried out earlier in the patient’s pathway.
- Reduction in the length of stay in the department of major’s patients.
- Supporting the overall objective of delivering patient care in the most appropriate care setting.

There will be an improved patient experience for adults and paediatrics, as well as a better working environment for staff. The co-location of the admissions ward and A&E means that the length of time it takes to move patients is reduced, releasing nursing and portering time. The change in the patient pathway for GP heralded patients will mean that the A&E doctors will not clerk the patient as there will be a single clerking process on the new ward, reducing the amount of medical time involved in this patient pathway.

Paediatric Emergency Care

The paediatric emergency care service will be reconfigured to centralise paediatric functions that include the paediatric cubicles, a Short Stay Paediatric Assessment Unit (SSPAU), a short stay paediatric unit for medically complex children which will be adjacent to Paediatric UCC cubicles.

Expected benefits include:

- Creation of a community healthcare ambiance for the paediatric waiting and treatment areas which feels less “clinical” to patients.
- Improved patient experience and continuity of care.
- Reduction in length of time of first assessment and in length of stay.
- Reduction in the risk of transferring and treating patients on the paediatric ward.
- Increased number of patients redirected to appropriate alternative community care.

The expansion of the number of beds in the SSPAU will produce a productivity benefit for the paediatricians, which will be reinvested in more patient contact. The scope of the service will also have an impact on the amount of paediatric inpatient beds which can be closed. Further work is required to fully model and outline the implications of the planned paediatric model of are although the estate proposals support a level of flexibility in the use and function of the clinical space.

Home Safe

The Home Safe model is an early supported discharge initiative as a result of an innovative 3 year CQUIN beginning in 2013. Its aim is to improve the interface between local primary and secondary care providers when reacting to the needs of the local frail older population. The project focuses on providing a seamless service for patients aged 65+ who have been admitted to the Emergency Assessment Unit and been identified as appropriate for a Comprehensive Geriatric Assessment (CGA) centred approach to their care.

By commissioning specialist support from local community partners in health, social care and the voluntary sector, patients can be rapidly turned around in the initial days of admission, reducing their length of stay and enabling them to return home with additional support on a temporary or more long-term basis. This model of care will expand to offer eligible patients who have already been admitted onto the base wards opportunities to receive early supported discharge using the same comprehensive multi-disciplinary principles. Falls assessment and discharge services and THH respiratory nurse specialist outreach team also contribute and deliver the early supported discharge service.

Scenario 2:

The impact of reconfiguring the provider landscape in NWL has been modelled by commissioners to include additional A&E attendances per year for Hillingdon from the downsizing of Ealing’s A&E; however Commissioners also propose that much of this increased activity will be offset by changes in out of hospital services. Under scenario 2, only 75% of the commissioner QIPP would be delivered including through the out of hospital strategy. In this event, and without SaHF investment in additional majors cubicles, the existing A&E facility would be unable to cope with the volumes of patients, causing major delays in ambulance handover and patient waits.

3.4.5 Scenario modelling Pathology

Pathology services at THHFT are currently provided in-house by a very well established and respected team. The service provides the full range of tests for Hillingdon and Mount Vernon hospitals but also has a number of external contracts including the Mount Vernon Cancer Centre, GP direct access services in Hillingdon and GP direct access services in Hounslow and parts of Buckinghamshire. On the 14th May 2014 the Trust was successful in winning the tender to provide GP direct access services to Ealing. Subject to contract, this service will commence on 1st October 2014. With the addition of the Ealing work the total number of tests performed per annum will rise by 50% from the current level of circa 5m to 7.5m. The economies of scale arising from these contracts mean that the Trust net cost of pathology tests is favourably low.

Looking forward the Trust is engaged in detailed planning for the NWL Modernising Pathology project with partners Imperial College Healthcare NHS Trust, Chelsea and Westminster NHS Foundation Trust and West Middlesex University Hospital. The objective is to create a joint venture that will run a centralised pathology lab for all cold pathology testing. The timescales for this venture are approximately 3 years. As

part of the negotiations for the creation of this venture the Trust has ensured that it will retain the current benefit of the low net cost of pathology tests. Any further efficiencies gains arising from the JV will be shared amongst the partners.

It should be noted that neither the Ealing contract nor any potential benefits from the Modernising Pathology JV have been included in the long term financial model at this stage.

i) Scenario 1: SaHF programme delivers in full

Under the scenario where SAHF is implemented in full, we expect the Trust to experience a minor increase in demand for Pathology tests associated with the increase in maternity and A&E activity. The out of hospital strategy is not expected to affect pathology demand but rather to transfer the location of some of the sample collection to community locations. The small overall increase in demand will therefore be accommodated by the in house facilities until such time as the Modernising Pathology reconfiguration takes place.

ii) Scenario 2: SaHF programme only delivers partially, no capital funding

If SAHF is only partially implemented we still expect to see an increase in maternity activity however as described above this will have only a minor impact on overall Pathology test volumes.

3.4.6 Scenario Modelling for Dermatology

In May 2014 the CCG commenced a competitive tender process for the provision of a consultant led community dermatology service in Hillingdon. When the full tender specification is available THHFT will decide whether it is commercially attractive to bid for this work. If the Trust does not bid, or if it loses the tender then a proportion of the current revenue, outpatient and daycase work will transfer to another provider. The exact proportion is not known until the tender spec is issued.

In all scenarios the Trust plans to pursue its goal of developing a specialist skin centre for secondary/tertiary treatment, probably on the Mount Vernon site. This will bring additional revenue which will either grow the dermatology service or compensate for the loss of the community outpatient work if THHFT does not win the tender.

The developments in dermatology described above apply under both the scenario 1 (full SAHF) and scenario 2 (partial SAHF)

3.4.7 Scenario modelling Research & Development

THHFT has a long history of participating in multi-centre research particularly in the areas of Cancer, Paediatrics, Cardiology, Haematology, Vascular and General Medicine that covers all the different types of studies; funded and unfunded both as chief investigator and as principal investigator. These have included commercial and non-commercial studies, the latter encompassing NIHR portfolio adopted studies and Student/Nursing /University research projects (MSc's, PhD's). The principal aim of the R&D department remains to protect the patients, the staff, the general public and the Trust from misadventure, whilst encouraging and permitting active research.

Established Active Research Areas

- Haematology
- Cancer (Colorectal / Breast / Urology / Prostate)
- Ophthalmology (NIHR funded research)
- Stroke medicine
- Cardiology

Active Areas for Targeted Development

- Diabetes Critical Care
- Ophthalmology (clinical trials)
- Urology
- Breast Surgery
- Rheumatology / musculoskeletal
- Paediatrics
- Reproductive health

- Respiratory
- Orthopaedics
- Hepatology

Ophthalmology is currently the most progressed of these initiatives. There is scope to monopolise on key reputational developments over the last year which includes being selected as the European training site for Novartis and the recruitment of a research and development consultant who is now the ophthalmic specialty lead for NW London Clinical Research Network (CRN). We have successfully bid for five clinical trials with a further seven planned. In the latest development THHFT have been selected for the Roche trials for new treatment of Dry AMD, one of 18 sites nationally and the only centre in NW London. Combined with a strong marketing strategy these are key building blocks that secures the Trust's position as a regional ophthalmology centre.

High quality R&D is best undertaken in partnership with other institutions and the Trust recognises that strong collaborative partnerships with Brunel University and other local universities are crucial for the success of our research activity. Alongside this, THHFT needs a strong relationship with the CRN to attract both the projects and the subsequent funding of research management and activity costs.

3.4.8 Scenario Modelling for Community Care Growth through New Business

A key part of the Trust's strategy over the next five years is to grow business by tendering for contracts to run community based services in surrounding geographies. This will be relevant in all SAHF scenarios assuming that CCGs continue to put services out for competitive tendering as required by the 2010 Health and Social Care Act. Running community health services will help to develop capabilities in integrated care and the Trust would expect to partner with other providers such as CNWL where appropriate.

The Hillingdon community health service is currently run by CNWL under a contract awarded in 2011 which is understood to be for three years extendable to 5 years. The immediate focus for THHFT growth is therefore in neighbouring geographies although there are significant potential collaboration opportunities with CNWL in Hillingdon as part of the Whole System Integrated Care Pilot and Better Care Fund initiative. There has been quite a wide variation in the amount of tender activity taking place in different CCGs. This probably reflects differences in quality of existing provision, the finances of the health economy as well as management philosophy. In recent months Ealing CCG has been particularly active and it is expected that other neighbouring CCGs will start to catch up over the coming years.

Services that lend themselves to delivery in the community include dermatology, MSK, diabetes, ophthalmology. Contract values vary substantially but are typically in the range of £2m-£3m per annum. A single contract therefore offers the potential for a material contribution to Trust sustainability assuming it can be won at a reasonable gross margin. To deliver on this strategy the Trust needs to develop its estates and IT infrastructure to deliver services in surrounding geographies. It also needs to develop systems of clinical and operational governance to ensure that remote services are safe and of high quality. Development of this capability will also help the Trust prepare to win defensive bids for the retention of any of its Hillingdon services that may be put out for tender by the CCG.