Public Document Pack

Health and Social Care Scrutiny Sub (Community and Children's Services) Committee

Date: **WEDNESDAY, 2 MAY 2012**

Time: **1.45pm**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL**

Members:
Revd Dr Martin Dudley (Chairman)
Angela Starling (Deputy Chairman)
Nicolas Cressey
Deputy Henry Jones
Peter Leck
Deputy Joyce Nash
Sheriff & Deputy Wendy Mead
Deputy Revd Stephen Haines
Dr Peter Hardwick
Vivienne Littlechild
Nick Kennedy
Steve Stevenson

Enquiries: **Caroline Webb**
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Lunch will be served in the Guildhall Club at 1.00pm

Chris Duffield
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **DECLARATIONS BY MEMBERS OF PERSONAL AND PREJUDICIAL INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**

3. **MINUTES**
To agree the public minutes of the meeting held on 17 February 2012 (copy attached).

For Decision
(Pages 1 - 6)

4. **OUTLINE BUSINESS CASE FOR ST LEONARD'S HOSPITAL**
Report presented by Steve Gilvin, Director of Primary Care Commissioning (copy attached).

For Information
(Pages 7 - 104)

5. **CITY AND HACKNEY URGENT CARE PROGRAMME**
Verbal update from Steve Gilvin, Director of Primary Care Commissioning.

For Information

6. **LONDON AMBULANCE SERVICE**
Report presented by Emma Williams, Service Development and Policy Manager and Anna Starling, Service Development Officer (copy attached).

For Information
(Pages 105 - 108)

7. **ASSISTED CONCEPTION POLICY FOR SUB-FERTILITY**
Report presented by Anna Stewart, Associate Director, Technical Contracting NHS ELC and Dr Maggie Harding, Locum Health Consultant NHS ELC (copy attached).

For Information
(Pages 109 - 118)

8. **LEAVING HOSPITAL**
Report presented by Jakki Mellor-Ellis, City LINk Urgent Care Lead and Jenny Purcell, City LINk Officer (copy attached).

For Information
(Pages 119 - 128)

9. **INSIGHT IN TO CITY DRINKERS**
A report of the City of London Substance Misuse Partnership (copy attached).

For Information
(Pages 129 - 168)

10. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

11. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

12. **DATE OF NEXT MEETING**
Tuesday 25 September at 1.45pm

13. **EXCLUSION OF THE PUBLIC**
MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act as follows:-

Item No.	Exempt Paragraph(s) in Schedule 12A
14	2
15-16	-

Part 2 - Non-Public Reports

14. **PROFILING MENTAL HEALTH SERVICE USE IN THE SQUARE MILE**
Report presented by Dr Cynthia White, City LINk Mental Health Lead and Dr Kevin Corbett, Canterbury Christ Church University (copy attached).

For Information
(Pages 169 - 258)

15. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY SERVICES) COMMITTEE

17 February 2012

Minutes of the meeting of the HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY SERVICES) COMMITTEE held at Guildhall, EC2 on Friday 17 February 2012 at 1.45pm.

Present
Members:
The Rev'd Dr Martin Dudley **(Chairman)**
Deputy Billy Dove **(Deputy Chairman)**
Deputy the Rev'd Stephen Decatur Haines
Deputy Henry Jones
Peter Leck
Angela Starling
Nicholas Cressey (appointed by Court of Common Council)
Vivienne Littlechild (appointed by Court of Common Council)
Steve Stevenson (co-opted - LINk Member)
Nick Kennedy (co-opted - LINk Member)

Officers:

Caroline Web	-	Town Clerk's Department
Neal Hounsell	-	Community & Children's Services Department
Farrah Meherali	-	Community & Children's Services Department
Keith Manaton	-	Community & Children's Services Department

In Attendance:

Lee Eborall	-	Head of Hospital Contracting, City and Hackney at NHS East London and the City

1. APOLOGIES

Apologies were received from Dr Peter Hardwick.

2. DECLARATIONS BY MEMBERS OF ANY PERSONAL AND PREJUDICIAL INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

City of London resident Members declared personal interests in all the agenda items, as users of the services under discussion. They did not consider these to be prejudicial interests.

Nick Kennedy declared a personal interest in Item 5 as Chairman of the City LINk, the current City Healthwatch Pathfinder organisation.

3. MINUTES

The public minutes and summary of the meeting held on 23 November 2011 were approved.

MATTERS ARISING

Merger of the Three NHS Trusts in North East London

Vivienne Littlechild stated her dissatisfaction in the response from Dr Lucy Moore regarding the annotated legal advice relative to formal consultation on the proposed merger of the three NHS Trusts. Mrs Littlechild stressed the importance of obtaining the full legal advice in order to demonstrate that the Sub Committee had fully scrutinised the proposals should they be accused of negligence in the future. The Deputy Chairman supported Mrs Littlechild's concerns. Acknowledging the risk involved in the merger, the Chairman pointed to the discussion with Dr Ryan recorded in the minutes that demonstrated the Sub Committee's attention to the matter. The Strategy and Performance Director was mindful of Mrs Littlechild's concerns but advised that a satisfactory response had been received in relation to the question that had been asked. The Strategy and Performance Director undertook to consult other Scrutiny Committees to investigate whether similar issues had been raised and felt that a joint-up approach may lead to a more detailed response.

4. URGENT CARE SERVICES UPDATE

The Sub-Committee received a brief presentation from Lee Eborall, Head of Hospital Contracting, relative to the proposed changes to urgent care services in the City of London and Hackney.

Mr Eborall highlighted that current provision for City residents is largely through the GP Out of Hours through Harmoni and A&E through Barts and the London Hospital. The 'Phone before you go' 111 service would allow City residents to receive urgent medical help or advice in non-life-threatening situations outside of GP opening hours, either as part of the telephone assessment or by directing residents to the right local service as quickly as possible. It was noted that there could be confusion around the difference between 'emergency' and 'urgent' care and that callers with non-urgent ailments would be referred back to their GP. Mr Eborall informed Members that the 111 programme was currently on hold and was likely to 'go live' within the next financial year.

The proposals to decommission the two walk in centres (WICs), Tollgate Lodge and Springfield, both in north east Hackney, would not have a direct impact on City residents. The WICs were working closely with Homerton Hospital to ensure there was appropriate GP coverage and good service response times. Mr Eborall informed Members that full engagement with residents had been conducted City wide, particularly through LINk events and group meetings. Patients using the walk in centres at Tollgate Lodge and Springfield had been consulted directly; however, no patients at the Barts minor injuries unit had been consulted, despite plans to decommission this City service. He stressed that City and Hackney were keen to realign the healthcare needs of the City, so, for example, options were currently being considered to align GP out of hours services with Tower Hamlets.

It was noted that the Neaman Practice had been selected as a potential pilot site for the 'GP Choice' scheme which would allow patients to choose whether to register with a practice close to their workplace or home. Another pilot site was situated in Tower Hamlets. The City pilot would run from June 2012 –

March 2013. Mrs Littlechild stated that this was not her understanding of the situation with regard to the Neaman Practice.

A number of Members, who were also City residents, expressed concern over the lack of consultation that had been carried out with residents. There were also questions raised over the training and experience of the call handlers. Mr Eborall stated that various resident engagement events had taken place and more would be held closer to the 'go live' date. He also reassured Members that various steps had been undertaken to ensure all members of staff were well trained and aware of the diversity within the City and Hackney.

Mr Eborall, in answer to a question from a Member, stated that the service provision for young people had also been investigated, particularly as they may be more reluctant to call for services. He highlighted that Bristol had created an application for smartphones in order to provide similar 111 services for young people and that a similar scheme could be launched in the City once 111 was launched. The Strategy and Performance Director agreed to work with Mr Eborall to explore options in consultation with City youth advisors.

A Member, also the Chairman of the LINk, expressed concern over the impact of decommissioning the Liverpool Street WIC in 2010 due to the high population density within the City. He stated that the WIC were highly valued where GPs were not accessible, particularly in regards to opening hours. WICs tended to be heavily used by immigrants, homeless people and by patients with mental health needs as they generally found A&E services difficult and aggressive. Mr Eborall assured the Member that his concerns would be addressed appropriately and articulated in future reports.

Mr Eborall stated that he could not comment on the costs of the 111 service at this moment in time as it was still undergoing the procurement process.

Members were informed that increased opening hours at current GP practices were being explored and that the websites were currently being developed to ensure City residents have easy access to consultation information.

The Strategy and Performance Director stressed to Members that the City Wellbeing Practice and the Neaman Practice had only agreed to meet with NHS East London and the City of London in March to discuss the GP Choice pilot scheme and had made no commitment to become a site for the City pilot.

RECEIVED

5. PROGRESS TOWARDS CITY HEALTHWATCH

The Sub Committee received a report of the Director of Community & Children's Services outlining the background to Healthwatch and the progress to date nationally.

RESOLVED: That:

(i) the progress in establishing Healthwatch nationally and locally and the proposals for Healthwatch England be noted;

(ii) the current City Healthwatch Pathfinder organisation (City LINk) should take on the City Healthwatch responsibilities from the 1st April 2013 be agreed principally; and

(iii) a progress report on the City Healthwatch be submitted to the Community & Children's Services Committee in September 2012, with a subsequent report submitted for approval by the Grand Committee following the successful establishment and incorporation of City Healthwatch in January 2013.

6. IMPACTS OF RECENT GOVERNMENT GUIDANCE RELATING TO PUBLIC HEALTH

The Sub Committee received a report of the Director of Community & Children's Services which provided an overview of recent public health policy guidance released by the Department of Health. The roles and responsibilities of local government in public health and the public health outcomes framework were also outlined.

It was noted that the public health budget estimate for the City had been released. This had been based upon the current joint public health budget with Hackney, with around £116 per head of population, the second highest in London, being allocated.

RECEIVED

7. HEALTH AND WELLBEING PROFILE 2011 (JOINT STRATEGIC NEEDS ASSESSMENT)

The Sub Committee received a report of the Director of Community & Children's Services summarising the 2011 Joint Strategic Needs Assessment (JSNA), locally known as the Health and Wellbeing profile.

It was noted that the proposed JSNA priorities for residents of the City were listed in order of significance; however the weighting attributed to each of the priorities was the result of an assessment which was based on available evidence, as well as acknowledging "known issues" which did not necessarily have as strong an evidence base e.g. 2001 census data.

The importance and significance of the views of the Health and Wellbeing Board were discussed in relation to the influence they may have on other departments throughout the City of London Corporation.

It was noted that the consequences of the current cuts to mental health and voluntary sector funding may need to be explored.

RECEIVED

8. ANY QUESTIONS RELATING TO THE WORK OF THE SUB COMMITTEE

There were no questions.

9. ANY OTHER URGENT BUSINESS

Commissioning Support Organisation

The Commissioning Support Organisation prospectus was tabled. The Strategy and Performance Director informed Members that a ONEL Joint Health Overview and Scrutiny Committee was to take a presentation on the proposed Commissioning Support Organisation at its next meeting on Tuesday 10 April at 3.30pm at Waltham Forest Town Hall. The Health and Social Care Scrutiny Sub Committee had been invited to nominate a representative to attend the meeting on the Sub Committee's behalf.

10. DATE OF NEXT MEETING

Wednesday 2 May 2012 at 1.45pm

The meeting closed at 3.00pm

CHAIRMAN

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BETTER SERVICES FOR ALL AT A REDEVELOPED ST.LEONARDS

Outline Business Case

NHS

North East London and the City

healthquantum
driving change in healthcare

Draft 2.0

12 April 2012

Document History			
Version	**Date**	**Author**	**Comments**
1.0	13 June 2011	Alan Davison	First Working Draft
1.1	23 June 2011	Alan Davison	Second Working Draft with strengthened service strategy and activity revisions
1.2	16 September 2011	Alan Davison	Additional do minimum option and services updates
1.3	25 January 2012	Alan Davison	Update re JNSA
1.4	21 February 2012	Alan Davison	Update re travel times, population data and primary care objectives / refresh
1.5	28 March 2012	Alan Davison	Update re further staff numbers, clinic use assumptions and benefits criteria / scoring.
2.0	12 April 2012	Alan Davison	Update re ward population growth and financial revisions.

CONTENTS

1 EXECUTIVE SUMMARY

1.1 Introduction and background

This outline business case proposes a new resource centre at St. Leonards Hospital, Hackney to provide high quality community services and new premises for GPs. The scheme will allow the demolition of existing poor quality buildings on site and, subje ct to planning, the disposal of the site to provide a significant capital receipt for the NHS.

1.2 The strategic case

The case for change is compelling and must start with the stark differences in the health of our residents across Inner North East London. The financial climate makes it imperative that we improve productivity and efficiency across the whole health system to ensure we get better value for money. Better use and part disposal of the St.Leonard's site is a striking opportunity.

The context and strategic landscape have changed radically over the last year. The key drivers in revisiting the service strategy include:

- the revised approach to clinical networks or polysystems and their affordability following the election of the new government in May 201
- the need to determine how activity is shared between GP surgeries and resource centres or hubs
- the need to review service strategies with GP commissioners following the revised NHS Operating Framework
- the need to satisfy the four Lansley tests
- the shift in balance towards clinical commissioning
- the requirement to ensure existing estate is fully utilised before any commitment to redevelopment
- the challenging financial climate
- the unaffordability of the previous business case proposals.

The proposals in this business case need to be seen in the context of the increasing influence and responsibilities of the two commissioning consortia, ELIC and KLEAR. In accordance with government plans to devolve commissioning responsibility clinical commissioning groups North East London & the City (NELC) has worked closely to ensure broad support for the strategy. NELC therefore developed a process for this review which included individual discussions with each PBC consortium, a workshop with the

Commissioning Clinical Executive, a workshop with senior managers and clinicians from the Community Services including senior managers from the Homerton.

The starting point has been to determine what services can appropriately and safely be provided more locally, consistent with a critical mass to use skills, equipment and other resources effectively. There is agreement around a requirement for a new development to accommodate a smaller range of services that is likely to require a significantly smaller building than originally proposed. The key services that will be accommodated within the redevelopment are as follows:

Primary Care:

- A new surgery for the Southgate Road practice to consolidate all of its services from the current Southgate Road surgery and Whiston branch surgery;

Adult Community Services:

- Reprovision of the wheelchair service;
- Adult Community Reablement Team;
- Locomotor service including physiotherapy gym;
- Sexual health services currently provided in the Ivy Centre and some development of services in early pregnancy including access to ultrasound;
- Foot health with a review of the referral thresholds for the service
- Mobile dentistry
- Mobile diagnostics
- Voluntary services
- Complementary therapy

Primary Mental Health Care:

- Primary care psychology including access to cognitive behavioural therapy
- Tavistock primary mental health services
- Further work to be done on improving liaison with Community Mental Health Team.

1.3 The economic case

In discussions with key stakeholders the following options were agreed:

- Do nothing where services remain as at present
- Option 1: Do minimum with some backlog maintenance eradicated
- Option 2: A new build development which accommodates all current services on the St. Leonards site and two neighbouring surgeries
- Option 3: As Option 2 but without the Whiston Road surgery which moves to its sister site at Southgate Road

Option 2, the new build, emerges as the preferred option in terms of weighted scores, with Option 3, the Southgate Road option, coming a poor second.

In terms of value for money Option 2 produced the lowest cost per unit of benefit and is therefore the preferred option.

1.4 The financial case

Current revenue costs of St. Leonards are some £1.2m p.a. for estates costs, such as maintenance, facilities management costs, security, rates, and capital charges. A commercial lease back to the NHS of the new facility with its lower running costs will mean there should be a net recurrent saving each year of just over £200,000. In addition there will be a capital receipt to the NHS from the disposal and development of the remainder of the site. One option open to NELC is to capitalise the lease cost and reduce or eliminate the rental costs by foregoing some or all of the capital receipt. The effect of this could be to avoid some £726,000 rent p.a. for a commercial lease thereby increasing the recurrent savings.

1.5 The commercial case

Specialist advice suggests that, taking account of likely density and planning constraints, the development will be a significant regeneration project providing approximately 267 residential units and approximately 2,700m2 of healthcare facilities. On this basis the conclusion is that the site has a baseline value without planning of £11.5m and with planning £16m. In addition, the NHS should be able to benefit from a share of profits over and above certain threshold and after costs have been recovered.

A joint venture approach is recommended to ensure the best commercial plan and deal is reached and the maximum capital gain realised for the NHS.

1.6 The management case

NELC has already identified clear responsibility for taking the project forward by designating David Butcher as the Project Director.

A formal project team should be established to take the scheme through the next stages.

1.7 Conclusions and recommendations

The main conclusions of this OBC are that:

- The status quo cannot continue given the state of the buildings at St. Leonard's and the need to meet patient needs after the aborted previous scheme
- There are significant revenue savings to be realised
- There is potential for achieving a significant capital receipt for the NHS
- The Lawson practice is willing to make better use of its modern and recently extended surgery
- The LIFT procurement route proposed in the last business case is no longer appropriate
- A joint venture approach would seem to offer the greatest reward to the NHS at minimal risk.

2 INTRODUCTION AND BACKGROUND

2.1 Introduction

This business case proposes a new resource centre at St. Leonards Hospital, Hackney to provide high quality community services and new premises for GPs. The scheme will allow the demolition of existing poor quality buildings on site and, subject to planning, the disposal of the site to provide a significant capital receipt for the NHS.

2.2 Previous plans

NHS City & Hackney had previously developed proposals for the redevelopment of St. Leonards as a Primary Care Resource Centre. The project received Outline Business Case (OBC) approval from NHS London in December 2008 for a building of approximately 6,650 sq metres. On this basis NELC proceeded to work up full design, working closely with East London NHS Foundation Trust (ELFT) in ensuring that the scheme was consistent with the plans for the redevelopment of the eastern half of the site for an in-patient Mental Health Unit (MHU.)

NHS City and Hackney achieved full planning approval for the project and ELFT received outline planning approval for the MHU following extensive discussions with the planners, GLA and English Heritage. NELC undertook extensive public consultation on the scheme including mail outs to the local population, meetings with local resident associations and immediate neighbours to the site. The Full Business Case was submitted to NHSL in January 2010 and was approved by the NHS City and Hackney Board in March 2010.

However, due to a number of factors NHS London, the East London and City Alliance and NHS City and Hackney agreed in May 2010 that a major review of the Business Case should be undertaken.

There were several factors that led to the decision to review the Business Case:

- The scale of the affordability challenge facing NELCs means that clinical commissioners need to identify services that might in future be delivered in the community (either in practice or other locations) instead of in hospital and activity assumptions needed to be revisited;

- All NELCs were required to review service strategies with GP commissioners following the revised NHS Operating Framework tests (June 2010).
- The requirement to ensure existing estate is fully utilised before any commitment to redevelopment.
- The need to take account of changes to the local strategic plan through the revised approach to polysystems following the election of the new government in May 2010 and the development of clinical networks and the Transforming Community Services (TCS) programme. In particular the size and cost of the project in a challenging financial environment for the NHS needed to be reviewed.
- The affordability of the clinical networks (or polysystem) leading NHS London to request that the Business Case demonstrate the affordability of the service model, in effect a requirement to provide a more detailed analysis of the activity to be undertaken in each Resource Centre and the proportion in the GP practices.

NHS City and Hackney has therefore worked with Practice Based Commissioners, the Community Services and the Homerton University Hospital to review the service case underpinning the original business case. A review was undertaken with the support of PwC with the following aims:

- To consult with clinical commissioners about the service plans that determine the proposed size of the Centre to agree with them the final versions of the service models and levels of activity that underpin them;

- To undertake a review of the options for St. Leonard's in the light of the activity and affordability analysis, including options for redesigning the Centre with reduced space. The option appraisal will include the impact of the redesign on the financing of the project and on the timetable for delivery.

- To consult the Community Services, the Homerton as the preferred new provider of Community Services on the plans for St. Leonard's.

The process for this review included individual discussions with each PBC consortium, a workshop with the Commissioning Clinical Executive, a workshop with senior managers and clinicians from the Community Services including senior managers from the Homerton followed by a joint workshop to agree the services that needed to be accommodated within the new development.

The outcome of this process has been agreement around a requirement for a new development to accommodate a smaller range of services that is likely to require a significantly smaller building than originally proposed.

2.3 The scope of this outline business case

In summary there is a case for developing a new primary care centre on the St. Leonards site but one that is significantly reduced in size from the proposed building in the Full Business Case approved by the Board at its meeting in March 2010. These changes have been made to take account of the changed financial position of the NHS, the renewed importance of ensuring that the plans have the support of GP commissioners and to ensure that the existing primary care estate has been fully utilised before new space is constructed.

This OBC has been prepared in accordance with the agreed standards and format for business cases, as set out in Capital Investment Manual and the Treasury Green Book: A Guide to Investment Appraisal in the Public Sector.

The document follows the approved format of the Five Case Model which allows the scheme to be explored from five perspectives:

The **strategic case** explores the case for change, whether the proposal is necessary and how it fits in with the overall local and national strategy.

The **economic case** asks whether the solution offered provides meets future service requirements and provides the best value for money – it requires alternative options to be considered and evaluated.

The **commercial case** tests the likely attractiveness of the proposal to developers – whether it is likely that a commercially beneficial deal can be struck.

The **financial case** asks whether asks whether the financial implication of the proposed investment is affordable and confirms funding arrangements.

The **management case** highlights implementation issues and demonstrates that the Trust is capable of delivering the proposed solution.

3 STRATEGIC CASE

3.1 The case for change

The case for change is compelling and must start with the stark differences in the health of our residents across Inner North East London. Health inequalities are unacceptably wide both within the sector and when compared to other parts of London. Hackney is the 2nd most deprived borough in the country. Tower Hamlets and Newham have the highest all age all cause mortality rates and although the 3 boroughs have seen a decrease in all age all cause mortality over the last ten years at a similar rate to that of London and England, the gap is not closing. The index of multiple deprivation shows severe inequalities.

The overarching vision of the East London and the City Alliance is to create a healthier future for local people, working within the health economy to ensure equitable access to high quality services, reducing health inequalities so that life expectancy improves and the quality of life is enhanced.

Planned economic regeneration will increase employment opportunities which will improve the overall well-being of families in some of the most deprived areas of London. North East London is home to two of the 'Zones of Change' within the Thames Gateway Development the UK's largest programme of urban regeneration in specific areas identified as most likely to see significant population growth over the next 15 to 20 years. Acknowledged as one of the most socially and economically deprived areas in England, the Thames Gateway is undergoing significant physical, social and environmental regeneration which brings many opportunities for the residents of inner NEL as it involves investment in the Lower Lea valley. Investment in housing and social regeneration stimulated by the Thames Gateway and the 2012 Olympic & Paralympic Games has continued despite uncertainty associated with the recession, with concentrated large site developments planned for Newham and Tower Hamlets.

The way we provide services and they way they are sometimes accessed by patients need a radical change of thinking and behaviours by both providers and users. Access to care is frequently poor both in terms of geography and delay. Care is often fragmented which means patients having to make several visits to different locations to access services all too often delivered by different staff. This is particularly a problem for people with long term conditions. The choices patients have are limited and we need not only to increase choice but to ensure that services are integrated or co-located as far as is practical and that staff skills are developed in more innovative ways and used more efficiently and effectively.

Finally, the financial climate makes it imperative that we improve productivity and efficiency across the whole health system to ensure we get better value for money.

Despite these economic and social challenges, however, there is much to be proud of and to celebrate. Although the forces that shape the health and wellbeing of the people of Hackney and the City are diverse, the considerable efforts of all partners in the local economy have made, and continue to make, a real difference to the health and wellbeing of local people. Across many areas of need, and many indicators of health and wellbeing, we can point to important year-on-year improvement,
including this year:

- A significant improvement in male life expectancy in Hackney, helping to close a long-standing inequalities gap
- The lowest rate of teenage pregnancy in Hackney and the City since concerted action began 10 years ago to reduce conceptions in the under 18 age group
- A further increase in the employment rate in Hackney, taking it above the average rate for London for the first time
- Reductions in violent crime in both Hackney and the City
- Improvements in educational achievement at all levels in Hackney
- A big increase in the number of people in Hackney and especially the City quitting smoking
- Falls in alcohol-related hospital admissions and alcohol-related crime in both Hackney and the City
- A decline and stabilisation of TB incidence in Hackney and the City
- Declining rates of new diagnoses of sexually transmitted infections in local sexual health clinics
- High and improving rates of breast-feeding in Hackney and the City;
- A major long-term decline in the number of children killed or seriously injured on the roads in Hackney and the City
- Significant improvement in the number of people surviving breast cancer
- Long-term decline in deaths from coronary heart disease and a narrowing of the inequality gap between men and women
- Lower than average emergency hospital admissions despite exceptionally high attendance rates at A&E departments.

Many longstanding obstacles to health and wellbeing in Hackney and the City will be overcome only through concerted, long-term effort. Challenges include:

- High levels of deprivation and child poverty throughout Hackney and in parts of the City
- A high rate of incapacity benefit claimants and an increasing rate of job seekers allowance claimants
- A projected increasing prevalence of illness in the over 65 age group in Hackney and the City
- High rates of dental decay among adults and young children in Hackney and the City
- High levels of childhood obesity and increasing prevalence of adult obesity in Hackney and the City
- High incidence of sexually transmitted infections and increasing prevalence of HIV in the local
- population
- Low rates of early booking for antenatal care in Hackney and the City
- Low rates of childhood immunisation in Hackney and the City

- Low awareness among local people of the behavioural risk factors for cancer and the symptoms of
- early cancer and low take-up of cancer screening
- High prevalence of severe mental health conditions and depression in Hackney and the City and a high incidence of suicide.

The recent draft of the Joint Strategic Needs Assessment states that people with long-term conditions are intensive users of health and social care services. It is estimated that the treatment and care of those with long-term conditions accounts for 69% of the primary and acute health care spend in England. The report adds that "long term conditions such as coronary heart disease stroke and cancer are among the leading causes of premature death locally and make a major contribution to the differences in life expectancy between Hackney, the City, and the average for England. Focusing on long term conditions makes economic sense and can transform lives, helping people achieve good health and wellbeing"[1].

3.2 Population profile

Table 1 shows the 2010 population projections for Hackney and the City produced by the ONS[2] and GLA[3]. The official ONS estimate suggests that the total population for Hackney and the City is 227,000 people. The GLA estimate is 5% higher than this (over 11,500 additional people). If the GLA estimate is more accurate, the funding currently provided by central government for local services may be inadequate. A local study which estimated the population of Hackney in 2007 using local administrative data also suggested that the official estimate is too low.

The ONS has recently changed its methodology for estimating population to take better account of student and international migration. This has resulted in a much higher population estimate for the City but not for Hackney. As there is no local evidence of the change in the City's population, particularly of an increase in the supply of housing, this revision may not be reliable. The ONS acknowledges that its population estimate for the City of London, which uses the same methodology as for much larger administrative areas, is 'considered to be less reliable than for other areas. The City of London uses the GLA's estimates for planning purposes as these take account of the constraints of housing supply.

[1] City and Hackney Health and Wellbeing Profile 2011/12: Our Joint Strategic Needs Assessment
[2] ONS: 2008-based Subnational Population Projections by sex and quinary age.
[3] GLA: 2009 Round of Demographic Projections - (Strategic Housing Land Availability Assessment revision), September 2010

Table 1: 2010 resident population estimates for Hackney and the City (ONS, GLA)

	City	Hackney	City & Hackney
ONS population estimate	12,400	214,600	227,000
GLA population estimate	9,502	229,036	238,538

The recent analysis by Mayhew Associates[4] found that from June 2007 to March 2011 the population of Hackney grew by 6.5% from 223,171 to 237,646. This growth was driven by an increase in the young adult and young child age groups, with particular growth in 25-34 year olds and under 5s.

Hackney is an inner London borough in the north east of the capital and has an area of 19.1 square kilometres. The City lies at the heart of London and covers an area of only 2.9km^2 ('the square mile') but has a relatively small resident population. The population density of Hackney is 11,249 people/ km^2 (using the ONS population estimate). By comparison, Greater London has a population density of 4,961 people/ km^2. Hackney's high population density – the fourth highest in London – reflects the character of the housing in the inner city which is dominated by flats and terraces rather than the larger, detached houses that are more common in outer London boroughs.

Hackney has a young population with more than one in four (26%) of its residents aged under 20 years and nearly two in five (39%) aged between 20 and 39 years. One in five (20%) of Hackney's population is aged over 50.

3.3 Future population growth

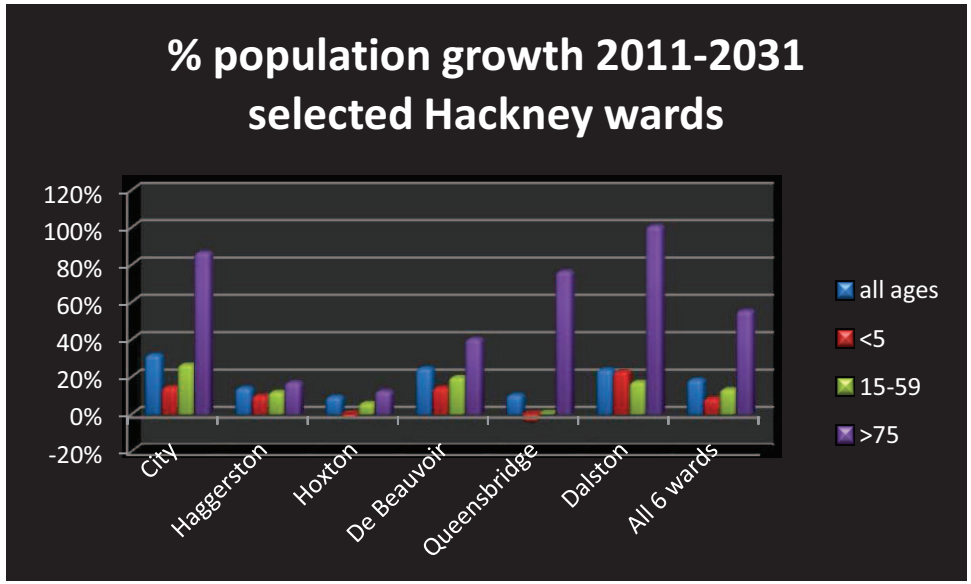
The most recent population projections from the GLA take account of the long-term prospects for housing availability in the area as defined by the 2009 Strategic Housing Land Availability Assessment for London[5]. The availability of housing is a core constraint on migration in an inner city area.

After decades of decline, Hackney's population started to grow in the early 1990s when there were more births than deaths and young people started moving into the borough. Growth is expected to continue over the coming decades, with the GLA predicting that Hackney's population will exceed a quarter of a million by 2021. By 2031 the population of Hackney is projected to increase by a fifth (20%) compared to 15% in London as a whole.

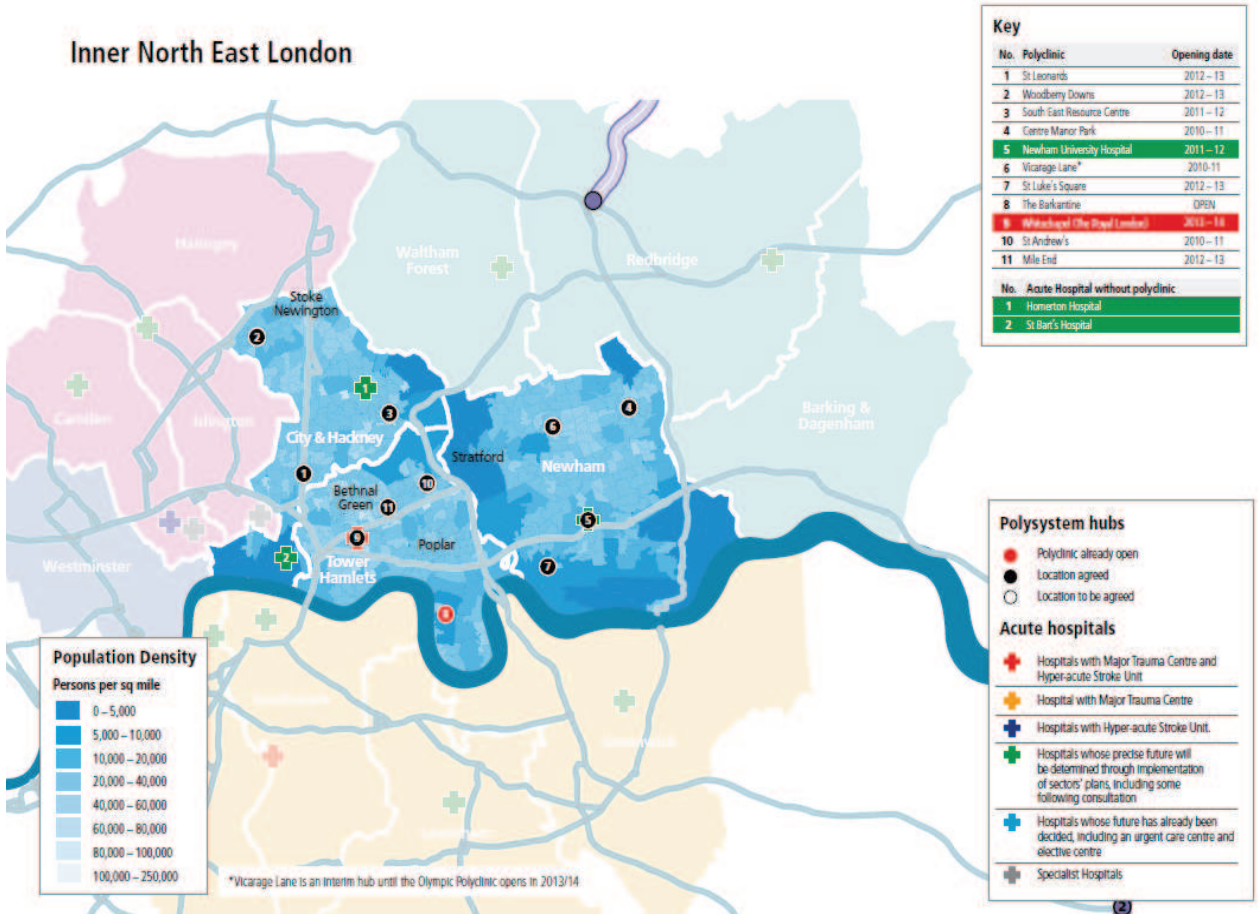
[4] Mayhew I, Harper G, Waples S: *Counting Hackney's population using administrative data – an analysis of change between 2007 and 2011*. Mayhew Harper Associates, 2011.
[5] Mayor of London: The London Strategic Housing Land Availability Assessment and Housing Capacity Study 2009, GLA 2009.

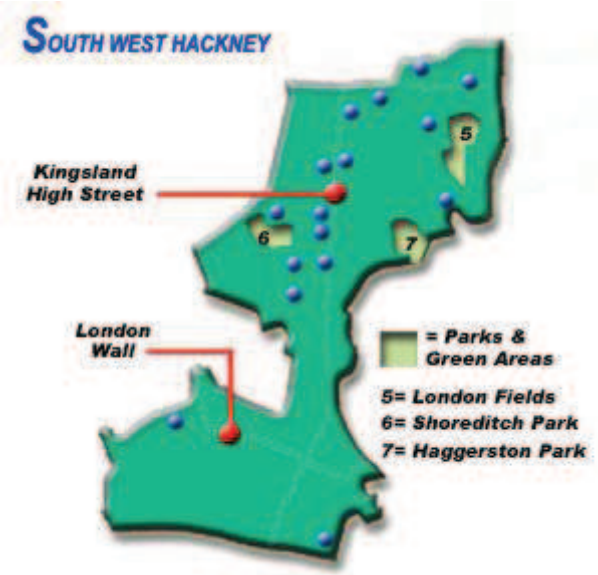
The growth in Hackney's population over the next 10-20 years is expected to be primarily in older age groups with the population under 20 years old remaining stable. The major growth to 2021 is projected to be in the 40-59 age group (a 24% increase on the 2006 population). In the decade following, to 2031, the major growth will be in the 60+ age group (a 38% increase on 2006 and a 20% increase on 2021).

Further updated analysis has been done by EL&C Health Intelligence Unit based on GLA 2010 estimates. This shows for the south west of Hackney and the City a change in the overall population from 85,070 in 2011 to 100,160 by 2031, a 17.7% increase. In order to adjust for any intra-Borough variations account has taken of the six wards likely to feed into the St.Leonard's site as shown below:



The increase in people over 75 years of age for the same period is 55%. The above confirms that it is prudent to allow for an expected growth assumption of 18% for all ages to 2031 and this has been fed into the activity and space modelling in this OBC.


Inner North East London
Waltham Forest
Redbridge
Barking & Dagenham
Stoke Newington
City & Hackney
Stratford
Newham
Bethnal Green
Poplar
Tower Hamlets
Westminster
Population Density
Persons per sq mile
0 – 5,000
5,000 – 10,000
10,000 – 20,000
20,000 – 40,000
40,000 – 60,000
60,000 – 80,000
80,000 – 100,000
100,000 – 250,000
*Vicarage Lane is an interim hub until the Olympic Polyclinic opens in 2013/14
Key
No. Polyclinic Opening date
1 St Leonards 2012 – 13
2 Woodberry Downs 2012 – 13
3 South East Resource Centre 2011 – 12
4 Centre Manor Park 2010 – 11
5 Newham University Hospital 2011 – 12
6 Vicarage Lane* 2010-11
7 St Luke's Square 2012 – 13
8 The Barkantine OPEN
9 [redacted]
10 St Andrew's 2010 – 11
11 Mile End 2012 – 13
No. Acute Hospital without polyclinic
1 Homerton Hospital
2 St Bart's Hospital
Polysystem hubs
Polyclinic already open
Location agreed
Location to be agreed
Acute hospitals
Hospitals with Major Trauma Centre and Hyper-acute Stroke Unit
Hospital with Major Trauma Centre
Hospitals with Hyper-acute Stroke Unit.
Hospitals whose precise future will be determined through implementation of sectors' plans, including some following consultation
Hospitals whose future has already been decided, including an urgent care centre and elective centre
Specialist Hospitals



The South West area of NHS City & Hackney covers Shoreditch, Hoxton, Dalston, Haggerston, London Fields and the City of London. It is bounded by Islington to the west, Tower Hamlets to the east, and the river Thames to the south. It is well connected by bus routes and overground trains. Although the southern part of the patch is connected to the underground the northern areas are not very conveniently connected. The City of London, as a major international centre for trade and finance, has a markedly different demographic, socio-economic, ethnic and health profile from the rest of the patch.

Local people endorsed the consultation proposals to develop the St Leonard's Hospital site as the Primary Care Resource Centre serving the South West and for 3 practices to operate from the site, of which 2 would be incorporated into a new building. Given the revised nature of the proposals in this OBC NELC intends to consult with local stakeholders once more. Section 244 of the National Health Service Act 2006 sets out the requirement for local health organisations to request Local Authority Health Overview and Scrutiny Committees (HOSCs) to review and scrutinise proposals for reconfiguration of health services. HOSCs have an important statutory role in relation to the reconfiguration of health services provided by NHS organisations in England. This includes the power to refer contested decisions to the Secretary of State for Health.

3.4 Clinical commissioning groups

At present, commissioning functions are split between NELCs and the two commissioning consortia, ELIC and KLEAR. The government plans are to devolve commissioning responsibility to GP consortia who will be renamed clinical commissioning groups. Shifting the commissioning function to these groups will ensure that clinical decisions are aligned with the financial consequences of those decisions. GPs are well placed to design care packages for patients, which should lead to improved health outcomes and tighter financial control.

GP commissioning will need assuring at a higher level. Alongside this, some commissioning decisions, for example those around specialised commissioning, will not be appropriate to be performed at GP consortia level, as the numbers of cases commissioned from any one consortia will be low. These functions will be undertaken by the NHS Commissioning Board who will be accountable to the Secretary of State.

The GPs and local commissioning boards have been fully engaged with the development of resource centres in City & Hackney and are supportive of the outcome of the proposal and this next phase to develop the Outline Business Case.

3.5 The key tests

The Secretary of State has identified four key tests for service change which are designed to build confidence within the service, with patients and communities. The tests were set out in the revised Operating Framework for 2010-11 and require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice.

In assessing compliance with these tests, "commissioners should apply a 'test of reasonableness' which considers the balance of evidence and stakeholder views in support of a substantial service change."[6]

[6] Department of Health, 29 July 2010 (Gateway reference 14543)

The practical outcome of these themes is to reinforce the direction of travel but to demonstrate GP ownership and community support for change. In order to bring care closer to people's homes we have encouraged the development of an ambitious hub and spoke model of care that seeks to address the common principles for changing healthcare in the sector:

- Services focused on individual needs and choices
- Localised where possible, centralised where necessary
- Truly integrated care and partnership working, maximising the contribution of the entire workforce
- Prevention is better than cure
- A focus on health inequalities and diversity

3.6 Our new service strategy

The context and strategic landscape have changed radically over the last year. The key drivers in revisiting the service strategy include:

- the revised approach to clinical networks or polysystems and their affordability following the election of the new government in May 2010
- the need to determine how activity is shared between GP surgeries and resource centres or hubs
- the need to review service strategies with GP commissioners following the revised NHS Operating Framework
- the need to satisfy the four Lansley tests
- the shift in balance towards clinical commissioning
- the requirement to ensure existing estate is fully utilised before any commitment to redevelopment
- the challenging financial climate
- the unaffordability of the previous business case proposals.

NELC therefore developed a process for this review which included individual discussions with each PBC consortium, a workshop with the Commissioning Clinical Executive, a workshop with senior managers and clinicians from the Community Services including senior managers from the Homerton. This was followed by a joint workshop to agree the services that needed to be accommodated within the new development at St. Leonard's.

3.7 Clinical networks

The previous strategy of NELC had been to develop four polysystems in the Borough each served by a resource centre. The first of these, the SERC has been developed through LIFT and has recently opened. In the north it now seems unlikely that two centres are wanted by GPs or that they are both affordable. The intention now is to have only one centre either as a redevelopment of the existing building and site or as part of the Woodberry Down regeneration scheme in the north west serving a wider catchment area and which would release the John Scott Health Centre. This is subject to a separate business case and work is under way with public health to update the needs assessment and identify the most appropriate population to be served.

NHS City and Hackney has reviewed the plans for development of primary care premises set out in the 2007 strategy, Bigger, Brighter, Better, in the context of the changed financial and policy context. At a special meeting of the Joint Commissioning Clinical Executive and Practice Based Commissioning Executive in July 2010 it was agreed that the development of primary and community services should be based on six clinical networks aligned with the existing Practice Based Commissioning consortia. These networks would be working within two polysystems based on north Hackney and south Hackney and the City.

The approach to clinical networks will be based on providing care as close to the patient as practical within the considerations of resources and quality. There will therefore be a tiered approach to the provision of services:

- services provided from each General Practice surgery – such as primary care management of people with long term conditions, maternity care
- services provided from some surgeries covering the Clinical Network – e.g. anti-coagulation therapy, extended minor surgery
- services provided within each polysystem – e.g. diagnostics (such as ultrasound, mobile MRI scanning.)

The implication in this model is that there will be a need for two Primary Care centres to be hubs with these hubs supporting the development of these clinical network systems. However, these hubs will not be of the scale previously envisaged as the service model supporting the requirement for these services no longer requires the clinical space for the range of services proposed in the Healthcare for London model of polysystem development. All of this has meant a refresh of Bigger, Brighter, Better over the last few months. We have been reviewing this strategy to make it fit for the future following the increased financial challenge, the publication of "Liberating the NHS", transfer of City and Hackney community health services to Homerton and the management merger of City and Hackney, Tower Hamlets and Newham NELCs.

We have established a Programme Board with representation from CCGs, LBH, CoL, HUHFT, ELFT and NHS ELC to oversee service and estate strategy development and implementation for the NHS across City and Hackney.

The key changes to have emerged are:

- Polysystems with significant shift of acute activity into primary care are no longer proposed
- Instead emphasis on pathway redesign to make best use of skills, providing care in GP practices wherever possible
- Diagnostic hubs in the community are no longer required - AQP
- Financial pressures and changes to the accounting model for capital developments have made it more difficult to justify new projects
- Implementation of GP Choice for non-resident workers planned for the City – will have major implications for demand for primary care in the City.

The timing of this OBC is such that this refresh has been able to take these changes into account. The need to avoid further delay however is underpinned by the poor state of the St. Leonard's buildings, the high cost of maintaining them, the opportunity to make better use of existing space and the potential for realising significant capital receipts. There is already considerable local GP momentum to reach early decisions on the way forward.

In the south west of the Borough the outcome of the review process and the recent workshop has been agreement around a requirement for a new development to accommodate a smaller range of services that is likely to require a significantly smaller building than originally proposed at St. Leonard's. The key principles agreed are that outpatients shifts, a key plank in the previous polysystem environment, are no longer deemed to be necessary or sensible and that more diagnostics in community settings are unlikely to achieve critical mass or become affordable. This has led to a considerably more modest scheme being proposed in this OBC. These principles and the options described in this OBC will be further tested and scored by key stakeholders in a further workshop to be held in August or early September.

3.8 The primary care objectives in City & Hackney

The following represents the agreed objectives of the further development of primary care in the Borough:

- To have a choice of at least two GP practices within half a mile (potentially stretching to three quarters of a mile)

- Improving access to primary care remains a key priority during 2012-15
- To increase the number of GPs providing services from fewer, larger locations, open for longer hours to provide a more consistent offer to patients
- To enable GP practices to grow their lists to meet demand through providing larger, better equipped premises
- To decrease the number of small GP practices operating in isolation
- To increase provision of integrated care through co-locating primary and community services and social care
- To support education and training provision within General Practice as part of workforce plan

3.9 Making best use of existing space

It is essential that best use is made of current good quality accommodation before any new proposals can be justified. There are several ways in which NELC is ensuring this:

- a commitment to working with the Homerton FT as the new provider of community health services to use space effectively. The business transfer agreement states that "...it is in the interests of both Parties to identify proposals for estate rationalisation that offer quality improvements in relation to the Community Services and/or cost savings ("Proposals") and that the Parties will share any benefits in respect of any Proposals by either Party on an agreed basis..."
- the transfer of dental services from St. Leonards to space at the new SERC originally earmarked for a GP practice.
- the potential for transferring other community services from St. Leonard's to the SERC. As stated in the BTA, "...the Provider reserves the right to nominate Recipient services to relocate into this building. Among the services or elements of service being considered for SERC are Physiotherapy, Foot Health, Psychology and several minor – normally sessional services currently provided at St Leonard's together with any services currently provided by CHS to GP surgeries as part of their primary care and extended primary care role. This specifically includes services for the Lea Surgery. The other major service occupying SERC is Community Dentistry. The opening of SERC will result in the closure of the current provision at St Leonard's"[7].
- making good use of the recently extended Lawson practice surgery adjacent to the St. Leonard's site which will further reduce the new build requirement. Discussions have begun with the GPs there who agree in principle that there is some unoccupied clinical and office space and that it could be used for community health services

[7] Business Transfer Agreement, Part 6, Estate rationalisation proposals, 2010

- centralising the Southgate Road and Whiston Road surgeries (one three GP practice) on one site at St. Leonard's
- ensuring as far as possible that space is used in a generic, bookable way to maximise efficiency.
- extending available hours for services to reduce the need for space.

3.10 The wider primary care estate

There has been significant progress against the original *Bigger, Brighter, Better* proposals during the last 3 years. The following LIFT schemes have reached key stages of development:

- South East Hackney Primary Care Resource Centre (SERC) – Full Business Case approved and the centre is scheduled for completion in summer of 2011
- Nightingale Medical Centre – Financial close achieved and the centre is scheduled for completion in January 2012
- Somerford Grove Health Centre –full planning permission achieved, the required land swap agreement has been agreed by the Cabinet of LBH - the scheme is currently under discussion at sector level as the recent change to delegated limits require NHS London agreement.

There has also been progress towards the strategy's goals through GP-led and third party-led developments:

- Theydon Road Medical Centre has opened and Clapton surgery and Upper Clapton Medical Practice have relocated with the former surgeries closing (August 2008)
- Lawson practice extension has been approved and this practice-led development is close to completion which is due March 2012
- Well Street surgery moved into new premises in Shore Road in January 2010
- Kingsland Basin development agreements are now being finalised with agreements expected to be completed in January 2011.

In addition, the following small surgeries have closed with changes to local practice configurations:

- Kingsland Medical Centre and Richmond Road Medical Centre practices have merged and the 414 Kingsland Road surgery has closed (March 2008) with the practice merging on the Richmond Road Medical Centre site
- Homerton High Street branch surgery closed in September 2009 following the practice entering into temporary management in advance of opening of SERC

- Brooksbys Walk surgery, Stoke Newington Church Street surgery and Amhurst Park surgery all closed during the period from 2007 to 2008 following the resignation of the GPs in those practices and neighbouring practices successfully applying to manage these practice lists.

There has therefore been a significant level of consolidation of primary care as well as progress in renewing the primary care estate in line with the strategy.

However, there remain some key areas where developments will need to be reviewed which impact on the St. Leonards case. The key gaps are as follows:

- John Scott Health Centre is in a poor state of repair and a proposal to provide a new primary care centre to accommodate the services from John Scott Health Centre as part of the new Woodberry Down estate regeneration initiative has been developed. A Business Case is being prepared to set out and assess the options for resolving the problem through the new development or refurbishment of the centre
- The Medical Centre in Oldhill Street in north-east Hackney which houses the Springfield GP-led Health Centre is on a short-term lease and is not adequate for primary care provision in the future. The Tollgate Lodge Integrated Practice and Walk-in Centre is in temporary accommodation which will also require accommodation in the near future. A solution for these 2 practices is urgently required.

These 2 developments had originally been ear-marked as hubs for polysystems. The new model would suggest that only one of these sites would be required for such services and that both schemes would need to be significantly reduced in size and scope as a result. They are the most pressing estate problems facing primary care in City and Hackney.

In addition the following issues need to be tackled:

- The refurbishment of Lower Clapton Health Centre which is in an ideal location but is also in a poor condition
- There are 3 practices in the Stoke Newington Church Street area where there continues to be pressure on space and there is currently no solution planned – Abney House Medical Centre, Barton House Health Centre and Statham Grove Practice
- London Fields Medical Centre is suffering from severe pressure on space and discussions are in the early stages with London Borough of Hackney regarding a potential development as part of a refurbishment of Haggerston baths but funding for this scheme has not yet been confirmed

- There remain a number of other estates issues for resolution including the future of Barretts Grove surgery, the consolidation Wick practice on the Wick Health Centre site and the closure of Median Road branch surgery and the future of Beechwood Medical Centre.

This summarises the current primary care estates position that is a key consideration in the assessment of the St. Leonards business case options. There has been a significant level of consolidation of premises as well as improvement in the quality of the primary care estate through these schemes. In addition, there has been an increase in capacity through the development of SERC, the Lawson practice extension and the new Well Street surgery in particular.

These schemes have not yet addressed the accommodation needs of Community Health Services but provide opportunities in reconsidering the future location of these services.

3.11 Planning for the SW Resource Centre

We have adopted a systematic approach to the task. The process has been service and activity driven, not finance nor estates led. The starting point has been to determine what services can appropriately and safely be provided more locally, consistent with a critical mass to use skills, equipment and other resources effectively.

The outcome of this process has been agreement around a requirement for a new development to accommodate a smaller range of services that is likely to require a significantly smaller building than originally proposed. The key services that will be accommodated within the redevelopment are as follows:

Primary Care:

- A new surgery for the Southgate Road practice to consolidate all of its services from the current Southgate Road surgery and Whiston branch surgery;

Adult Community Services:

- Reprovision of the wheelchair service;
- Adult Community Reablement Team;

- Locomotor service including physiotherapy gym;
- Sexual health services currently provided in the Ivy Centre and some development of services in early pregnancy including access to ultrasound;
- Foot health with a review of the referral thresholds for the service
- Mobile dentistry
- Mobile diagnostics
- Voluntary services
- Complementary therapy

Primary Mental Health Care:

- Primary care psychology including access to cognitive behavioural therapy
- Tavistock primary mental health services
- Further work to be done on improving liaison with Community Mental Health Team

There is no longer a requirement for the following services:

- An Urgent Care Centre – given the approach to extended primary care that is being developed in partnership with GP commissioners
- Diagnostics and out-patient services – this is not the model of planned care that GP commissioners wish to see provided in the future;
- Community Dental Services which will now be centralised in the new centre at South East Hackney.

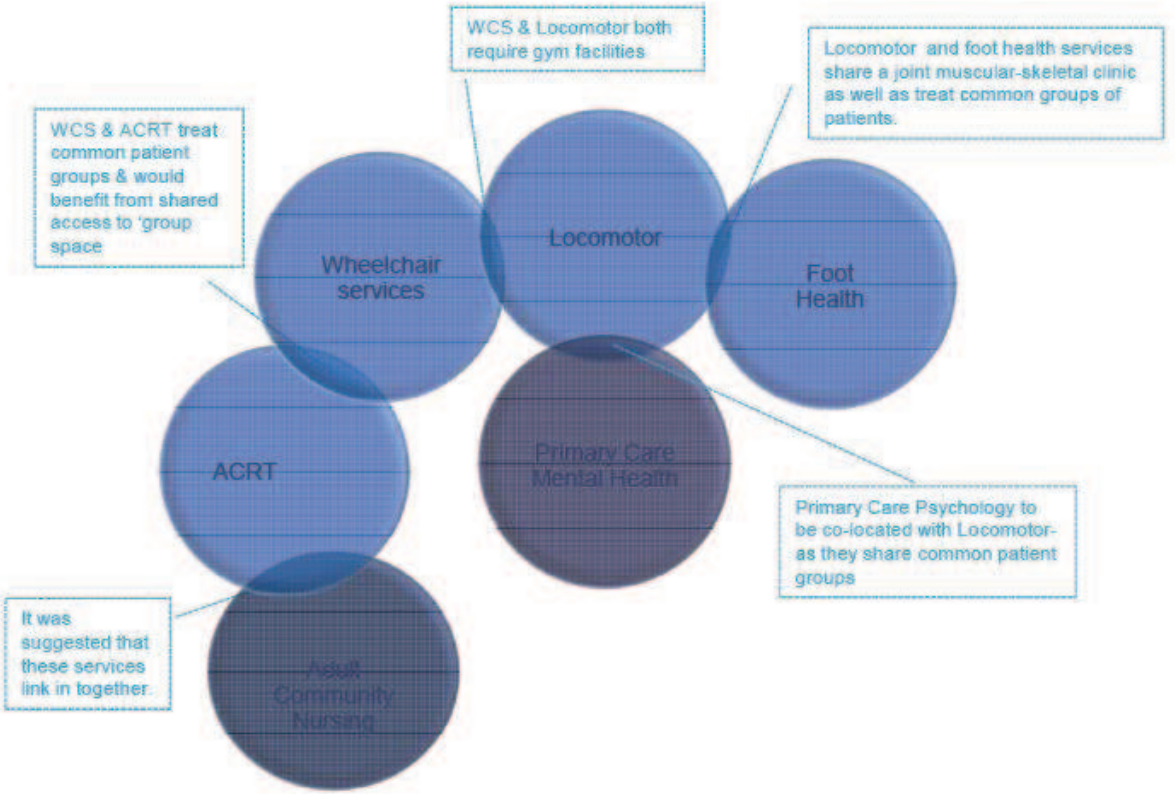
The general conclusion from the discussions was that there is a case for a number of the adult community services in particular to be accommodated in 3 centres which could be regarded as hubs. There will be further work on this concept and the potential locations with GP commissioners and the Homerton but it was agreed that St. Leonards should form one of these 3 centres.

The workshop also recognised that key adjacencies and interdependence would be an important driver of planning as shown below:

During the course of the workshop participants identified and agreed that there were some critical dependencies and inter-connections between services.

These are illustrated in the diagram opposite.

It was agreed that these should be taken into consideration in the next phase of options appraisal.

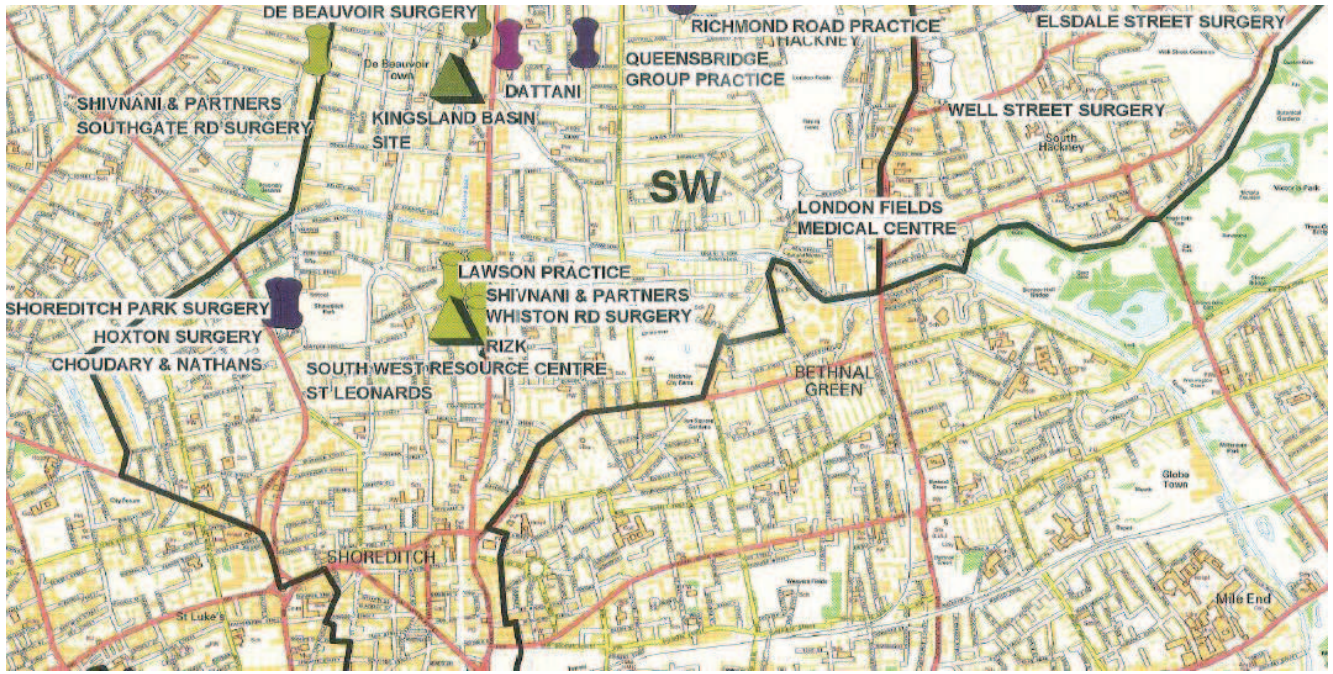


Agreement has also been reached on the level at which it is sensible to provide services. In other words which services are best delivered at Borough level or in exceptional cases supra-Borough? Which services because of critical mass need to be provided at no more than 2 or 3 centres? Finally, how are services to be split between GP surgery level and resource centres? All of these agreements and assumptions have been incorporated in the activity and space model described later. The following sections describe the agreement reached for the individual services relevant to the St. Leonard's site.

3.12 Primary care and the current and proposed location of practices

The Southgate Road practice operates from two surgeries at Southgate Road and at Whiston Road situated on the St. Leonard's site. The GPs primary concern is to centralise on one site to provide a more integrated service and to ensure best use is made of clinical time. The proposal is to consolidate all of their services in the new development and relinquish their existing surgeries. The creation of a consolidated practice on site close to the existing Lawson practice will maintain a healthy competitive tension between the practices and off considerable patient choice. It will also mean that other community services in the resource centre will have the advantage of co-location with primary care. This and an alternative option of centralising at Southgate Road are considered in the options section of the economic case.

The nearby Kingsland practice is a small single handed practice which can either be co-located in the resource centre or whose patients can choose to re-register with either the Lawson or Southgate practices. The following map shows the location of current practices in the vicinity of St. Leonard's Hospital:



Surgeries currently in the immediate vicinity of St. Leonard's are:

- the Lawson practice in modern accommodation and recently extended
- the Whiston Road surgery on the St. Leonard's site and part of the Southlands Road practice
- Kingsland surgery some 500 metres to the south of St. Leonard's.

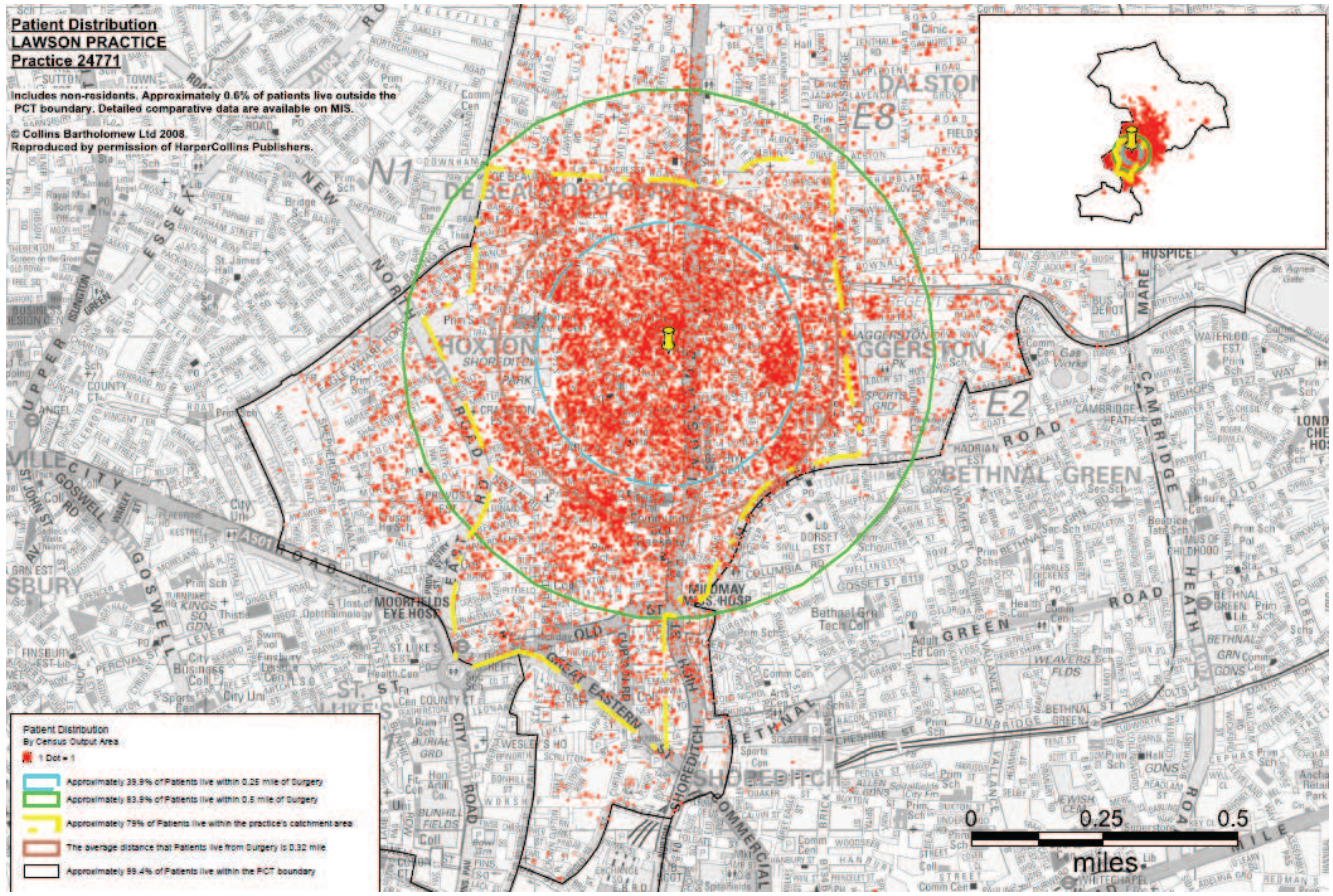
The aerial view below shows in more detail the surgeries both on and adjacent to the St. Leonard's site:

- Lawson practice: modern building, recently extended with 11,000 registered patients

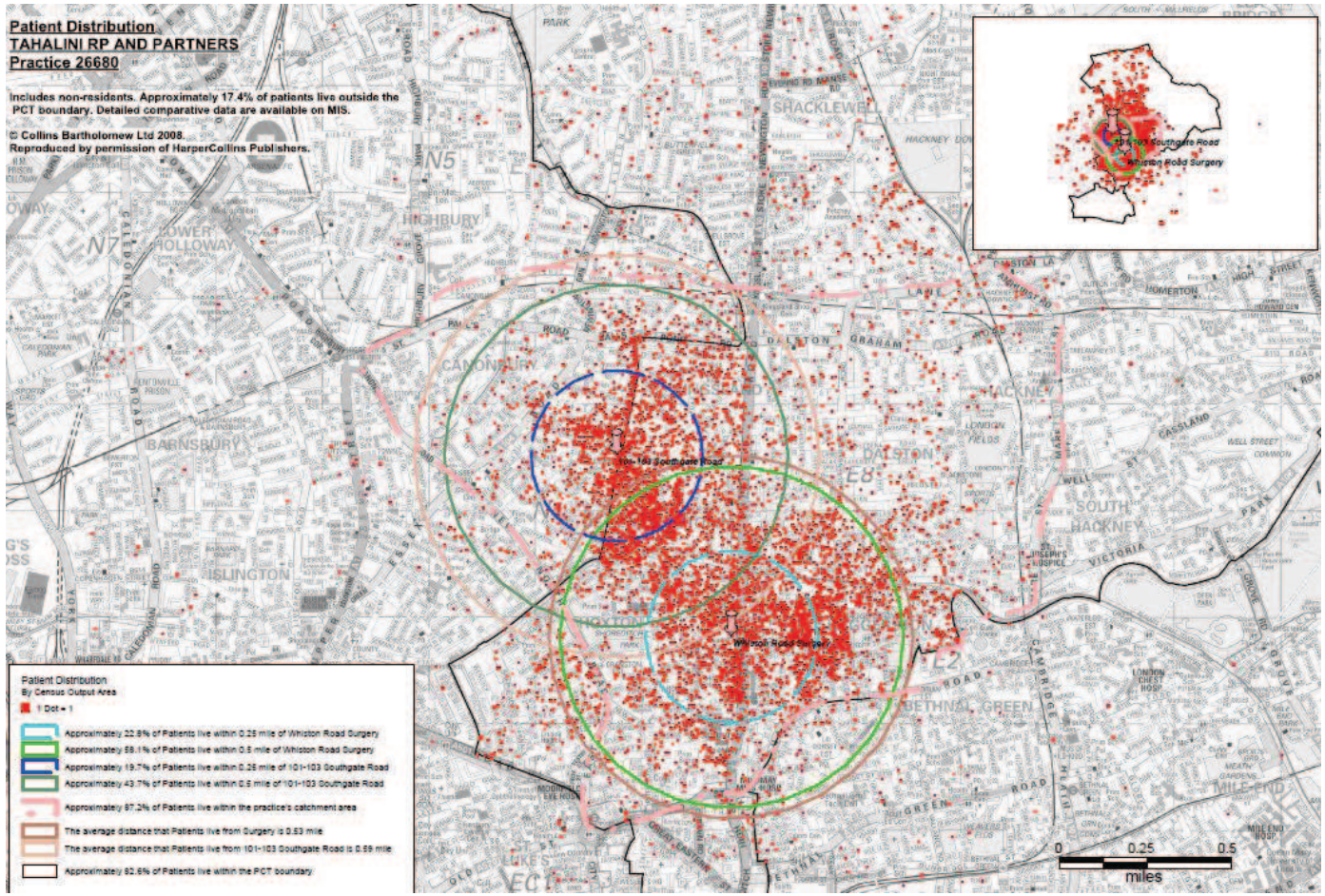
- Whiston Road in poor accommodation with 5,000 patients registered here, compared to 1,900 at its sister surgery in Southgate Road

- Kingsland surgery, a single handed practice in poor accommodation with 2,181 registered patients.

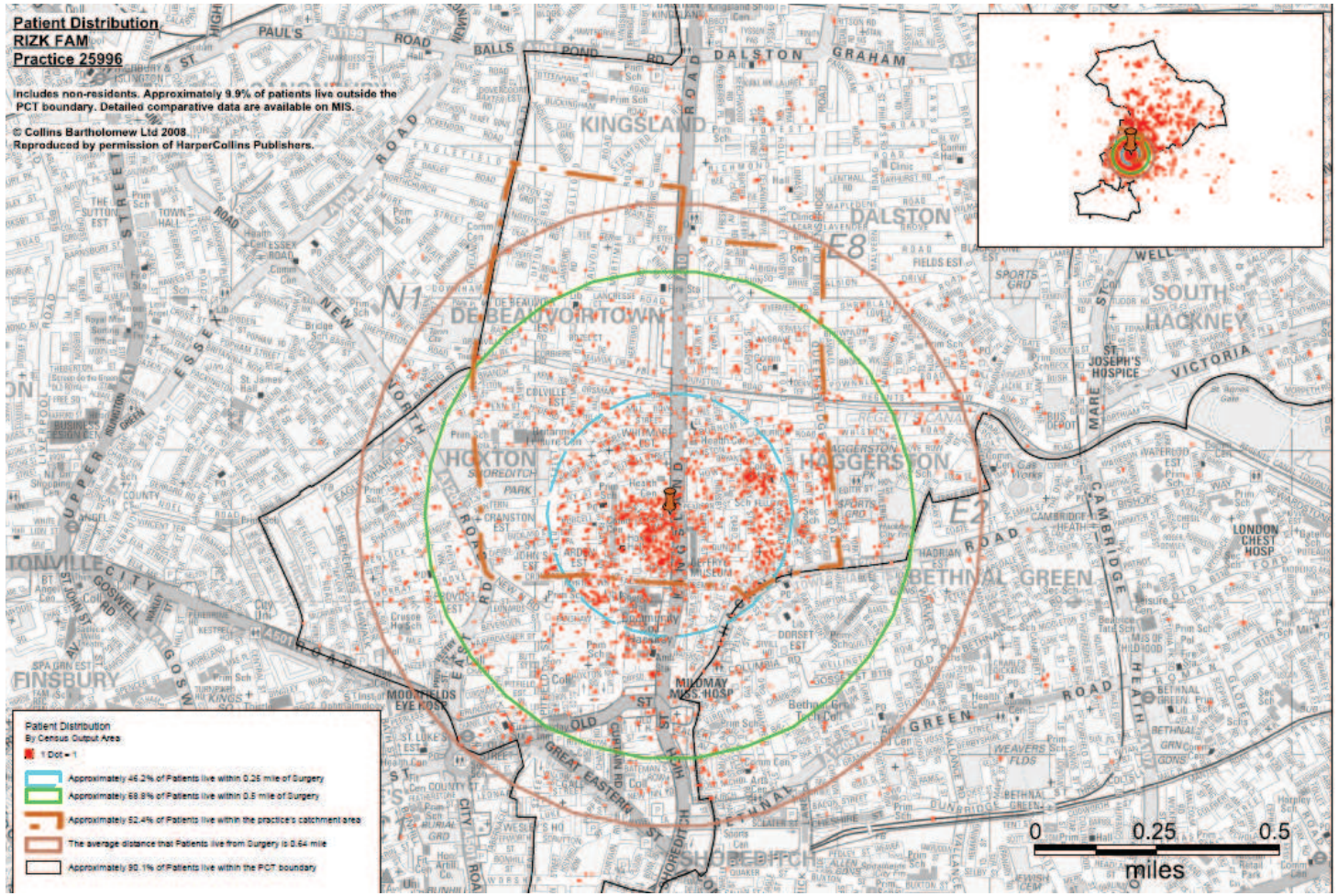
The followings maps show the distribution of patients for each surgery with a red dot representing one patient. The first shows how local the patients are in the Lawson practice with 84% of patients living within half a mile of the surgery and less than 1% living outside NELC boundary.



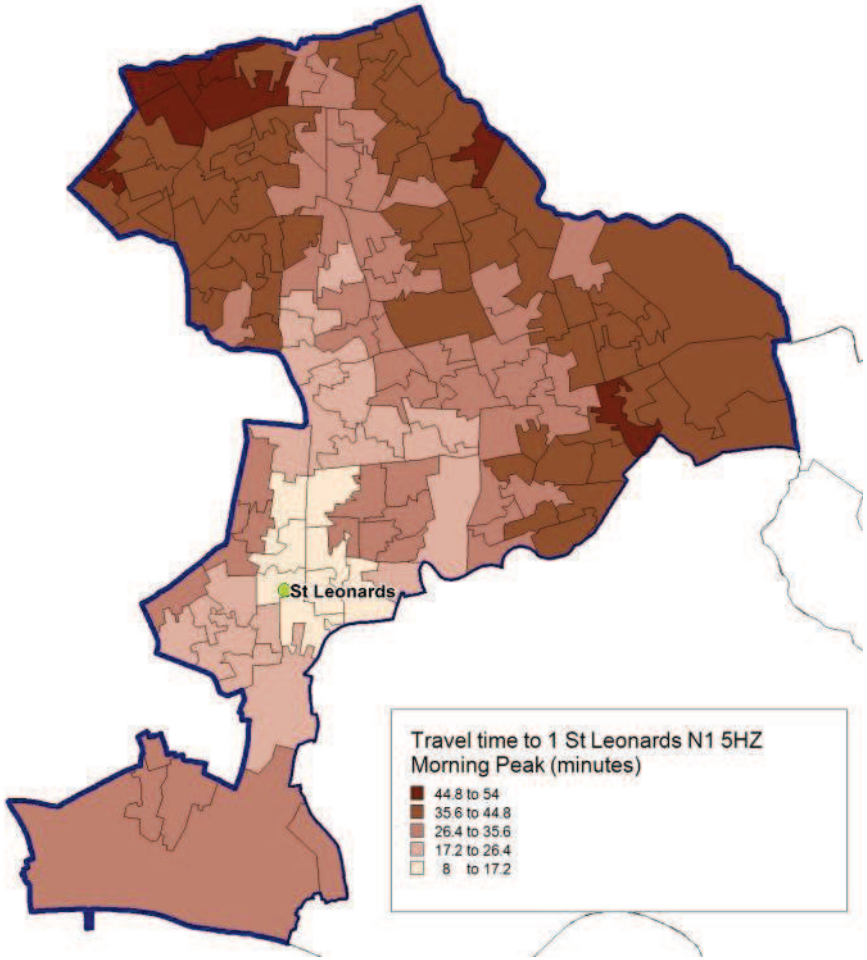
The next map shows the distribution of patients for the practice located on the two sites at Southlands Road and at Whiston on the St. Leonard's site. There is, in marked contrast to that of the Lawson practice, a far greater geographic spread of patients with only 44% of patients registered at Southlands Road and 58% at Whiston living within half a mile of their respective surgeries. In total more than 17% of the combined lists live outside NELC boundaries, mainly in Islington.



The final map shows the spread of patients for the 2,181 Kingsland Road patients, for most of whom the proposed new St.Leonard's site should be just as accessible.



3.13 Travel times



Health economists at the NHS East London & the City Commissioning Support Services were asked to look at the location of health services in City & Hackney and how far patients had to travel to reach their nearest service, when walking or using public transport. They looked at GP practices, A&E/maternity, psychology, physiotherapy and sexual health.

The data used was from the HSTAT (Health Service Travel Analysis Tool) travel time database which was supplied by Transport for London (TfL). The public transport times are derived from CAPITAL, TfL's strategic accessibility model.

The map opposite shows travel times to the St.Leonard's site at morning peak travel times.

3.14 Wheelchair services (WCS) & Adult Community Rehabilitation Treatment (ACRT)

The workshop concluded that one centralised service was ideal with St Leonard's suggested as a preferred location. Patients will require access to a gym facility, co-located with locomotor services, again ideally at St. Leonard's. It was acknowledged that if it were deemed unaffordable at options appraisal stage, then would be a need to consider exploring shared WCS provision with other Boroughs, for instance across ELCA or with Islington & Camden. However, concern was raised about locating the service outside of the Borough with the possible negative impact of referrals back to ACRT

There was a consensus that quality standards will continue to be maintained therefore the storage facilities are to be co-located with the WCS.

The case for co-locating WCS and ACRT is that they:

- currently treat common groups
- are able to share 'group' space i.e. rooms to accommodate 12 – 15 per session
- benefit from co-location and key points such as infrastructure and bookable consulting rooms.

If it were necessary to seek location beyond borough, it was thought appropriate to explore options with Islington / Camden as well as Mile End Hospital in Tower Hamlets.

3.15 Sexual health

There is a very clear directive that sexual health services are a priority for delivery not only for the general health of the population but also in a context of public health improvement. Key performance indicators around 48 hour access to sexual health services make it clear that sexual health services should be easily accessed and free from any charge for the whole of the population.

Within the UK, London has the highest need for services in the country. This is driven by the high levels of deprivation and a young, often transitory population. Evidence suggests that those most at risk of sexually transmitted infections (STIs) are the young, black

minority communities and men who have sex with men (MSM)[i8] London has a much higher proportion of these groups of individuals and therefore a higher need for sexual health services.

The population of London is transitory with high numbers of overseas visitors which impacts on the types of services that are required. Services need to be designed to ensure they are self referring and easily accessible to anyone regardless of whether they are registered with a GP or who their host NELC is. London also has the highest birth rate in the UK and natural population growth in London accounts for 70% of the whole of the UK despite only having 12% of the population. There are also high levels of repeat abortions and rates of teenage pregnancy. This requires access to all methods of contraception particularly long acting reversible contraception (LARC).

Of the 33 Local Authority areas in London, 20 rank within the top 50 most deprived areas (out of 354) in England on at least one measure. Hackney and its neighbouring boroughs of Newham and Tower Hamlets are the most deprived London boroughs. This means that sexual health services in Hackney are a vital component of ensuring the health and well being of the population in this area.

Current Provision in City and Hackney Community Sexual Health Services (CSHS)

Following a formal review of CSHS in 2008 a significant amount of work has take place over the past 18 months in modernising and redesigning the service model and making it 'fit for purpose' allowing us to: see more male clients, increase the levels of STI testing and utilise our space capacity more efficiently. City and Hackney CSHS currently provides a service to over 8300 people per year. The demand for services is increasing annually with an increase of 30% for Sexually Transmitted Infection (STI) screens last year alone.

At present services are provided on the St Leonard's site in the Ivy Centre and satellite services are offered at John Scott Health Centre and Lower Clapton Health Centre. The Ivy Centre is a purpose- building on the St Leonard's site while the satellite clinics are offered within 2 existing health centres. In addition to this outreach services are provided in a variety of community settings for targeted groups including, young people, lesbian, gay, bisexual and transgender (LGBT) and sex workers for the boroughs of City and Hackney, Newham and Tower Hamlets.

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[8] Sex and our city: Achieving better sexual health services for London. Project findings & recommendations

Medical Foundation for AIDS & Sexual Health (MedFASH) November 2008

The service provides both appointments and drop-ins for clients ensuring the widest range of access. Services provided are based around a one stop shop model giving the most convenient and integrated service possible for people.

The services provided are currently at level 2 for the management of STIs and level 3 for contraception. This means a much wider provision of Sexual Health Services are offered within CHS than would be available within Primary Urgent Care Centres (PUCC) or within GP surgeries. PUCC and GPs would only be able to provide level 1 STI management and level 1 or possibly 2 for contraception. City and Hackney CSHS is currently the only provider of these levels of care for clients, outside of an acute setting, for the whole borough. CSHS therefore has well developed competencies supporting people in the community particularly those who are vulnerable.

STI management

Level 1 STI management is designated as appropriate to deliver:

- Asymptomatic screening of women and heterosexual men
- Gonorrhoea and Chlamydia tests
- Serology for HIV and syphilis

For this it is entirely appropriate that this provided in GP surgeries and PUCCs. For anything over this level other standards need to be met which would be very hard for generalist settings to achieve. This is because the outlay required in terms of time and staff training would be prohibitive. Of the standards set by the Medical Foundation for Aids and Sexual Health (Med-FASH) and the British Association of HIV and Sexual Health (BASHH) the following would make achievement of level 2 hard:

- Standard 2 appropriately trained staff who have completed competency based training
- Standard 5 – Clinical management where clinicians who are interpreting results are competent to do so in light of the service users clinical presentation and standards around partner notification
- Standard 8 – Clinical governance with all staff appropriately trained and participating annually in regional or national audit.

If City and Hackney CSHS ceased to provide specialist services this would mean that there would be no level 2 provision outside of the acute settings. This in turn would push more activity into the acute setting thereby working against the objective of providing care closer to home for patients and would also reduce the access points available for these services.

Contraception

As with STI screening PUCC and GPs should be providing level 1 or 2 contraception however the achievement of level 3 status would be harder to achieve due to the outlay in staff training and time. Level 3 services are expected to provide all contraceptive methods and participate regularly in audit as well as have the appropriate clinical leadership. These services would also be expected to provide support to the wider health economy in terms of training for other staff around contraceptive methods. They would also be expected to be providing some measure of nurse led clinics for the provision of sexual health. The standards set by the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists that would be harder for a generalist setting to provide are as follows:

- Standard 1 leadership with all services providing level 2 or 3 led by a full time consultant accredited with MFFP/FFFP
- Standard 9 Nurse Led Service Provision where nurses prescribe or provide contraception under Patient Group Directives (PGDs) and have competencies to provide LARC
- Standard 10 Monitoring and Evaluation with structures and processes for evaluation of services and regular audit.

City & Hackney CSHS has a track record of service delivery for well over 10 years and with well developed specialist skills and appropriate medical and nursing clinical leadership.

Other Benefits of having specialist sexual health services

One of the key aspects of providing successful sexual health services is the provision of open access clinics in a variety of settings. This is to enable as much choice as possible for the patients. There is still much stigma attached to sexual health and many individuals, particularly young people, do not wish to access sexual health via their GP. CHS therefore provides a vital service in terms of offering a choice of locations for people to be seen.

The service provided by CHS is a fully integrated sexual health service providing a wide range of tests and treatments for asymptomatic and symptomatic clients as well as the full range of contraception available. There is evidence to support that there is a high rate of treatment access and uptake when the testing site is the same as the treatment site. This has obvious benefits for the client and general public health.

At present as CHS is a level 3 site for contraception it provides training and support to GPs and nurses within the community around contraception. This is an invaluable service that helps to spread best practice and provides hands on experience to clinical staff wishing to develop competencies around LARC.

The service currently aims to provide a one stop shop; often clients who attend for contraception or STI screening have other needs. This model provides an excellent opportunity for other health promotion, promotion of screening, LARC and education for clients when they attend. Clients have a choice of appointments or drop-ins so they can choose the type of access that they wish.

CHS provides near patient testing for pregnancy and HIV with fully trained staff to manage the communication of results.

CHS also employs counsellors and health advisors who are fully trained to provide support for clients with positive results, partner notification and counselling around risk taking behaviour. This is again integrated with the services provided, giving the clients seamless and integrated care. There are also community Gynaecologists who work out of the Ivy and provide a range of outpatient community gynaecology appointments as well as contraceptive implants.

Activity stats & Opening Times

The Ivy Centre is open from 9am to 8pm Monday to Thursday and 9am to 5pm on Friday. At present the Ivy utilises on average 5 clinic rooms per session (average of 3 in the evenings). Clinicenta, a private provider is open from 8:30 to 7:30 on Saturdays and uses the Ivy premises. Appointment times for clients are 20 minutes for smear test and general sexual health. For implants and for coil fittings the time allowed is 30 minutes.

At present there are vacancies in the department which are being recruited to, however with a full complement of staff there would be on average 3 nurses, 1 doctor and 1 health care assistant or health advisor seeing a mixture of appointments and walk in patients during the morning and afternoon sessions and 3 staff members in the evening. Each of these members of staff would need a room each to see the patients. Currently within the Ivy we have 6 clinic rooms and two counselling rooms, which would all be used in a busy clinic.

CSHS saw in excess of 8300 clients in the Ivy 2009/10, for the last 6 months the since the introduction of drop-in sessions there has been an increase of 120 clients seen per month on the previous 6 months and in the year there has been an increase of 30% of STI screens. This demonstrates that there is an increasing demand for services. With the predicted increase being maintained it is expected that the Ivy will see an additional 720 clients in 2010/11. It may be more than this once the Ivy is fully established with 2 additional members of staff as at present we are turning clients away as there is not enough staff to see them. It is estimated that there will be at least 60% usage of the 6 clinic over an 8am to 8pm opening model.

Open Doors runs a weekly clinic with booked appointments for a maximum of 5 slots for street and off street sex workers.

The 2009/10 data reflects that Open doors saw 253 sex workers in Hackney, 747 off street sex workers in Newham, Tower Hamlets and Hackney of whom 29 have been seen 86 times at the Ivy clinic. On average they would see 10 sex workers for case management at St Leonard's site per week and would bring a further 5 per week into St Leonards to access other community services such as foot health or community dentistry.

Other Developments

With continuing move to provide more care in the community and closer to peoples homes particularly in light of the merger with Homerton University Hospital more services could be provided in CSHS settings. Much of the non-specialist activity undertaken by the Department of Sexual Health at Homerton could and should be provided in the community. In addition to this there is a potential to provide more community gynaecology appointments and potentially maternity services. The service is also looking to develop provision of medical terminations in the community providing better access to this service for clients.

Conclusions

CSHS have clearly identified through is service review and work on modernizing the service model that there is a very clear need for specialist services for sexual health in the community. Without this provision there would be large gaps in service with a huge impact on the health and well being of the population of Hackney. There would be increased attendances at Homerton University Hospital to compensate for the loss of specialised community based sexual health services. There would also be a loss of valuable knowledge, expertise and training capacity within the borough.

People would see a reduction in choice of services with potentially large numbers of individuals going undiagnosed as they did not wish to attend their GP service.

There is huge scope to grow the work that is currently being provided in Community Sexual Health with increasing demand and care closer to home this will be a reality for the future.

The workshop

It was against this background that the recent workshop considered sexual health in the context of the changing clinical network developments. The conclusion of the workshop participants was to retain 2 hubs (Homerton & St. Leonard's) with satellites at John Scott and Lower Clapton. The same team will work across the two hubs with additional services at St. Leonard's hub, including medical

terminations and Early Pregnancy Assessment Unit (EPAU). Additional space requirements would need to be factored into the options development.

All agreed that the current accommodation on St. Leonard's site is unsuitable and that an interim solution is needed to ensure security and access for patients and staff. The Louis Freedman building was suggested as a potential location. Given the long timescale for any redevelopment of the St. Leonard's site this was the primary concern.

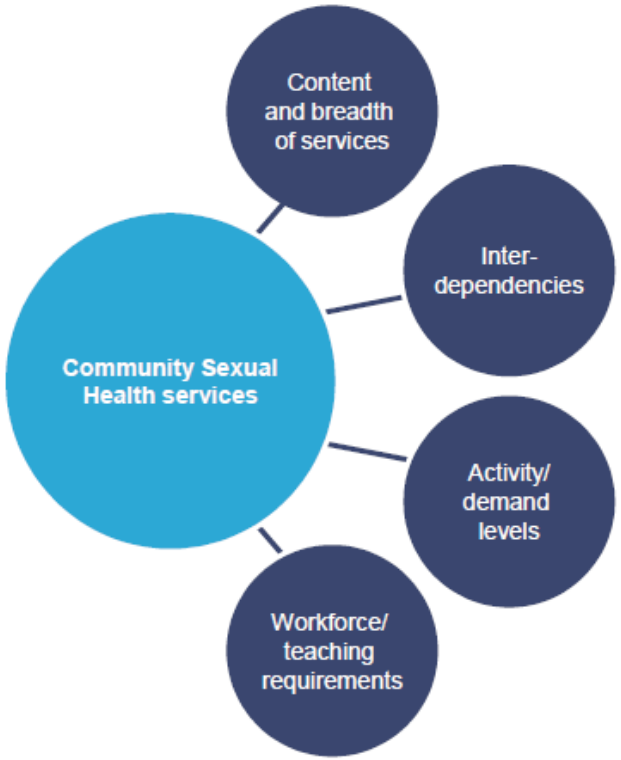
It was also agreed that practice activity should continue for people happy to access the service in this way.

Future space planning/design needs to ensure that:

- different areas are 'zoned' for different patient groups, to ensure key groups such as men are encouraged to and continue to access services
- accommodation is provided for non clinical service i.e. outreach administration
- we should explore whether medical terminations can be offered in GP practices
- links are maintained to Children's services but co-location not essential.

The following is an overview of the community sexual health service in the future:

- One Stop providing all services in one consultation
- Site for hub for community services including support and outreach
- Satellite sites
- Accessibility for client
- Publicity
- All day opening and extended hours
- Clinical IT system
- Privacy and Zoning



- Open access sexual health for women and men of all ages
- Specifically accessible for young people
- Specialist services
- Outreach teams

- Within the department
- Community Services
- Homerton
- Chlamydia outreach
- HIV/health advisors

- 48 hour access
- 18 week wait
- Individual team targets
- Increasing activity/transfer from HUH

- Teaching centre – doctors, nurses and other
- Aspiration for a medical TOP community based service

3.16 Locomotor services including physiotherapy and foot health

The key factors considered were:

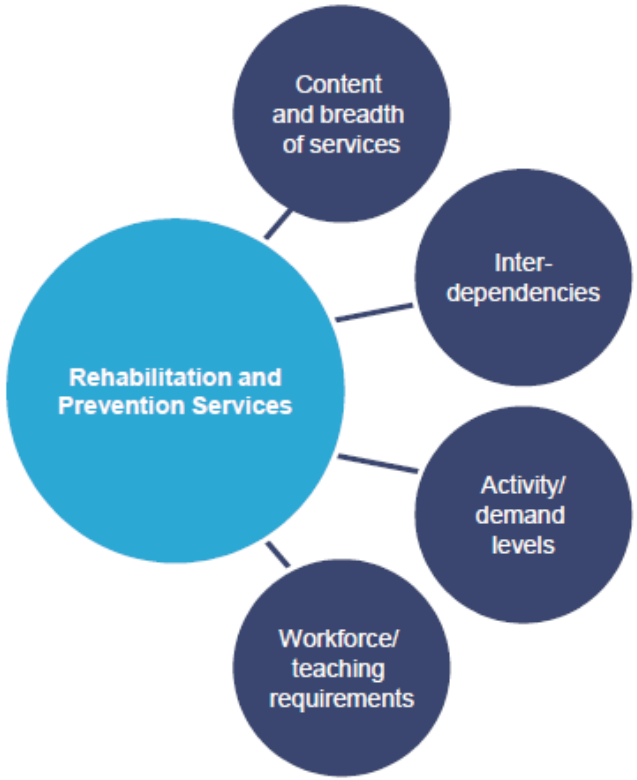
- Case for co-locating locomotor and foot health - currently share a joint muscular-skeletal clinic and treat common patient groups
- Benefits of co-location include easier and more efficient to manage service such staff supervision and resource planning, reduced travel time between sites and staff development where it would be easier to transfer knowledge and plan and deliver specific teaching /training sessions
- Important to consider locations and populations we need to serve in selecting appropriate service models
- Access to transport and other infrastructure surrounding potential sites & locations needs to be factored into decision-making
- Acknowledged need to look at possibility of introducing mobile foot clinics (to increase efficiency) at options appraisal stage
- Agreed that the development of a central room booking system whereby clinicians can book space would be beneficial
- Space requirements will be affected by decision on low clinical need foot health referrals / service provision

The agreed service model is based on:

- 3 hub locations spread across the Borough
- an acknowledgement that if, at options appraisal stage, affordability is a key issue, will need an option to reduce to 2 hub
- access to one gym facility with St. Leonard's suggested as a preferred location with space to use equipment at other location
- the need to explore with GPs referrals procedure for 'low clinical need' foot health conditions. Options to discuss include treatment within primary care setting or decommission service
- maintaining current level of provision in primary care setting
- looking at rolling out extended hours.

The following is an overview of the rehabilitation and prevention services:

- Locomotor
- Foot Health
- Wheelchair service/ space
- ACRT
- 3/4 core sites and practices where viable
- Space for data entry, team meetings
- Service Improvements. Skill mix; protocol guided work; group work; triage; empowerment/ goal setting; patient involvement
- Extended Hours



- WCS customised seating and posture control.
- FH Diabetes, MSK, vascular, rheumatology General foot care (derm/ preventive foot care for fallers) nail surgery
- Locomotor. MSK and Pain (Multi-disc)
- ACRT domiciliary ; groups and assessments for activity daily living
- Active discharge

- Advocacy
- Broad working relationships – access to nursing. LBH/CoL
- Joint clinics (foot health and locomotor)
- Shared clients (MDT mtgs)
- Joint use of gym/therapy room
- Hub and spoke for FH and L

- Referral criteria and active discharge
- 5 week and 18 week
- General trend is increasing/ impact on waits

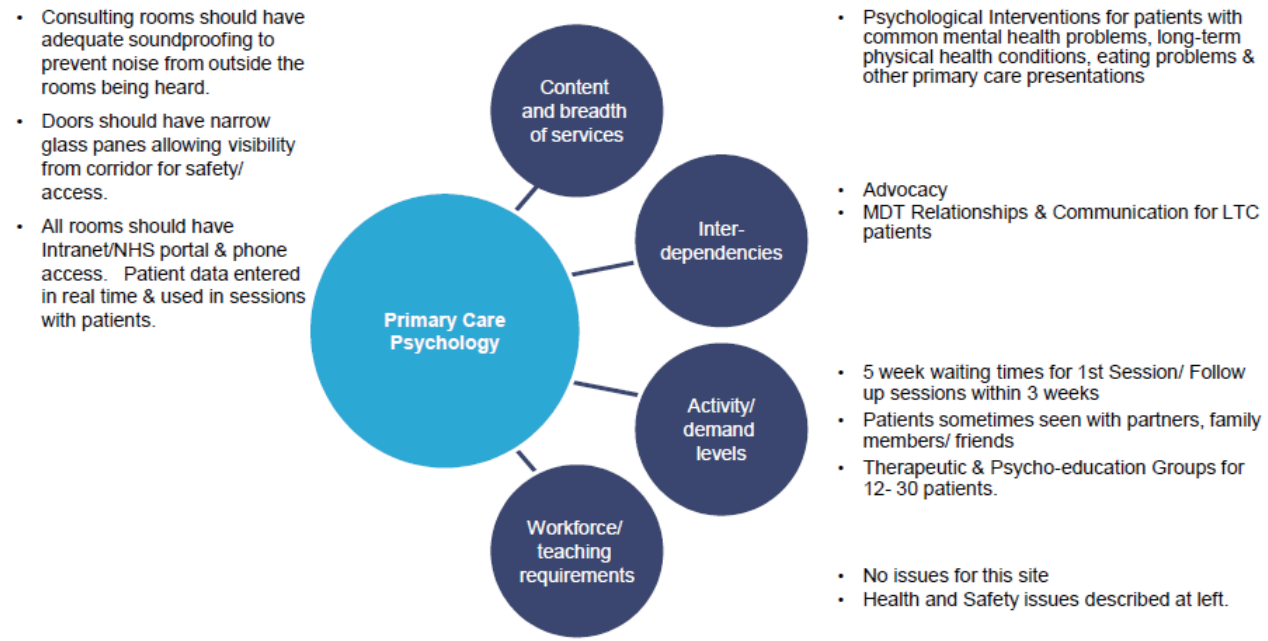
- All services take students; group and 121 and rooms in close proximity
- Space for 121s and supervision - discharge
- Access to PCs for data entry etc

3.17 Primary care mental health

The agreed service model is based on:

- 3 hub locations spread across the Borough for Primary Care Psychology to be co-located with Locomotor services. Opportunities to share some admin functions between these services
- Tavistock services to be co-located with Primary Care Psychology
- Continue to seek out opportunities for Primary Care Psychology services to be delivered from GP practices
- Acknowledged that if at options appraisal stage, affordability is a key issue, will need an option to reduce to 2 hubs
- Potential here to extend links with long term condition patients – possibly through Homerton location.

The following is an overview of the service requirements and dependencies:



3.18 Breast screening

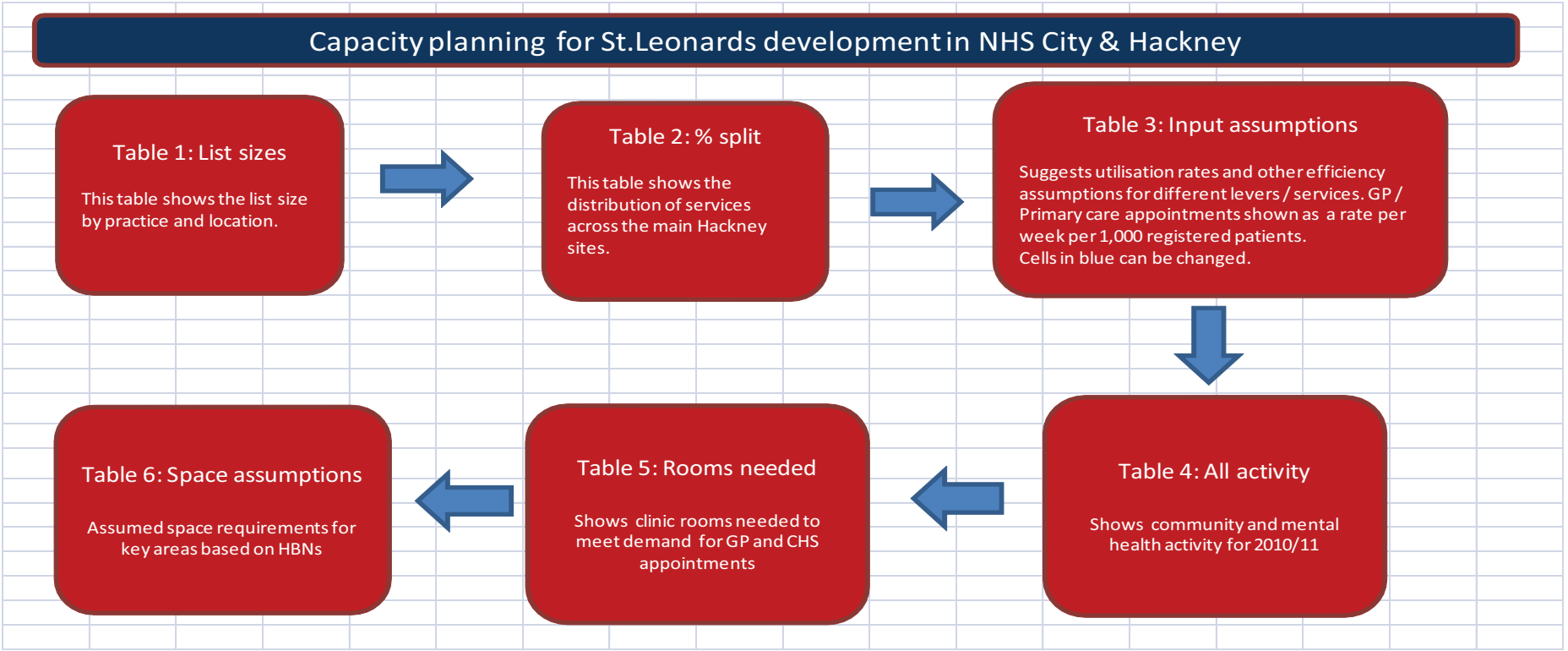
Breast cancer screening services in City and Hackney are currently provided by the Central and East London Breast Screening Service (CELBSS) in the form of two mobile units. These units have a limited lifespan of approximately seven years, which will soon come to an end in December 2011.

CELBSS, in collaboration with ELCA SCU as lead commissioner and public health colleagues in NHS City and Hackney as joint commissioner, are looking at longer-term plans to replace the mobile vans with fixed site digital mammography units to improve coverage and screening quality. Newham and City and Hackney are two of six NELCs in the breast screening consortium without digital mammography. Digital mammography is necessary because the mobile analogue units are coming to the end of their life, and digital offers better image quality, easier storage and is recommended by quality assurance.

To ensure good coverage, the site needs to be accessible and well known and Homerton University Hospital would be a good location. Other potential locations for the units are being identified as part of the wider plans to deliver the age extension for screening services. Any potential site for digital mammography must be widely accessible and acceptable to eligible women if coverage is to be increased. CELBSS have put together a business case which is going through the BLT capital processes which would, if approved, cover the cost of the equipment. Space requirements at some 40m2 are modest. St.Leonard's is one potential site and this OBC keeps this option open.

3.19 Activity and space modelling

The scheme as it develops must be large enough to cope efficiently with present and future demand and not be oversized resulting in waste, unnecessary expenditure and reduced capital receipts. The approach followed by the business case team is set out below:



The list sizes and location of GP practices is given in Appendix 1.

Table 2 below shows the split of community services between the main resource centres and the staff based at each.

Table 2: % split of services between sites

	Clinic space requirements								Office space requirements					Notes
	% of service on sites				open (no. weeks pa)	no. sessions pw	length of session (hrs)	average cons. time (mins)	no. staff requiring desks	number of staff at desks what % of time				
	JSHC %	StL %	SERC %	Other %						100%	75%	50%	25%	
Psychology	25	70	0	5	51									
Foothealth	15	47	15	23	51	104	3.5	30	20	3	0	2	15	will admin move to SERC? Transport query. Clinical staff 15% time desk based
Locomotor (1 & fup)	15	53	25	2	51	280	4.5	30	34	8	1	6	21	plus 2 students and 1 dietician
Pain management	0	100	0	0	51	60	4	60	5	1	0	2	3	plus psych intern, 3-4 visiting pain consultants
Sexual health	5	85	0	15	51	124	3.5	20-30	32	8	1	22	0	
ACRT	0	100	0	0	51	70	1	60	50	7	9	34	0	
WCS	0	100	0	0	51	15	1	1.5	13	3	6	0	4	
Learning Disabilities Service	0	100	0	0	51	54	1.5		11	2	3	2	4	
SLT	20	0	0	80	51	5	1 to 2	60	9wte	0	0	6	3	staff in schools so at desk early and late, difficult to flex this. Plus 6 students
Dermatology	yes				51	4	4		2	2	0	0	0	
Continence						2	4		4	1	0	3	0	
Healed leg ulcer						2	4			0	0	0	0	
Audiology	yes	0				2	4		2	1	0		1	
Health Visiting	15	0	0	85	51	10	4	30	9	1	0	8	0	plus students at different times
District Nursing									16	2	0	14	0	plus students at different times
School nursing		0							5	0	0	1	4	plus students at different times
Enuresis		0				3	4		1	1	0	0	0	
Community Dietetics		0				2	4.5	30	0	0	0	0	0	
Advocacy	yes		0						4	0	0	0	4	

The next table makes assumptions, which are open to challenge, about how the centre will operate. One of the critical factors about improving efficiency is the way in which users work. For example if clinical staff operate a bookable room system, similar to that at the Barkantine in Tower Hamlets, where staff move from the consulting / examination room to an administrative / IT area, then better use can be made of clinic space leading to a reduction in size and costs. However, this is not always acceptable to staff. The Lawson practice began with this system but have since reverted to room "ownership".

Utlisation low at outset with increased utilisation to meet future , unfunded growth

Table 3: Input assumptions

Service type	Open (weeks p.a.)	Core sessions pw	% patients seen in core sessions	Length of session (hrs)	Average cons. Time (minutes)	Room utilisation	Population growth to 2031	List size / % of Hackney served	Assumed appts. p.w. per 000 reg. pts
GP appointments Lawson practice	50	10	90%	3.5	12	85%	17.7%	11,443	80
GP appointments Southgate practice	50	10	90%	3.5	12	85%	17.7%	6,728	80
GP appointments Whiston practice	50	10	90%	3.5	12	85%	17.7%	0	80
GP appointments Kingsland practice	50	10	90%	3.5	12	85%	17.7%	2,182	80
Appointments other primary care professionals	50	10	90%	3.5	20	85%	17.7%	20,353	20
Psychological therapies	50	10	90%	3.5	20	85%	17.7%	70%	
Tavistock OPs	50	10	90%	3.5	60	85%	17.7%	20%	
Adult social care	50	10	90%	3.5	20	85%	17.7%	50%	
Foot health	50	10	90%	3.5	20	85%	17.7%	47%	
Locomotor new appointments	50	10	90%	3.5	45	85%	17.7%	53%	
Locomotor follow-up appointments	50	10	90%	3.5	30	90%	17.7%	53%	
Pain management	50	10	90%	3.5	30	85%	17.7%	100%	
Sexual health	50	10	90%	3.5	15	75%	17.7%	85%	
ACRT	50	10	90%	3.5	30	85%	17.7%	100%	
Outpatients	50	10	90%	3.5	15	85%	17.7%	0%	
Dental	50	10	90%	3.5	20	85%	17.7%	0%	

This assumption is above the minimum BMA agreed 72 but below the national median level of 5.3 average consultations per annum

This assumption reflects the trend to a greater proportion of appointmrnts with other professionals

These assumptions are then applied to the current activity data shown in Appendix 2 to derive the requirement for consulting / examination rooms. Whilst it is assumed that any additional use of the Lawson practice is interim only as their list sizes grow, there is clearly some spare capacity in the Lawson building which will need further effort to lever improved efficiency. Initial discussions with the Lawson practice have indicated a willingness in principle to accommodate some community services on site in the interim and this may reduce the new build requirement and maximise the capital receipt to the NHS. The new extension to the Lawson premises is assumed to be taken up by clinical commissioning office use.

Table 5: Clinic rooms needed in SWRC

System	Activity per year		C/E rooms needed	C/E rooms available
	2011	2031	2031	2011
GP appointments Lawson practice	45,772	53,874	6.5	22
GP appointments Southgate practice	26,912	31,675	3.8	6
GP appointments Whiston practice	0	0	0.0	4
GP appointments Kingsland practice	8,728	10,273	1.2	
Appointments other primary care professionals	20,353	23,955	4.8	
Psychological therapies	19,182	22,577	4.6	
Tavistock OPs	1,210	1,424	0.9	
Adult social care	0	0	0.0	
Foot health	14,853	17,482	3.5	
Locomotor new appts.	5,696	6,705	3.0	
Locomotor follow-up appts.	22,786	26,819	7.7	
Pain management	6,448	7,589	2.3	
Sexual health	18,700	22,010	3.8	
ACRT	2,100	2,472	0.7	
Outpatients	0	0	0.0	
Dental	0	0	0.0	
Totals	192,740	226,856	42.9	

There are 16 C/E rooms in the Lawson surgery . It has been stated that although a further 6 rooms could be available in the new extension such space is available only in the interim.

Activity based on actual activity pro rated to 12 months not lower target figure.

Finally, the consulting rooms required have been added to other functions to create an initial space requirement as shown bellow. A fuller schedule of accommodation is given in Appendix 3. The working hypothesis is that the new development would have a net additional requirement for 27 consulting / examination rooms after deducting the 16 rooms currently available in the Lawson practice as shown below:

Table 6: Space assumptions	HBN m2	Number required	Space required m2
Clinic rooms	16	27	430
x ray	40	0	0
Other diagnostics	17	0	0
Pharmacy	60	0	0
Dental chairs	18	0	0
Dental support areas	40	0	0
Treatment rooms	22	2	44
Physiotherapy / gym	218	1	218
Occupational therapy	54	1	54
Wheelchair store	80	1	80
Office 1 person	12.5	1	13
Office 10 workstations	195	1	195
Office 20 workstations	275	1	275
Group room small	30	1	30
Group room large	41		0
Meeting / seminar room small	30	1	30
Meeting / seminar room large	41		0
Staff room / kitchen	8	1	8
Sub total			**1377**
WCs, shower, patients / staff	7%		96
Ancillary areas	15%		207
Waiting, cafe	35%		482
Other	12%		165
Total excl circulation			**2327**
Circulation	25%		582
Gross internal area m2			**2908**

Rooms required are the additional rooms needed and assumes best use is made of the existing and new capacity in the Lawson

ed and assumes best use is made of the sp

Office space requirements based on 165 community stafff located at St.Leonards.

Other spaces given as % rather than m2 to allow for flexiblie relationship to SWLRC size.

The above space requirements for staff based at the centre have been estimated on accepted space allowances per person and the proportion of staff time based at a desk. This gives an indicative number of workstations required,

StL staff needs		Office space requirements						Space requirements per office staff category m2	
		no. staff requiring desks	number of staff at desks what % of time					A	6
			A	B	C	D		B	4
			100%	75%	50%	25%		C	3
Psychology	25% JSHC, 75% StL	30	4			26		D	2
Foothealth	StL	20	3	0	2	15			
Locomotor (1 & fup)	StL	34	8	1	6	19			
Pain management	StL	5	1	0	2	2			
Sexual health	StL	32	8	1	21	0			
ACRT	StL	50	7	9	34	0			
WCS	StL	13	3	6	0	4			
Learning Disabilities Service	StL	11	2	3	2	4			
		195	36	20	67	70	**Totals**		
Total meterage for desks m2			**216**	**80**	**201**	**140**	**637**		

4 ECONOMIC CASE

4.1 Our approach

This section of the business case provides evidence to demonstrate that NELC have selected the most economically advantageous solution which best meets their future service needs and optimises value for money. A key component of any option appraisal is the assessment of the non-financial benefits that are likely to accrue from the options under consideration.

The benefits appraisal process had five main stages:

- Deriving a shortlist of options
- Identifying the benefits criteria relating to each of the investment objectives;
- Weighting the relative importance (as a %) of each benefit criterion in relation to each investment objective;
- Scoring each of the short-listed options against benefit criteria on a scale of 0 to 10
- Deriving a weighted benefits score for each option.

The role of the benefit criteria is to provide a basis against which each of the options can be evaluated in terms of their potential for meeting the objectives of the proposed capital investment. Individual criteria have differing degrees of importance in determining the preferred solution to emerge from the appraisal, so it is necessary to weight the criteria to reflect the degree to which each will affect the outcome of the scoring exercise.

4.2 Option appraisal

The first step is to identify a range of options and a set of criteria by which they must be judged, initially in non-financial terms. In assessing the non-financial benefits of potential options criteria were developed. These were based around the Quality, Improvement, Productivity & Prevention (QIPP) initiative as key enablers. QIPP represents a coming together of existing policies and is designed to improve delivery at a time of financial challenges across the NHS.

4.3 Long list of options

It is usual in an outline business case for a long list of options to be drawn up. However, given the work around the previous business case, the extensive consultation and the recent workshop it was felt there were only a few practical options. The larger scheme involving

mental health and urgent care had already been rejected as unaffordable. Consideration was, however, given to a further possible long listed option whereby there would be no health facilities at all on the St.Leonard's site. In view of the practical difficulty of finding space for the displaced services and the commitments to the public, this option was rejected. This would almost certainly fail at least two of the Lansley tests, the acceptance by GPs and support from the public.

Such an option is also unlikely to be acceptable to the local authority. In planning terms the existence of a health facility is likely to help a new future planning application and indeed potentially could increase site disposal values through a less onerous Section 106 affordable housing requirement.

Also considered was a total refurbishment option of the existing buildings. However, the buildings are of such poor condition in general and in terms of disability. Importantly, this approach would make poor use of the site, as now, and would miss the opportunity to develop at least part of the site for alternative use and gain a capital receipt for the NHS. For these reasons the refurbishment option was rejected.

4.4 Short-list of options

The business case team held a workshop including representatives of service users, estates, commissioning, community care providers, patient groups and a GP. The purpose was to carry out the option appraisal for the future of St Leonard's hospital and its services and to agree the range of options under considerations, the criteria by which the options are evaluated and to agree how they should be scored. This process is essential for the development of this Outline Business Case. (There are different ways of delivering the preferred option but this is addressed later).

These key stakeholders confirmed the range of services to be accommodated as listed earlier and agreed the following short-list of options:

<u>Do nothing</u>

- Services and facilities remain as at present
- There is no investment
- GP practices remain where they are
- This will mean a limited lifespan of the buildings

.

Option 1: Do minimum

- This would mean minimum expenditure on the existing buildings
- This will eradicate the essential back log maintenance
- Services and GP practices remain where they are
- This will extend the lifespan of the buildings, but is not a full refurbishment

Option 2: A new build development

- This option accommodates all current community services plus Tavistock (Kingsland Road) and allows for the centralisation of the Southgate Road and the Whiston Road surgeries on the St Leonard's site
- There would be a disposal and redevelopment of part of the site

Option 3: A new build development for community services only

- This option accommodates all current community services plus Tavistock (Kingsland Road) and allows for the centralisation of the Southgate Road and the Whiston Road surgeries at Southgate Road which would be upgraded.
- There would be a disposal and redevelopment of part of the site

There is some spare capacity in the recently extended Lawson practice and the GPs there are happy in principle with accommodating some community services but for an interim period only until such time as demand grows. Whilst this opportunity should be pursued with levers to improve the efficiency of all the space at the Lawson practice, such gains are not felt to minimise the space needed long term for the new build options.

The business case team agreed a list of benefits criteria by which the options would be scored. Each of the options was given a score from 1-10 with 10 being the highest for each criterion. Table 1 shows the raw, or unweighted, scores allocated. Option 2, the new build, scored better on all criteria. Option 3, moving the Whiston surgery to Southgate Road scored worse than Options 2 because more patients would be suffer greater geographical inconvenience and also because of the problems in modifying or refurbishing Southgate Road surgery to accommodate a large increase in patients. All three GPs at this practice are united in their desire to rationalise on one site, their driving aim, but are less certain about which one. Either would be acceptable to them but on balance a new development at St.Leonard's would be preferable subject to finances. As can be seen below, Option 2, the new build at St.Leonard's, emerges as the preferred option in terms of unweighted scores, with Option 3, the Southgate Road option, coming a poor second.

Table 1: Unweighted scores

Benefits criteria			Do nothing	Option 1 Do minimum	Option 2 New build St.Leonards	Option 3 GPs to Southgate Rd.
Enabler	**Key benefits**	**Examples**				
Quality	Improving health outcomes	expanded access to primary care programme admission avoidance speedier access to diagnostics clinical evidence for changes good strategic fit care packages	2	4	9	6
	Reducing health inequality	service change to accommodate new models of care opportunity to locate facilities in areas of greatest need				
	Better patient experience	more choice and control by patients changes supported by public good local access / public transport extended hours				
	Capacity and fitness of the NHS estate	high quality, fit-for-purpose buildings decommissioning surplus and poor quality estate				
Innovation	Current & future flexibility	degree to which changes can be made in service delivery ensuring sustainable and flexible buildings for the future align estates planning with sector based service planning opportunity for new and better use of workforce skills whole system approach for integrated primary care avoid incrementalism	1	2	8	6
Productivity	Integrated services	vertical / horizontal integration of services opportunity for shared services and resources	1	2	9	6
	Optimising use of the estate	radical improved performance of the estate release of cost & value from inefficiently used estate				
	Improved efficiency	better management staffing efficiency and critical mass use of generic space and scheduling of rooms improved staff recruitment / retention				
Prevention	Wider community impact	focus on prevention developing the expert patient employment opportunities links to education, library / internet facilities regeneration of communities	1	1	8	7
Practicality	Ease of implementation	available project management skills timescales and site availability	5	6	7	5
	Acceptability	managing public expectation acceptability to service users acceptability to GPs and community staff				
	Constraints	planning consents site constraints / operational difficulty restrictive covenants access to funding				
		Total scores	**10**	**15**	**41**	**30**
		Rank order	**4**	**3**	**1**	**2**

Next, because some criteria are more important than others a weighting was given to each so that the sum of the weights equalled 100. The raw scores are then multiplied by these weightings to produce weighted scores as shown in Table 2. The weightings reflect the stakeholders' view that quality is the most important criterion and, given the long history of delays over St.Leonard's, the practicality criterion was deemed equal second most important. Option 2 is the strongly preferred option in terms of weighted scores

Table 2: Weighted scores

Benefits criteria			Weighting	Do nothing	Option 1 Do minimum	Option 2 New build St.Leonards	Option 3 GPs to Southgate Rd.
Enabler	**Key benefits**	**Examples**					
Quality	Improving health outcomes	expanded access to primary care programme admission avoidance speedier access to diagnostics clinical evidence for changes good strategic fit care packages	30	60	120	270	180
	Reducing health inequality	service change to accommodate new models of care opportunity to locate facilities in areas of greatest need					
	Better patient experience	more choice and control by patients changes supported by public good local access / public transport extended hours					
	Capacity and fitness of the NHS estate	high quality, fit-for-purpose buildings decommissioning surplus and poor quality estate					
Innovation	Current & future flexibility	degree to which changes can be made in service delivery ensuring sustainable and flexible buildings for the future align estates planning with sector based service planning opportunity for new and better use of workforce skills whole system approach for integrated primary care avoid incrementalism	15	15	30	120	90
Productivity	Integrated services	vertical / horizontal integration of services opportunity for shared services and resources	20	20	40	180	120
	Optimising use of the estate	radical improved performance of the estate release of cost & value from inefficiently used estate					
	Improved efficiency	better management staffing efficiency and critical mass use of generic space and scheduling of rooms improved staff recruitment / retention					
Prevention	Wider community impact	focus on prevention developing the expert patient employment opportunities links to education, library / internet facilities regeneration of communities	15	15	15	120	105
Practicality	Ease of implementation	available project management skills timescales and site availability	20	100	120	140	100
	Acceptability	managing public expectation acceptability to service users acceptability to GPs and community staff					
	Constraints	planning consents site constraints restrictive covenants access to funding					
		Total scores	**100**	**210**	**325**	**830**	**595**
		Rank order		**4**	**3**	**1**	**2**

Finally, we need to determine the extent to which the weights of the criteria need to be changed in order to change the ranks. This is known as sensitivity testing and challenges the robustness of the preferred option. In this case because Option 2 did not score less than Option 3 on any one criterion it is impossible to switch their rankings. It is possible only to close the gap by reducing the importance of the one criterion on which their scores were close, namely the prevention benefit. When the weight of this criterion is increased to 60 and the others all reduced to 10 then the gap between the two leading options drops from 235 to 160. This demonstrates that the options are not susceptible to changes in weightings and that the leading Option 2 is a robust preference in non-financial terms.

Table 3: Sensitivity

Benefits criteria			Weighting	Do nothing	Option 1 Do minimum	Option 2 New build St.Leonards	Option 3 GPs to Southgate Rd.
Enabler	**Key benefits**	**Examples**					
Quality	Improving health outcomes	expanded access to primary care programme admission avoidance speedier access to diagnostics clinical evidence for changes good strategic fit care packages	10	20	40	90	60
	Reducing health inequality	service change to accommodate new models of care opportunity to locate facilities in areas of greatest need					
	Better patient experience	more choice and control by patients changes supported by public good local access / public transport extended hours					
	Capacity and fitness of the NHS estate	high quality, fit-for-purpose buildings decommissioning surplus and poor quality estate					
Innovation	Current & future flexibility	degree to which changes can be made in service delivery ensuring sustainable and flexible buildings for the future align estates planning with sector based service planning opportunity for new and better use of workforce skills whole system approach for integrated primary care avoid incrementalism	10	10	20	80	60
Productivity	Integrated services	vertical / horizontal integration of services opportunity for shared services and resources	10	10	20	90	60
	Optimising use of the estate	radical improved performance of the estate release of cost & value from inefficiently used estate					
	Improved efficiency	better management staffing efficiency and critical mass use of generic space and scheduling of rooms improved staff recruitment / retention					
Prevention	Wider community impact	focus on prevention developing the expert patient employment opportunities links to education, library / internet facilities regeneration of communities	60	60	60	480	420
Practicality	Ease of implementation	available project management skills timescales and site availability	10	50	60	70	50
	Acceptability	managing public expectation acceptability to service users acceptability to GPs and community staff					
	Constraints	planning consents site constraints restrictive covenants access to funding					
		Total scores	**100**	**150**	**200**	**810**	**650**
		Rank order		**4**	**3**	**1**	**2**

The distortion of the weightings however is unrealistic and therefore the weighted scores in Table 2 can be deemed to be robust. These weighted benefits scores can then be assessed later by applying costs to arrive at a value for money conclusion as described in the next section.

4.5 Value for money assessment

Value for money assessment (vfm) is a key part of the business case and is the economic evaluation of costs and benefits. This can be treated initially through the Capital Investment Manual approach showing the net present values of the options set against the benefits.

Costs, savings and capital receipts have been applied to the Do nothing / do minimum option and the new build options as if they were to be delivered through NHS funding, in effect a public sector comparator. (In accordance with Treasury advice VAT and capital charges are excluded from this analysis as they remain with the public sector.) This produces a net present cost or value for each option. The full tables are shown in Appendix 4 and more detail behind the assumptions is described in the next section. These costs are then set against the weighted benefits determined earlier to produce the following costs per unit of benefit:

Value for money	Do minimum	Option 1 Do minimum	Option 2 New build St.Leonards	Option 3 GPs to Southgate Rd.
Discounted Cash Flow (£000s)	4,467	16,028	10,096	7,412
Sum of Discount Factors	8.61	13.09	21.89	21.86
Equivalent Annual Costs (£000s)	518.97	1224.09	461.16	339.02
Benefit Score	210	325	830	595
Cost Benefit Score (£)	2471.30	3766.42	555.62	569.78

As can be seen the do nothing and do minimum options offer poor value for money. Running costs are high and the benefits are low. Option 2, the new build offers best value for money with the lowest cost per unit of benefit (£555.62). Option 3 where the GPs on site from the Whiston surgery move to the Southgate Road surgery is only marginally poorer value for money. Although the benefits are lower there is a reduced size of new build and as a consequence a slightly higher capital receipt expected from the sale of the site.

In economic terms therefore the preferred Option 2 offers the best value for money. Next we need to consider this preferred option against the alternative procurement through a publicly funded route, a public sector comparator. Appendix 5 shows that the NPV of the PSC over its 50 year life is £14.7m. compared to the commercial lease NPV of £9.7m. However as these are of different period the EAC has been calculated as before to allow for a fair comparison of the economic benefits as shown below:

Value for money	Option 2 New build St.Leonards lease	Option 2a new build PSC
Discounted Cash Flow (£000s)	9,752	14,725
Sum of Discount Factors	21.61	25.25
Equivalent Annual Costs (£000s)	451.23	583.16
Benefit Score	830	830
Cost Benefit Score (£)	543.65	702.60

The commercial lease shows good value for money and suggests this should be taken forward to the FBC stage.

However, any preferred option, if it is to proceed, must be both good value for money and affordable. The next section is the financial case and deals with the affordability.

5 FINANCIAL CASE

5.1 Affordability scenarios

This section deals with the overall affordability of the preferred option in both capital and revenue terms and compared to the costs of running services as now. Various assumptions have been made as shown in the following tables:

St.Leonard's cost assumptions

Inputs	Do nothing	Option 1 Do minimum	Option 2 New build St.Leonards	Option 3 GPs to Southgate Rd
GIA m2		11,945	2,700	2,200
Land sales receipts- assume with planning (£000s)	0.00	0.00	16,000	16,250
Rent & rates Southgate Road practice (£000s)	73.38	73.38		100
Refurbishment at Southgate Road				750
Kingsland Road surgery rent & rates	42.02	42.02		
Abortive fees (£000s)	2,300.00	2,300.00	2,300	2,300
Lease period/ economic life (yrs)	10	15	35	35
Construction cost (£pm2)		800.00	2,900	2,900
Equipment costs (£m2)			85	75
Commercial lease cost (£m2)			269	269
LPA equivalent (£m2)			350	350
Hard FM pa (incl in LPA) (£m2)			35	35
Whole Life cycle pa (incl in LPA) (£m2)			30	30
Soft FM (£m2 pa)			64	64
Utilities, insurance, etc. (£m2 pa)			24	24
Rates (£m2 pa)			39	39
IT maintenance (£m2 pa)			9	9
Hard FM £pa (internal only, assume 50%)			47,250	38,500
Whole Life cycle £pa (internal only, assume 50%)			40,500	33,000
Soft FM (£pa)			172,800	140,800
Utilities, insurance, etc. (£pa)			64,800	52,800
Rates St.Leonards (£pa)			105,300	85,800
Rent & rates Southgate Road practice (£000s)				100,000
IT maintenance (£pa)			24,300	19,800
Premises revenue costs p.a. excl. lease costs			**454,950**	**470,700**
Lease costs p.a.			**726,300**	**591,800**
Total premises costs p.a.			**1,181,250**	**1,062,500**
Construction and equipment costs excl. VAT				

St Leonards Site - Annual Budget 2010-11	
	£
Electricity	146,784
Gas	12,000
Water	30,000
Rates	66,492
Bldg/Eng Equip Maint/Rep	35,000
Ext Contr Window Clean	1,151
Cleaning Equipment	7,464
Cleaning Materials	7,119
Contr Refuse and Clinical Waste	32,045
Contr Pest Control	1,130
Domestic & Houskeeping	84,842
Security	94,946
Sub total	**518,973**
Capital charges	756,000
Total costs	**1,274,973**

The table on the right above shows the current estates costs of running St. Leonard's. Staffing costs have been excluded as no savings are expected with staff transferring to the new build and / or the Lawson practice. However future commissioning contracts may be able to lever some economies of scope and scale.

The table on the left above shows:

- Different gross internal areas of the three options showing the large amount of space taken by the current services
- A reducing capital receipt inversely proportionate to the NHS facility size. The more space needed for NHS use, the less will be available for disposal.
- Rent & rates that would be avoided at Southgate Road under Options 1 and 2
- An expected increase in rent & rates under Option 3
- An allowance for refurbishment at Southgate Road to accommodate Whiston patients
- Abortive fees to LIFTco for the abandonment of the previous scheme (rationale for this discussed in the next section).

5.2 Capital costs

The capital costs for the preferred option if the development were to be built by the public sector are shown in the OB forms at Appendix 6. The gross cost of this public sector comparator (PSC) at PUBSEC 173 based on a requirement of some 2,643m2 is £9.67m including fees and inflation but excluding VAT. Such a funding route is unlikely to be followed however. This is due in part to the lack of capital funds available and partly due to the fact that a stand-alone facility will almost certainly take up more space on the site than an integrated solution as part of a larger development which would reduce the amount land to be sold. However this initial PSC forms the baseline against which other delivery routes can be assessed.

5.3 Optimism Bias

Treasury advice on public sector projects states that there is a demonstrated, systematic, tendency for project appraisers to be overly optimistic, and not to build in sufficient provision for things going wrong. To compensate, an optimism bias adjustment needs to be made to the project's costs, benefits and duration, which basically adds a further adjustment for risk. The calculation examines characteristics such as type of build, location, and whether there are facilities management and IT infrastructure.

As shown in Appendix 7 an upper bound figure of 32.5% is put forward for this project, mainly due to the constraints of the existing site which needs to operate throughout the construction phases and the need for a new planning consent. This is then mitigated by an assessment of how the contributory factors to things going wrong can be managed by people in charge of the project shown as the second table in Appendix 7. The overall mitigation for this project is not high given the amount of development and design work to be

done. It is thought that risk mitigation brings down the risks to 78%, which means the original upper bound 32.5% becomes 25.4% (i.e. 32.5%x78%).

The construction costs are therefore increased by 25.4% in the vfm analysis in addition to normal contingency. Revised guidance no longer deems it necessary to calculate optimism bias for operating costs because of the lack of reliable evidence.

5.4 Revenue affordability

The following table shows the impact that the new build, under a commercial lease, will have compared with the existing costs of running St. Leonard's:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
St.Leonard's premises costs existing							
Electricity	146.78	146.78					
Gas	12.00	12.00					
Water	30.00	30.00					
Rates	66.49	66.49					
Bldg/Eng Equip Maint/Rep	35.00	35.00					
Ext Contr Window Clean	1.15	1.15					
Cleaning Equipment	7.46	7.46					
Cleaning Materials	7.12	7.12					
Contr Refuse and Clinical Waste	32.05	32.05					
Contr Pest Control	1.13	1.13					
Domestic & Houskeeping	84.84	84.84					
Security	94.95	94.95					
Sub totals	518.97	518.97					
Capital charges St.Leonard's	756.00	756.00					
Southlands Road costs	73.38	73.38					
Kingsland surgery costs	42.02	42.02					
Option 3: reduced new build costs							
Lease costs (assuming capital retained)			726.30	726.30	726.30	726.30	726.30
Hard FM £pa			47.25	47.25	47.25	47.25	47.25
Whole Life cycle costs			40.50	40.50	40.50	40.50	40.50
Soft FM			172.80	172.80	172.80	172.80	172.80
Utilities, insurance, etc.			64.80	64.80	64.80	64.80	64.80
Rates			105.30	105.30	105.30	105.30	105.30
IT maintenance			24.30	24.30	24.30	24.30	24.30
Total expenditure p.a.	**1390.37**	**1390.37**	**1181.25**	**1181.25**	**1181.25**	**1181.25**	**1181.25**
Annual saving			209.12	209.12	209.12	209.12	209.12

As can be seen there will a net recurrent saving each year of over £200,000. In addition there will be a capital receipt to the NHS from the disposal and development of the remainder of the site.

However, one option open to NELC is to capitalise the lease cost and reduce or eliminate the rental costs by foregoing some or all of the capital receipt. An example is given below:

Net present values of different leases										
Discount rate	Years 1-30	1.035								
Discount rate	Years 31-35	1.030								
	Option 2 Commercial lease					Option 2a Peppercorn rent				
Year	Capital receipt £000s	Lease payments £000s	Total cost £000s	Discount factor	NPV	Capital £000s	Lease payments £000s	Total cost £000s	Discount factor	NPV
2012				1.00					1.00	
2013				0.97					0.97	
2014				0.93					0.93	
2015	-16,000.00	726.30	-15,273.70	0.90	-15,273.70	-744.01	0.00	-744.01	0.90	-744.01
2016		726.30	726.30	0.87	701.74		0.00	0.00	0.87	0.00
2017		726.30	726.30	0.84	678.01		0.00	0.00	0.84	0.00
2018		726.30	726.30	0.81	655.08		0.00	0.00	0.81	0.00
2019		726.30	726.30	0.79	632.93		0.00	0.00	0.79	0.00
2020		726.30	726.30	0.76	611.53		0.00	0.00	0.76	0.00
2021		726.30	726.30	0.73	590.85		0.00	0.00	0.73	0.00
2022		726.30	726.30	0.71	570.87		0.00	0.00	0.71	0.00
2023		726.30	726.30	0.68	551.56		0.00	0.00	0.68	0.00
2024		726.30	726.30	0.66	532.91		0.00	0.00	0.66	0.00
2025		726.30	726.30	0.64	514.89		0.00	0.00	0.64	0.00
2026		726.30	726.30	0.62	497.48		0.00	0.00	0.62	0.00
2027		726.30	726.30	0.60	480.65		0.00	0.00	0.60	0.00
2028		726.30	726.30	0.58	464.40		0.00	0.00	0.58	0.00
2029		726.30	726.30	0.56	448.69		0.00	0.00	0.56	0.00
2030		726.30	726.30	0.54	433.52		0.00	0.00	0.54	0.00
2031		726.30	726.30	0.52	418.86		0.00	0.00	0.52	0.00
2032		726.30	726.30	0.50	404.70		0.00	0.00	0.50	0.00
2033		726.30	726.30	0.49	391.01		0.00	0.00	0.49	0.00
2034		726.30	726.30	0.47	377.79		0.00	0.00	0.47	0.00
2035		726.30	726.30	0.45	365.01		0.00	0.00	0.45	0.00
2036		726.30	726.30	0.44	352.67		0.00	0.00	0.44	0.00
2037		726.30	726.30	0.42	340.74		0.00	0.00	0.42	0.00
2038		726.30	726.30	0.41	329.22		0.00	0.00	0.41	0.00
2039		726.30	726.30	0.40	318.09		0.00	0.00	0.40	0.00
2040		726.30	726.30	0.38	307.33		0.00	0.00	0.38	0.00
2041		726.30	726.30	0.37	296.94		0.00	0.00	0.37	0.00
2042		726.30	726.30	0.36	286.90		0.00	0.00	0.36	0.00
2043		726.30	726.30	0.34	277.20		0.00	0.00	0.34	0.00
2044		726.30	726.30	0.33	267.82		0.00	0.00	0.33	0.00
2045		726.30	726.30	0.32	258.77		0.00	0.00	0.32	0.00
2046		726.30	726.30	0.31	250.01		0.00	0.00	0.31	0.00
2047		726.30	726.30	0.30	241.56		0.00	0.00	0.30	0.00
2048		726.30	726.30	0.29	233.39		0.00	0.00	0.29	0.00
2049		726.30	726.30	0.29	226.59		0.00	0.00	0.29	0.00
2050		726.30	726.30	0.28	219.99		0.00	0.00	0.28	0.00
	-16,000.00	**26,146.80**	**10,146.80**	**21.01**	**-744.01**	**-744.01**	**0.00**	**-744.01**	**21.01**	**-744.01**

If the capital receipt for the site is £16m and the commercial lease were £726,000 p.a., NELC could forego all but £744,000 of the sale proceeds in order to achieve rent free occupation for 35 years at the same net present cost. The effect of this would be to produce revenue savings of almost £1m compared to current costs. This is further discussed in the next commercial section and would be subject to final evaluation and approval at the full business case stage.

5.5 Accounting treatment

NELC has considered the accounting treatment of the disposal and leaseback of clinical space. The relevant guidance[9] states: *"In determining which standard to apply, it is necessary to consider the substance of the transaction. Where the contract is clearly solely for the construction of an asset then IAS 16 should be applied. Where the contract is clearly for the lease of an asset then it should be accounted for as either a finance lease or an operating lease, as appropriate, under IAS 17..... In practice, therefore, wherever an NHS body receives a service, it should in the first instance consider whether it is in substance a service concession in accordance with IFRIC 12, and if not, whether it is an arrangement containing a lease under IFRIC 4".*

The nature of the preferred option is a transaction with two components:

- The freehold sale of the St. Leonards land and buildings freehold to the selected developer
- the lease of the health resource centre on a 35 year lease at a commercial rate

The freehold disposal is clearly an off-balance sheet transaction. The lease will be either an operating lease or a finance lease. Under IAS 17 if the lease is considered a finance lease, an asset and liability will be recognised in the balance sheet and capital charges, interest and service components are recognised in the Income and expenditure statement. The standard is being reviewed at the moment, the distinction between finance and operating lease will be removed and an asset and liability will be recognised on the balance sheet. It is expected this change will occur during 2013/14.

NELC will seek the advice of the District Valuer for an open market value at FBC stage. The net book value St. Leonards is £20.1m. comprising £10.64m. for the land and £9.47m. for the existing buildings. The write-off of the assets will need further consideration.

[9] NHS Finance, Performance & Operations Accounting for PFI under IFRS – April 2009

6 COMMERCIAL CASE

6.1 Procurement routes

There are many funding options for the delivery of a new facility. The table below, based on work with PwC, summaries the main routes available to NELC:

Procurement route	Description	Benefits & Considerations	Revenue cost
LIFT	Facility via a 25 year lease commitment which incorporates lifecycle replacement services, ensuring delivery and maintenance of new facilities through annual revenue payments	**Lower risk** approach ensuring that high quality facilities are developed and maintained for at least 25 years. LIFT company also takes design and delivery risks/costs and fees.	£398 per sq m
Traditional Capital Investment	Bid for NHS capital with the scheme delivered through Procure 21. NELC is responsible for the ongoing maintenance and has to pay capital charges	Reliant on the NHS having capital to invest, and the relative need of the borough. NELC holds the development, management and planning risk including a significant resource burden. **Higher Risk**	£234 per sq m (paid through capital charges)
Private Developer	encourage landlords and private developers to build/refurbish pre-let facilities for NELC who can enter lease arrangements with the developer. NELC will then be responsible for running and maintaining the facilities.	NELC has minimal control over quality of the facility. This is **medium risk** and minimal NELC resource requirement. NELC retains the maintenance and LCR responsibility.	£314 per sq m
GP led development	Encourage individual or GP consortia to buy/develop private facilities using commercial finance (mortgages) in exchange for guaranteed notional rent arrangements with NELC	**Lower risk** approach but reliant on entrepreneurial GP's. NELC retains some LCR and maintenance responsibility.	£314 per sq m
Joint venture	Private sector manages property disposals and exits, in order to: maximise value, limit vacant possession costs; and ensure that the local economy derives the maximum benefit from disposals	Disposal and vacant possession costs are covered by the vehicle and therefore deducted from the gross disposal receipt. Enhanced disposal receipts (although profit split with partner. Suitable for development sites where planning effort is greater. Reduction in estates skill required in-house	£269m2 for lease rent. NELC retains responsibility for maintenance

Under the previously agreed procurement route for the larger scheme NELC intended to follow the land retention agreement (LPA) instead of the transfer to the LIFTco under the usual LPA. Analysis by NELC's financial advisors, Grant Thornton, showed that under the DH's required approach to accounting for PFI under IFRS, the impact on NELC's Income and Expenditure Account would be lower under a LRA than under a LPA. Furthermore the LRA would be better value for money then a LPA because the land on which it is proposed to build the SLRC is likely to have a rising redevelopment value beyond the life of the SLRC, due to its location on the main artery of the Borough (the A10) with improving access to other forms of transport (East London Line opening in 2011). Retaining the land would therefore provide better value for NELC, than disposing of the land to LIFTCo which would be required under a LPA approach.

Furthermore the Grant Thornton analysis demonstrates that it would not be good value for money to subsidise the scheme with the then expected £7.5 million proceeds (at mid-range market prices) from selling the rest of the St Leonard's Hospital site to ELFT, because the proceeds could only used by way of advanced rental payments, thus attracting capital charges and amortisation over the 25 year Agreement. The conclusion was therefore that better value for money could be achieved by using the proceeds for other non-recurrent purposes or projects.

6.2 Why a JV is likely to be better than LIFT

The Director of Estates for NELC has taken advice about the potential values and how a joint venture approach may be followed. Because the potential proceeds far outweigh the costs of the NHS facility LIFT would not appear to be the best vehicle. LIFTcos were not established to be property developers or take significant risk and therefore the LIFT exclusivity is deemed irrelevant in this case. Abortive fees for design, planning and other costs incurred on the previous scheme however will be due and this is under negotiation. NELC is seeking legal advice on this from its solicitors, Capsticks. An allowance of £2.3m has been made in the earlier vfm and affordability analysis which concluded that even with this penalty the preferred option is good value for money and affordable.

A JV approach is best suited to:
1. Development sites which the private sector can package together to add value
2. Buildings requiring refurbishment or redevelopment;
3. Buildings with significant vacant possession costs i.e. rates, security, etc; and
4. Leased premises which are difficult to sub-let, and where the private sector can help support lease premium negotiations to exit (whilst using other disposal profits to pay for the exit costs).

St.Leonard's fulfils the first three of these conditions and would appear to be the preferred procurement route. There are restrictions on the ability for NELC's to hold equity stakes in JV vehicles which will therefore need to be negotiated with NHS London.

6.3 Market intelligence

Specialist advice has been commissioned from Montagu Evans, one of the leading property advisers. Their report concluded that, "the principle of redeveloping the site for residential purposes appears to be in broad accordance with the Development Plan... subject to the NHS Trust's support for the redevelopment....robust justification of the loss/relocation of the healthcare facilities and adequate provision of affordable housing."[10]

The report states that LB Hackney's emerging Core Strategy seeks to achieve a borough wide target of 50% affordable housing at a 60/40 split in favour of social rented accommodation. The emerging Core Strategy policy is consistent with the London Plan. Both policies suggest the borough wide target of 50% can be negotiated upon to take account of viability, location and site characteristics. In light of the potential cost of providing the healthcare facility, cost of repairs/conversion to the listed buildings and Montagu Evans' knowledge of recent consented developments in this area, it would be reasonable to assume 35% affordable housing at a 60/40 split. Any planning application that proposes affordable housing below 50% will need to be supported by a financial appraisal/toolkit assessment in order to demonstrate the scheme is not viable at 50%.

Taking account of likely density and planning constraints the advice is that the development will be a significant regeneration project providing approximately 267 residential units and approximately 2,500m2 of healthcare facilities. On this basis the conclusion is that the site has a baseline value without planning of £11.5m and with planning £16m. In addition the NHS should be able to benefit from a share of profits over and above certain threshold and after costs have been recovered.

Clearly, these are key issues requiring detailed negotiation and would need to be reflected in the full business case. To achieve this point however requires considerable resource capacity and capability. NELC does not have this specialist skill nor the resources expected to be some £0.5m to achieve a successful planning outcome and maximise the capital receipt to the NHS. For these reasons the business case proposes, subject to agreement to the preferred option that it works with its advisers who will help select a joint venture partner who will fund the speculative costs and offer the best deal for the NHS. The fees of the advisers for this next stage of the work would not necessarily met in full by NELC but could be met from the eventual sale proceeds subject to a satisfactory outcome and

[10] St. Leonards Hospital, Kingsland Road, London, Report and Indicative Valuation, Montagu Evans, 31 October, 2010

in a spirit of openness and partnering. One approach would be the sale without planning but with overage clauses significant share of the sales receipt above this level. Differing approaches to the deferring of fees would be part of the adviser procurement process. These will require discussion with NHS London.

6.4 Estate strategy

A recent review of the estates strategy by PwC identified St. Leonards and Plaistow Hospitals as the best opportunities for redevelopment / disposal. The previous proposals for moving each service off the St. Leonard's site are summarised on the following map:

Clearly some of these moves are no longer relevant as the development will be smaller than originally intended and the demolition greater. The Montagu Evans report states that listing applies only to Blocks A and B (i.e. the block fronting Kingsland Road and the block running perpendicular to it). The facade to Hoxton Street is also noted as being covered by the listing. The list description explicitly states that the other buildings on the site do not possess special interest. The principle of demolition appears to have been established, but any application would need to be supported by a PPS5 justification to cover the effect of the replacement on the setting of the listed building and the character and appearance of the Conservation Area. Any demolitions would require express Listed Building Consent. As a substantial demolition of a listed building, the application would be referable to English Heritage who have authorisations powers on listed building consent applications in London.


St Leonards

7 MANAGEMENT CASE

7.1 Project Management arrangements

Good governance of major programmes and projects is essential covering:

- Project initiation document
- effective project structure
- people with delegated authority
- greater sense of discipline
- proper skill and resources
- realistic timelines
- active risk registers
- clinical engagement.

The DH Gateway process is a helpful methodology for assessing whether we have the right arrangements. Recent Office of Government Commerce delivery confidence assurance approach and is now used to determine whether a programme or project is likely to succeed. However its use must be proportionate to the size and scope of the project and in this case its use would seem unnecessary although the principles still hold true.

7.2 Decant arrangements

A decant strategy will be developed as part of the full business case and which will need to be consistent with continuing business and the phased construction and demolition programme.

7.3 Key responsibilities

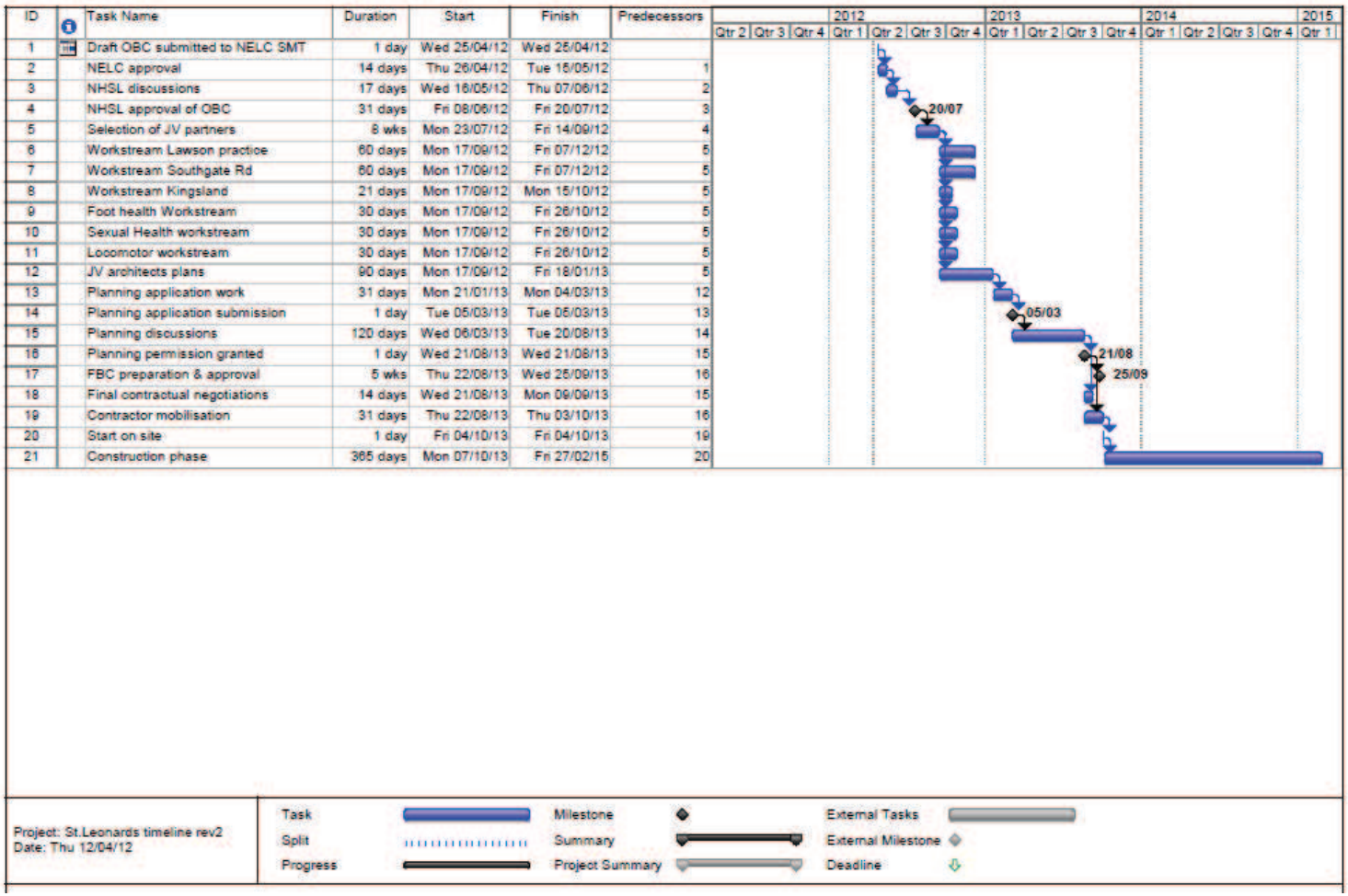
NELC has already identified clear responsibility for taking the project forward by designating David Butcher as the Project Director. There will need to be a project manager and a Senior Responsible Owner who should be a Trust Board director.

A formal project team should be established to take the scheme through the next stages.

7.4 Timeline

The following Gantt chart suggests a possible timeline with completion in early 2015.

ID	Task Name	Duration	Start	Finish	Predecessors
1	Draft OBC submitted to NELC SMT	1 day	Wed 25/04/12	Wed 25/04/12	
2	NELC approval	14 days	Thu 26/04/12	Tue 15/05/12	1
3	NHSL discussions	17 days	Wed 16/05/12	Thu 07/06/12	2
4	NHSL approval of OBC	31 days	Fri 08/06/12	Fri 20/07/12	3
5	Selection of JV partners	8 wks	Mon 23/07/12	Fri 14/09/12	4
6	Workstream Lawson practice	60 days	Mon 17/09/12	Fri 07/12/12	5
7	Workstream Southgate Rd	60 days	Mon 17/09/12	Fri 07/12/12	5
8	Workstream Kingsland	21 days	Mon 17/09/12	Mon 15/10/12	5
9	Foot health Workstream	30 days	Mon 17/09/12	Fri 26/10/12	5
10	Sexual Health workstream	30 days	Mon 17/09/12	Fri 26/10/12	5
11	Locomotor workstream	30 days	Mon 17/09/12	Fri 26/10/12	5
12	JV architects plans	90 days	Mon 17/09/12	Fri 18/01/13	5
13	Planning application work	31 days	Mon 21/01/13	Mon 04/03/13	12
14	Planning application submission	1 day	Tue 05/03/13	Tue 05/03/13	13
15	Planning discussions	120 days	Wed 06/03/13	Tue 20/08/13	14
16	Planning permission granted	1 day	Wed 21/08/13	Wed 21/08/13	15
17	FBC preparation & approval	5 wks	Thu 22/08/13	Wed 25/09/13	16
18	Final contractual negotiations	14 days	Wed 21/08/13	Mon 09/09/13	15
19	Contractor mobilisation	31 days	Thu 22/08/13	Thu 03/10/13	16
20	Start on site	1 day	Fri 04/10/13	Fri 04/10/13	19
21	Construction phase	365 days	Mon 07/10/13	Fri 27/02/15	20



7.5 Benefits realisation

NELC applies an integrated approach to Benefits Realisation to ensure all key objectives are included within the Benefits Realisation Plan and in turn reflected in arrangements for Post Project Evaluation. As part of programme management, project implementation will be reviewed on a regular basis to monitor project delivery against programme milestones and the benefits realised against project objectives and the benefits sought.

7.6 Post Project Evaluation

The Trust is committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. These lessons learnt will be of benefit to:

- the Trust in using this knowledge for future capital schemes
- other key local stakeholders to inform their approaches to future projects
- the NHS more widely to test whether the policies and procedures which have been used in this procurement effectively.

PPE also sets in place a framework within which the benefits realisation plan can be tested to identify which of the anticipated benefits have been achieved with the reasons made clear. The Trust will comply with the newly published NHS guidance on PPE during the various evaluation stages.

8 CONCLUSION AND RECOMMENDATIONS

8.1 Main conclusions

The main conclusions of this OBC are that:

- The status quo cannot continue given the state of the buildings at St. Leonard's and the need to meet patient needs after the aborted previous scheme
- There are significant revenue savings to be realised
- There is potential for achieving a significant capital receipt for the NHS
- The Lawson practice is willing to make better use of its modern and recently extended surgery at least in the interim
- The LIFT procurement route proposed in the last business case is no longer appropriate
- A joint venture approach would seem to offer the greatest reward to the NHS at minimal risk.

8.2 Key recommendations

The key recommendations of this outline business case are to:

- agree the OBC and secure NHSL support and approval
- consider the use of the capital receipt in line with the objectives described
- establish a formal project group to take the scheme forward
- engage with representatives of the Lawson practice to agree the potential use of space
- engage with the GPs at Southgate Road and Kingsland to determine needs and agree solutions
- develop workstreams to develop the plans service heads for individual services such as sexual health, locomotor and foot health
- Collaborate iteratively with the sector and NHSL in developing the next steps.

9 APPENDICES

Appendix 1: GP list sizes and location

Appendix 2: Activity data Community Services

Appendix 3: Draft Schedule of Accommodation

Appendix 4: Net present values

Appendix 5: Net present values of public sector comparator v. commercial lease

Appendix 6: Outline business case cost forms

Appendix 7: Optimism Bias

9.1 Appendix 1: GP list sizes and location

PCT/Patch Practice List Sizes by Ageband and Practice.

Updated on 30th Sept 2011

Practice	Code	Patch	Total
ABNEY HOUSE MEDICAL CENTRE	F84624	CHNW	3,286
ALLERTON ROAD SURGERY	F84716	CHNW	4,399
ATHENA MEDICAL CENTRE	F84060	CHNE	5,462
BARTON HOUSE GROUP PRACTICE	F84008	CHNW	12,409
BROOKE ROAD SURGERY	F84694	CHNW	3,047
CEDAR PRACTICE	F84036	CHNW	6,956
CHOUDARY & NATHANS	F84038	CHSW	3,328
CLAPTON SURGERY	F84668	CHNE	6,615
DALSTON PRACTICE	F84063	CHSW	7,370
DE BEAUVOIR SURGERY	F84072	CHSW	4,504
ELM PRACTICE	F84685	CHNE	2,928
ELSDALE STREET SURGERY	F84601	CHSE	5,747
GADHVI AND GADHVI	F84080	CHNE	4,948
GANGOLA RL	F84636	CHNW	3,587
GREENHOUSE PRACTICE	F84632	CHSE	614
HEALY MEDICAL CENTRE PRACTICE	F84720	CHNE	6,145
HERON PRACTICE	F84119	CHNW	9,123
HOXTON SURGERY	F84692	CHSW	5,840
KINGSMEAD HEALTHCARE	F84015	CHSE	5,637
LATIMER HEALTH CENTRE	F84719	CHSE	4,463
LAWSON PRACTICE	F84096	CHSW	11,443
LEA SURGERY, THE	F84105	CHSE	9,991
LONDON FIELDS MEDICAL CENTRE	F84021	CHSW	8,894
LOWER CLAPTON GROUP PRACTICE	F84003	CHSE	11,749
NEAMAN PRACTICE, THE	F84640	CHSW	8,917
NIGHTINGALE PRACTICE	F84018	CHNE	8,657
PATEL VN	F84653	CHNW	1,684
QUEENSBRIDGE GROUP PRACTICE	F84117	CHSW	8,381
RICHMOND ROAD PRACTICE	F84035	CHSW	3,923
RIVERSIDE PRACTICE, THE	F84619	CHNE	3,964
RIZK FAM	F84042	CHSW	2,182
SANDRINGHAM PRACTICE	F84621	CHSW	4,572
SHARIFF SI	F84711	CHNE	2,074
SHOREDITCH PARK SURGERY	F84635	CHSW	7,052
SOMERFORD GROVE GROUP PRACTICE	F84033	CHNW	11,001
SORSBY GROUP PRACTICE	F84043	CHSE	5,267
SPITZER AND PARTNERS	F84686	CHNE	5,933
SPRINGFIELD GP-LED HEALTH CENTRE	Y03049	CHNE	5,480
STAMFORD HILL GROUP PRACTICE	F84013	CHNE	13,971
STATHAM GROVE SURGERY, THE	F84115	CHNW	8,060
TAHALINI RP AND PARTNERS	F84041	CHSW	6,728
TOLLGATE LODGE PRIMARY CARE CENTRE	Y01177	CHNE	6,178
TOWER OF LONDON MEDICAL OFFICER	F84659	CHSW	60
TROWBRIDGE PRACTICE	Y00403	CHSE	4,018
WELL STREET SURGERY	F84069	CHSE	12,356
WICK HEALTH CENTRE	F84620	CHSE	5,415
TOTAL			**284,358**

Extracted from East London MIS, compiled by ELCIS.

9.2 Appendix 2: Activity data Community Services

Table 3

Service Line	Unit of Measurement	10/11 Annual Target	Month 10 YTD Actual Activity	Forecast Outturn 10/11	
Adult Services Directorate					
Locomotor	New Episodes	**10,748**	9,286	11,143	
Locomotor follow-up	FU	**42,992**			Figure taken from revised activity data June 2010
Pain management		**6,448**			Figure taken from revised activity data June 2011
Dermatology	Attendance	**2,184**	1,374	1,649	
New Contacts	Attendance	1,344	734	881	
Follow Up Contacts	Attendance	840	640	768	
Foot Health	Attendance	**31,603**	21,919	31,603	
Urgent Care	Patients	**34,624**	26,904	34,624	
ECG	Patients	-	579		
ABP	Patients	-	532		
Primary Care Psychology Therapy	Contacts	**15,982**	22,836	TBA	
Dietetics	Contacts	**2,681**	2,730	3,276	
Adult Community Nursing	Contacts	**139,616**	158,864	190,637	
Wheelchair Services	Contacts	**1,800**	1,496	1,795	
Adult	Contacts	-	1,082	1,298	
Paediatric	Contacts	-	414	497	
ACRT	New Episodes	**2,100**	1,705	2,046	What about FUs?
Bilingual Advocacy	Contacts	**33,340**	29,541	35,449	
Child and Family Services Directorate					
Paediatrics	Attendance	**2,331**	2,047	2,456	
Occupational Therapy	Contacts	**4,456**	3,266	3,919	
Physiotherapy	Contacts	**4,000**	3,376	4,051	
Speech & Language Therapy	Contacts	**32,277**	27,058	32,470	
CHYPS Plus	Contacts	**7,500**	9,196	11,035	
CHYPS text messages	Texts		957	1,148	
LAC/Safeguarding	Contacts	**736**	680	816	
Sickle Cell And Thalassaemia	Contacts	**2,514**	3,475	4,170	
Health Visiting	Contacts	**101,283**	110,797	132,956	
Children's Specialist Nursing	Contacts	**5,562**	8,745	10,494	
School Nursing	Contacts	**18,850**	18,940	22,728	
Audiology	Attendance	**2,290**	3,304	3,965	
Newborn Hearing Screening	Contacts	**5,225**	4,851	5,821	
First Steps	Clin Contact Hr	**10,890**	5,882	11/12 target based on clinical hours & WTE	
Disability CAMHS	Clin Contact Hr	**2,616**	2,262	11/12 target based on clinical hours & WTE	
Community Sexual Health	Contacts/Scree	**22,000**	21,420	25,704	

9.3 Appendix 3: Draft Schedule of Accommodation

St.Leonards Resource Centre

Schedule of Accommodation

1.00	**Functional Zone 1**					
	Entrance, Reception, Waiting, Pharmacy					
Number	**Room**	**Room area m²**	**Quantity**	**Total area m²**		**Comment**
	Entrance					
1.01	Entrance Lobby	10.0	1	10.0		
1.02	Entrance Hall	15.0	1	15.0		
1.03	Meet & Greet Reception	6.0	1	6.0		
1.04	Reception (4 position)/Active Records	25.0	1	25.0		
1.05	Interview Room/Multi Use	15.0	1	15.0		
1.06	Waiting (20 persons incl 2 wheelchair positions)	20.0	1	20.0		
					91.0	
	Café					
1.07	Kitchen/Servery	20.0	1	20.0		
1.08	Seating	80.0	1	80.0		
					100.0	
	Ancillary					
1.09	Medical Records Storage	0.0	1	0.0		Assumed Electronic
1.10	WC Patient	2.5	4	10.0		
1.11	WC Patient Accessible	4.5	4	18.0		
1.12	WC Patient Ambulant/Assisted	4.5	2	9.0		
1.13	Nappy Changing	4.0	1	4.0		
1.14	Storage: General and Equipment	15.0	1	15.0		
1.15	Staff Change, 3 WC, Shower, female (30 staff)	15.0	1	15.0		
1.16	Staff Change, WC, Shower, male (10 staff)	15.0	1	15.0		
1.17	Staff Rest incl Kitchenette (20 persons)	20.0	0	0.0		
1.18	Staff WC	2.0	2	4.0		
1.19	Cleaner	7.0	1	7.0		
1.20	Disposal Hold	10.0	1	10.0		
1.21	Linen Holding Area	12.0	1	12.0		
					119.0	
	Pharmacy (remote-outpatient services)					
1.24	Dispensary - primary	25.0	0	0.0		
1.25	Waiting Area	15.0	0	0.0		
1.26	Interview	9.0	0	0.0		
					0.0	
	Subtotal			**310.0**		
	Planning allowance	5%		15.5		
	Total			**325.5**		
	Engineering allowance	3%		9.8		
	Circulation allowance	25%		81.4		
	Department Area			**416.6**		

2.00	Functional Zone 2				
	Consulting Suites				
Number	Room	Room area m^2	Quantity	Total area m^2	Comment
2.01	Reception	25.0	1	25.0	
2.02	Waiting	25.0	1	25.0	
2.03	Consulting/Treatment Rooms	16.5	27	445.5	
2.04	Interview Rooms	11.0	2	22.0	
2.05	Offices	10.0	0	0.0	
2.06	WC and handwash accessible: staff and patients	4.5	2	9.0	
2.07	Storage	20.0	1	20.0	
	Subtotal			**546.5**	
	Planning allowance	5%		27.3	
	Total			**573.8**	
	Engineering allowance	3%		17.2	
	Circulation allowance	25%		143.5	
	Department Area			**734.5**	

3.00	Functional Zone 3					
	Diagnostic					
Number	**Room**	**Room area m²**	**Quantity**	**Total area m²**		**Comment**
	General X-Ray					
3.01	Imaging Room: Conventional general x-ray with chest & skull	35.0		0.0		
3.02	Processing and viewing	21.0		0.0		
3.03	Waiting Area: 5	9.0		0.0		
3.04	Refreshments: drinks	0.5		0.0		
3.05	Patient changing	4.0		0.0		
3.06	Linen bay	0.5		0.0		
					0.0	
	Ultra-sound: General & minor interventional					
3.07	Imaging Room: Ultrasound	24.0		0.0		
3.08	Waiting area: 5p	9.0		0.0		
3.09	Refreshments: drinks	0.5		0.0		
					0.0	
	Computed Tomography					
3.10	Scanner Room CT	36.0		0.0		
3.11	Control Room	16.0		0.0		
3.12	Lead aprons bay	0.5		0.0		
3.13	Waiting area: 5p	9.0		0.0		
3.14	Patient changing	4.0		0.0		
3.15	Linen bay	0.5		0.0		
3.16	Locker bay	0.5		0.0		
					0.0	
	MRI suite					
3.17	Docking bay / lobby	10.0		0.0		
3.18	Reporting room	15.0		0.0		
					0.0	
	Dexa bone densitometry					
3.19	Imaging room	18.0		0.0		
3.20	Waiting area: 5 persons	9.0		0.0		
3.21	Refreshments	0.5		0.0		
					0.0	
	Audiology					
3.22	Office: 1 Staff; med reporting	10.5		0.0		
3.23	Waiting Area; 5 Persons	9.0		0.0		
3.24	Refreshment; Vending machine	3.0		0.0		
3.25	Consulting and Examining	16.5		0.0		
3.26	Vestibular Function Test Room	17.0		0.0		
3.27	Fitting and Interview Room	9.5		0.0		
3.28	WC and Handwash accessible `	4.5		0.0		
3.29	Store Clinical Supplies	9.0		0.0		
					0.0	
	Pathology/Patient Testing					
3.30	Treatment Room	15.0	1	15.0		
3.31	WC/ specimen	5.0	1	5.0		
3.32	Dirty Utility/ urine testing	15.0	1	15.0		
					35.0	
	Sub-total			**35.0**		
	Planning allowance	5%		1.8		
	Total			**36.8**		
	Engineering allowance	3%		1.1		
	Circulation allowance	25%		9.2		
	Department Area			**47.0**		

4.00	Functional Zone 4					
	Treatment					
Number	Room	Room area m^2	Quantity	Total area m^2		Comment
	Physiotherapy					
4.01	Physiotherapy Reception 2 positions	10.0	1	10.0		
4.02	Physiotherapy Waiting Area 5 persons including 1 wheelchair user	9.0	1	9.0		
4.03	Patient wc wheelchair user	4.5	2	9.0		
4.04	Consulting/Examining - dual sided couch access	16.5	0	0.0		
4.05	Rehabilitation interview and assessment	10.0	0	0.0		
4.06	Patient Changing Cubicles; 6 places	11.0	1	11.0		
4.07	Treatment Cubicle: Traction	10.0	2	20.0		
4.08	Treatment Cubicle: Physiotherapy	10.0	2	20.0		
4.09	Activity Area: Physiotherapy, 5 patients	50.0	1	50.0		
4.10	Store: Exercise equipment, activity area	9.0	1	9.0		
4.11	ADL kitchen	22.0	1	22.0		
4.12	Clean utility	9.0	1	9.0		
4.13	Dirty utility	9.0	1	9.0		
4.14	Administrative office	10.5	1	10.5		
4.15	Staff changing/ lockers - 10 places	14.0		0.0		
4.16	Staff wc	2.5		0.0		
4.17	Staff shower	2.0		0.0		
4.18	Staff rest room -10 places	16.0		0.0		
4.19	Cleaner	7.0	1	7.0		
4.20	Wheelchair store	80.0	1	80.0		
4.21	Store: General	12.0	1	12.0		
					287.5	
	Podiatry/Chiropody					
4.22	Surgery	15.0	1	15.0		
4.23	Admin/Supplies	10.0	1	10.0		
					25.0	
	Ambulatory Treatment Centre					
	Outpatients					
4.24	Consulting Room	10.0		0.0		
4.25	Examination Room	10.0		0.0		
4.26	Consulting/Examination Room	15.0		0.0		
4.27	Physical Measurement	3.5		0.0		
4.28	WC Specimen	4.5		0.0		
4.29	Office	11.0		0.0		
					0.0	
	Treatment/Minor Injuries					
4.30	Consulting Room	15.0		0.0		
4.31	Patient Change	2.5		0.0		
4.32	Resuscitation Trolley - For all Ground Floor users	2.5		0.0		
4.33	Phlebotomy	8.0		0.0		
4.34	Diagnostics Room	15.0		0.0		
4.35	Utility Room	10.0		0.0		
					0.0	
	Dental (ancillary spaces shared with Treatment/MI)					
4.36	Dental Surgery	15.0		0.0		
4.37	X-ray/Processing	10.0		0.0		
4.38	Office	10.0		0.0		
4.39	Storage	4.5		0.0		
4.40	Laboratory/Processing	7.0		0.0		
					0.0	
	Sub-total			**312.5**		
	Planning allowance	5%		15.6		
	Total			**328.1**		
	Engineering allowance	3%		9.8		
	Circulation allowance	25%		82.0		
	Department Area			**420.0**		

6.00	Functional Zone 6					
	Support Functions, Shared Staff Facilities					
Number	Room	Room area m^2	Quantity	Total area m^2		Comment
	Offices and Admin					
6.01	Office 1 person	12.5	1	12.5		
6.02	Office 10 workstations	195.0	1	195.0		
6.03	Office 20 workstations	275.0	1	275.0		
6.04	Meeting / Seminar Room 10 persons	20.0	1	20.0		
6.05	Stationery Store	16.0	1	16.0		
6.06	Printer / Photocopy Room	8.0	1	8.0		
					526.5	
	Ancillary					
6.07	Linen Holding Area	18.0	3	54.0		
6.08	Linen Room	9.0	2	18.0		
6.09	Cleaning Supplies Storage	15.0	2	30.0		
6.10	Cleaning Trolley Area	12.0	2	24.0		
6.11	Building Manager Office	10.0	2	20.0		
6.12	Building Maintenance Materials Store/Workshop	15.0	2	30.0		
					176.0	
	Subtotal			**702.5**		
	Planning allowance	5%		35.1		
	Total			**737.6**		
	Engineering allowance	3%		22.1		
	Circulation allowance	25%		184.4		
	Department Area			**944.2**		

7.00	Functional Zone 7					
	External Areas					
Number	Room	Room area m^2	Quantity	Total area m^2		Comment
7.01	Domestic Waste Store	18.0	1	18.0		
7.02	Clinical Waste	18.0	1	18.0		
7.03	Medical gases	20.0		0.0		
7.04	Plant room	20.0	1	20.0		
7.05	Generator	18.0		0.0		
7.06	Bike Store	25.0	1	25.0		
	Department Area			**81.0**		

Summary		m2
Zone	1	416.6
Zone	2	734.5
Zone	3	47.0
Zone	4	420.0
Zone	5	0.0
Zone	6	944.2
Zone	7	81.0
Total		**2,643.3**

9.4 Appendix 4: Net present values

Net present values of options		
Discount rate	Years 1-30	1.035
Discount rate	Ydears 31-35	1.030

	Do nothing					Option 1 Do minimum					Option 2 New build St.Leonards (lease)						Option 3 GPs to Southgate Rd.					
Year	Capital £000s	Current rents, rates & utilities, soft FM £000s	Total cost £000s	Discount factor	NPV	Capital £000s	Current rents, rates & utilities, soft FM £000s	Total cost £000s	Discount factor	NPV	Capital £000s	Lease rental costs £000s	All premises revenue costs £000s	Total cost £000s	Discount factor	NPV	Capital £000s	Lease rental costs £000s	All premises revenue costs £000s	Total cost £000s	Discount factor	NPV
2012		518.97	518.97	1.000	518.97		518.97	518.97	1.000	518.97			518.97	518.97	1.000	518.97			518.97	518.97	1.000	518.97
2013		518.97	518.97	0.966	501.42	9556	518.97	10074.97	0.966	9734.27			518.97	518.97	0.966	501.42			518.97	518.97	0.966	501.42
2014		518.97	518.97	0.934	484.47		518.97	518.97	0.934	484.47	229.50		518.97	748.47	0.934	698.71	165.00		518.97	683.97	0.934	638.50
2015		518.97	518.97	0.902	468.08		518.97	518.97	0.902	468.08	-16,000.00	726.30	454.95	-14818.75	0.902	-13365.66	-16,250.00	591.80	470.70	-15187.50	0.902	-13698.25
2016		518.97	518.97	0.871	452.25		518.97	518.97	0.871	452.25		726.30	454.95	1181.25	0.871	1029.39		591.80	470.70	1062.50	0.871	925.91
2017		518.97	518.97	0.842	436.96		518.97	518.97	0.842	436.96		726.30	454.95	1181.25	0.842	994.58		591.80	470.70	1062.50	0.842	894.60
2018		518.97	518.97	0.814	422.18		518.97	518.97	0.814	422.18		726.30	454.95	1181.25	0.814	960.95		591.80	470.70	1062.50	0.814	864.34
2019		518.97	518.97	0.786	407.91		518.97	518.97	0.786	407.91		726.30	454.95	1181.25	0.786	928.45		591.80	470.70	1062.50	0.786	835.12
2020		518.97	518.97	0.759	394.11		518.97	518.97	0.759	394.11		726.30	454.95	1181.25	0.759	897.05		591.80	470.70	1062.50	0.759	806.87
2021		518.97	518.97	0.734	380.79		518.97	518.97	0.734	380.79		726.30	454.95	1181.25	0.734	866.72		591.80	470.70	1062.50	0.734	779.59
2022							518.97	518.97	0.709	367.91		726.30	454.95	1181.25	0.709	837.41		591.80	470.70	1062.50	0.709	753.23
2023							518.97	518.97	0.685	355.47	229.50	726.30	454.95	1410.75	0.685	966.29	165.00	591.80	470.70	1227.50	0.685	840.77
2024							518.97	518.97	0.662	343.45		726.30	454.95	1181.25	0.662	781.73		591.80	470.70	1062.50	0.662	703.14
2025							518.97	518.97	0.639	331.83		726.30	454.95	1181.25	0.639	755.30		591.80	470.70	1062.50	0.639	679.37
2026							518.97	518.97	0.618	320.61		726.30	454.95	1181.25	0.618	729.75		591.80	470.70	1062.50	0.618	656.39
2027							518.97	518.97	0.597	309.77		726.30	454.95	1181.25	0.597	705.08		591.80	470.70	1062.50	0.597	634.20
2028							518.97	518.97	0.577	299.29		726.30	454.95	1181.25	0.577	681.23		591.80	470.70	1062.50	0.577	612.75
2029												726.30	454.95	1181.25	0.557	658.20		591.80	470.70	1062.50	0.557	592.03
2030												726.30	454.95	1181.25	0.538	635.94		591.80	470.70	1062.50	0.538	572.01
2031												726.30	454.95	1181.25	0.520	614.43		591.80	470.70	1062.50	0.520	552.67
2032												726.30	454.95	1181.25	0.503	593.66		591.80	470.70	1062.50	0.503	533.98
2033											229.50	726.30	454.95	1410.75	0.486	685.02	165.00	591.80	470.70	1227.50	0.486	596.04
2034												726.30	454.95	1181.25	0.469	554.18		591.80	470.70	1062.50	0.469	498.47
2035												726.30	454.95	1181.25	0.453	535.44		591.80	470.70	1062.50	0.453	481.62
2036												726.30	454.95	1181.25	0.438	517.34		591.80	470.70	1062.50	0.438	465.33
2037												726.30	454.95	1181.25	0.423	499.84		591.80	470.70	1062.50	0.423	449.59
2038												726.30	454.95	1181.25	0.409	482.94		591.80	470.70	1062.50	0.409	434.39
2039												726.30	454.95	1181.25	0.395	466.61		591.80	470.70	1062.50	0.395	419.70
2040												726.30	454.95	1181.25	0.382	450.83		591.80	470.70	1062.50	0.382	405.51
2041												726.30	454.95	1181.25	0.369	435.58		591.80	470.70	1062.50	0.369	391.79
2042												726.30	454.95	1181.25	0.356	420.85		591.80	470.70	1062.50	0.356	378.55
2043											300.00	726.30	454.95	1481.25	0.346	512.37	200.00	591.80	470.70	1262.50	0.344	434.59
2044												726.30	454.95	1181.25	0.336	396.70		591.80	470.70	1062.50	0.333	353.38
2045												726.30	454.95	1181.25	0.326	385.14		591.80	470.70	1062.50	0.321	341.43
2046												726.30	454.95	1181.25	0.317	373.92		591.80	470.70	1062.50	0.312	331.48
2047												726.30	454.95	1181.25	0.307	363.03		591.80	470.70	1062.50	0.303	321.83
2048												726.30	454.95	1181.25	0.298	352.46		591.80	470.70	1062.50	0.294	312.45
2049												726.30	454.95	1181.25	0.290	342.19		591.80	470.70	1062.50	0.286	303.35
2050												726.30	454.95	1181.25	0.281	332.23		591.80	470.70	1062.50	0.277	294.52
	0.00	**5,189.73**	**5,189.73**	**8.61**	**4,467.16**	**9,556.00**	**8,822.54**	**18,378.54**	**13.09**	**16,028.34**	**-15,011.50**	**26,146.80**	**17,935.12**	**29,070.42**	**21.89**	**10,096.28**	**-15,555.00**	**21,304.80**	**18,502.12**	**24,251.92**	**21.86**	**7,411.61**

9.5 Appendix 5: Net present values of public sector comparator v. commercial lease

Net present values of options		
Discount rate	Years 1-30	1.035
Discount rate	Years 31-35	1.030

	Option 2 New build St.Leonards (lease)						Option 2a PSC				
Year	Capital £000s	Lease rental costs £000s	All premises revenue costs £000s	Total cost £000s	Discount factor	NPV	Capital £000s	All premises revenue costs £000s	Total cost £000s	Discount factor	NPV
2012			518.97	518.97	1.000	518.97		518.97	518.97	1.000	518.97
2013			518.97	518.97	0.966	501.42	4838.62	518.97	5357.59	0.966	5176.41
2014	229.50		518.97	748.47	0.934	698.71	4838.62	518.97	5357.59	0.934	5001.37
2015	-16,000.00	726.30	454.95	-14818.75	0.902	-13365.66	229.50	470.70	700.20	0.902	631.54
2016		726.30	454.95	1181.25	0.871	1029.39	-8,125.00	470.70	-7654.30	0.871	-6670.28
2017		726.30	454.95	1181.25	0.842	994.58		470.70	470.70	0.842	396.32
2018		726.30	454.95	1181.25	0.814	960.95		470.70	470.70	0.814	382.91
2019		726.30	454.95	1181.25	0.786	928.45		470.70	470.70	0.786	369.97
2020		726.30	454.95	1181.25	0.759	897.05		470.70	470.70	0.759	357.46
2021		726.30	454.95	1181.25	0.734	866.72		470.70	470.70	0.734	345.37
2022		726.30	454.95	1181.25	0.709	837.41		470.70	470.70	0.709	333.69
2023		726.30	454.95	1181.25	0.685	809.09		470.70	470.70	0.685	322.40
2024	229.50	726.30	454.95	1410.75	0.662	933.61		470.70	470.70	0.662	311.50
2025		726.30	454.95	1181.25	0.639	755.30	229.50	470.70	700.20	0.639	447.71
2026		726.30	454.95	1181.25	0.618	729.75		470.70	470.70	0.618	290.79
2027		726.30	454.95	1181.25	0.597	705.08		470.70	470.70	0.597	280.96
2028		726.30	454.95	1181.25	0.577	681.23		470.70	470.70	0.577	271.46
2029		726.30	454.95	1181.25	0.557	658.20		470.70	470.70	0.557	262.28
2030		726.30	454.95	1181.25	0.538	635.94		470.70	470.70	0.538	253.41
2031		726.30	454.95	1181.25	0.520	614.43		470.70	470.70	0.520	244.84
2032		726.30	454.95	1181.25	0.503	593.66		470.70	470.70	0.503	236.56
2033		726.30	454.95	1181.25	0.486	573.58		470.70	470.70	0.486	228.56
2034	229.50	726.30	454.95	1410.75	0.469	661.85		470.70	470.70	0.469	220.83
2035		726.30	454.95	1181.25	0.453	535.44	229.50	470.70	700.20	0.453	317.39
2036		726.30	454.95	1181.25	0.438	517.34		470.70	470.70	0.438	206.15
2037		726.30	454.95	1181.25	0.423	499.84		470.70	470.70	0.423	199.18
2038		726.30	454.95	1181.25	0.409	482.94		470.70	470.70	0.409	192.44
2039		726.30	454.95	1181.25	0.395	466.61		470.70	470.70	0.395	185.93
2040		726.30	454.95	1181.25	0.382	450.83		470.70	470.70	0.382	179.64
2041		726.30	454.95	1181.25	0.369	435.58		470.70	470.70	0.369	173.57
2042		726.30	454.95	1181.25	0.356	420.85		470.70	470.70	0.356	167.70
2043		726.30	454.95	1181.25	0.346	408.60		470.70	470.70	0.346	162.82
2044	300.00	726.30	454.95	1481.25	0.336	497.44		470.70	470.70	0.336	158.07
2045		726.30	454.95	1181.25	0.326	385.14	229.50	470.70	700.20	0.326	228.30
2046		726.30	454.95	1181.25	0.317	373.92		470.70	470.70	0.317	149.00
2047		726.30	454.95	1181.25	0.307	363.03		470.70	470.70	0.307	144.66
2048		726.30	454.95	1181.25	0.298	352.46		470.70	470.70	0.298	140.45
2049		726.30	454.95	1181.25	0.290	342.19		470.70	470.70	0.290	136.36
2050								470.70	470.70	0.281	132.38
2051								470.70	470.70	0.273	128.53
2052								470.70	470.70	0.265	124.78
2053								470.70	470.70	0.257	121.15
2054								470.70	470.70	0.250	117.62
2055							229.50	470.70	700.20	0.243	169.87
2056								470.70	470.70	0.236	110.87
2057								470.70	470.70	0.229	107.64
2058								470.70	470.70	0.222	104.51
2059								470.70	470.70	0.216	101.46
2060								470.70	470.70	0.209	98.51
2061								470.70	470.70	0.203	95.64
2062								470.70	470.70	0.197	92.85
2063								470.70	470.70	0.192	90.15
2064								470.70	470.70	0.186	87.52
2065								470.70	470.70	0.181	84.97
	-15,011.50	**25,420.50**	**17,480.17**	**27,889.17**	**21.61**	**9,751.95**	**2,699.73**	**25,562.62**	**28,262.35**	**25.25**	**14,725.11**

9.6 Appendix 6: Outline Business Case Cost Forms

OUTLINE BUSINESS CASE **DRAFT** **COST FORM OB1**

TRUST/ORGANISATION:	**NHS C&H**
SCHEME:	**St.Leonards Resource Centre**
STRATEGIC HA:	**NHSL**
PHASE:	OBC
PROJECT DIRECTOR:	**David Butcher**

ORGANISATIONAL CODE:

CAPITAL COSTS SUMMARY

		Cost Excl. VAT £	VAT £	Cost Incl. VAT £
1	Departmental Costs (from Form OB2)	3,642,946	728,589	4,371,535
2	On Costs (from Form OB3) (43.62% of Departmental Cost)	1,589,037	317,807	1,906,844
3	Works Cost Total (1+2) at 480 MIPS FP/~~VOP~~* BIS PUBSEC 173	5,231,983	1,046,397	6,278,379
4	Provisional location adjustment BIS PUBSEC (10.00 % of Works Cost) (b)	523,198	104,640	627,838
5	Sub Total (3+4)	5,755,181	1,151,036	6,906,217
6	Fees (c) of sub-total 5)	784,797	(d) xxxxxxxxxxx	784,797
7	Non-Works Costs (from Form FB4) (e) LAND			
	OTHER	45,000	9,000	54,000
8	Equipment Costs (from Form OB2) (6.45% of Departmental Cost)	234,974	46,995	281,969
9	Planning Contingency 10%	**681,995**	136,399	818,394
9a	Sub Total (5+6+7+8+9)	7,501,948	1,343,430	8,845,378
9b	Optimism Bias 25%	1,905,495	341,231	2,246,726
10	**TOTAL (for approval purposes) (5+6+7+8+9+9b)**	**9,407,443**	**1,343,430**	**11,092,104**
11	Inflation adjustments (f) 2Q2013 PUBSEC 179	269,789	47,213	317,002
12	FORECAST OUTTURN BUSINESS CASE TOTAL (10+11)	9,677,232	1,390,643	11,409,106

Proposed start on site (g) **01 Apr 2013** Proposed completion date (g) **31 Mar 2015**

Cash Flow:- Year yy/yy	SOURCE EFL	OTHER GOVERNMENT	PRIVATE	£ TOTAL
Total Cost (as 10 above)				

Total (for approval purposes) match against Cashflow ERROR

Notes :

* Delete as appropriate

(a) On-costs should be supported by a breakdown of the percentage or a brief description of their scope (form OB3 may be used if appropriate)

(b) Adjustments of national average DCA price levels & on-costs for local market conditions

(c) Fees include all resource costs associated with the scheme e.g. project sponsorship, clerk of works, building regulation & planning fees etc.

(d) Not applicable to professional fees - VAT reclaimable EL (90) P64 refers

(e) Non-works costs should be supported by a breakdown & include such items as contributions to statutory & local authorities ; land costs & associated legal fees

(f) Estimate of tender price inflation up to proposed tender date (plus construction cost for VOP contracts only)

(g) Overall timescale including any preliminary works

(h) MIPS taken from Quarterly Briefing 19.2

Name (capitals)	**Alan Davison, Health Quantum**
Position	
Address	
Telephone	

Authorised for issue

Project Director

Date

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OUTLINE BUSINESS CASE **COST FORM OB2**

TRUST/ORGANISATION: NHS C&H

SCHEME: St.Leonards Resource Centre

PHASE: NHSL

PROJECT DIRECTOR: David Butcher

CAPITAL COSTS: DEPARTMENTAL COSTS AND EQUIPMENT COSTS

Functional Content	Functional Units/Space Requirements (1)	N/A/C (2)	Cost Allowance Version	Equipment Cost Version
			Version 2.1	**Version 2.1**
Zone 1	417 m2	N	414,557	29,462
Zone 2	734 m2	N	730,824	51,936
Zone 3	47 m2	N	45,864	3,326
Zone 4	420 m2	N	399,000	29,698
Zone 5	m2	N		
Zone 6	944 m2	N	1,062,180	66,762
Zone 7	81 m2	N	79,785	5,728
			2,732,209	186,912
Increase from MIPS 360 to MIPS 480			910,736	
Equal to BIS PUBSEC 173				
Increase from ECI 105 to ECI 132				48,063
Departmental Costs and Equipment Costs To Summary £			3,642,946	234,974

OUTLINE BUSINESS CASE **COST FORM OB3**

TRUST/ORGANISATION: NHS C&H
SCHEME: St.Leonards Resource Centre
PHASE: NHSL
CAPITAL COSTS: ON COSTS

			Estimated Cost (exc. VAT)	Percentage of Departmental Cost
1	Communications	£	£	%
	a. Space	109,288		3.00
	b. Lifts	163,204	272,492	4.48
2	"External" Building Works (1)			
	a. Drainage	309,650		8.50
	b. Roads, paths, parking	109,288		3.00
	c. Site layout, walls, fencing, gates	5,464		0.15
	d. Builders work for engineering services outside buildings	32,787	457,190	0.90
3	"External" Engineering Works (1)			
	a. Steam, condensate, heating, hot water and gas supply mains	155,554		4.27
	b. Cold water mains and storage	89,616		2.46
	c. Electricity mains, sub-stations, stand-by generating plant	81,966		2.25
	d. Calorifiers and associated plant	72,859		2.00
	e. Miscellaneous services	72,859	472,854	2.00
4	Auxiliary Buildings	9,107	9,107	0.25
5	Other on-costs and abnormals (2)			
	a. Building (demolition)	361,000		0.66
	b. Engineering	16,393	377,393	0.45
Total On-Costs to Summary FB1			£ 1,589,037	43.62

Notes:

Must be based on scheme specific assessments/measurements; attach details to define scope of works as appropriate.
Identify separately any proposed additional capital expenditure justifiable in value for money terms (details to be provided).

* Delete as appropriate.
(1) "External" to Departments
(2) Identify any enabling or preliminary works to prepare the site in advance e.g. demolitions; service diversions; decanting costs; site investigation and other exploratory works.

Completed by
Name (capitals): **Alan Davison, Health Quantum**
Position:
Address:
Telephone:

Authorised for issue:
Project Director
Date:

OUTLINE BUSINESS CASE **COST FORM OB4**

TRUST/ORGANISATION: NHS C&H
SCHEME: St.Leonards Resource Centre
PHASE: OBC

CAPITAL COSTS: FEES AND NON-WORKS COSTS

		£	Percentage of Works Cost %
1	Fees (including "in-house" resource costs)		15%
	a. Architects		
	b. Structural Engineers		
	c. Mechanical Engineers		
	d. Electrical Engineers		
	e. Quantity Surveyors		
	f. Project Management / Employers Agent		
	g. Project Sponsorship		
	h. Legal fees		
	i. Property		
	j. Building Regulations and Planning Fees		
	k. Other Planning Supervisor		
	Report's (Conservation etc)		
	Town Planning		
	Traffic Impact		
	Total Fees to Summary (FB1)	£ 784,797	

		£
2	Non-Works Costs	
	a. Land purchase costs and associated legal fees	
	b. Statutory and Local Authority charges	
	c. Other (specify)	45,000
	eg Decanting	
	Surveys	
	Non-Works Costs to Summary (FB1)	£ 45,000

Notes:
* Delete as appropriate.

Completed by			
Name (capitals)	**Alan Davison, Health Quantum**	Authorised for issue	
Position		Project Director	
Address			
		Date	
Telephone			

9.7 Appendix 7: Optimism Bias

Scheme:	**St. Leonards PSC**												
Optimism Bias - Upper Bound Calculation for Build													
Lowest % Upper Bound		**13%**											
Mid %		**40%**											
Upper %		**80%**											
Actual % Upper Bound for this project		**32.5%**											
Build complexity								**Scope of scheme**					
Choose 1 category		X						*Choose 1 category*		X			
Length of Build	< 2 years		0.50%	0				Facilities Management	Hard FM only or no FM		0.00%	0	
	2 to 4 years	x	2.00%		2.00%				Hard and soft FM	x	2.00%		
	Over 4 years		5.00%	0									2.00%
Choose 1 category								*Choose 1 category*					
Number of phases	1 or 2 Phases		0.50%	0				Equipment	Group 1 & 2 only		0.50%	0	
	3 or 4 Phases	x	2.00%		2.00%				major Medical equipment		1.50%	0	
	More than 4 Phases		5.00%	0					All equipment included	x	5.00%		5.00%
Choose 1 Category								*Choose 1 category*					
Number of sites involved (i.e. before and after change)	Single site*	x	2.00%		2.00%			IT	No IT implications		0.00%	0	
	2 Site		2.00%	0					Infrastructure	x	1.50%		1.50%
	More than 2 site		5.00%	0					Infrastructure & systems		5.00%	0	
* Single site means new build is on same site as existing facilities								*Choose more than 1 category if applicable*					
								External Stakeholders	1 or 2 local NHS organisations	x	1.00%		1.00%
Location									3 or more NHS organisations		4.00%	0	
									Universities/Private/Voluntary sector/Local government		8.00%	0	
Choose 1 Category													
Newsite - Green field	New build		3%	0				**Service changes - relates to service delivery e.g NSF's**					
Newsite - Brown Field	New Build		8%	0									
Existing site	New Build	x	5%		5.00%			*Choose 1 category*					
	or							Stable environment, i.e. no change to service			5%	0	
Existing site	Less than 15% refurb		6%	0				Identified changes not quantified		x	10%		10.00%
Existing site	15% - 50% refurb		10%	0				Longer time frame service changes			20%	0	
Existing site	Over 50% refurb		16%	0									
					11.00%			**Gateway**					
								Choose 1 category					
								RPA Score	Low		0%	0	
									Medium	x	2%		2.00%
									High		5%	0	
													21.50%

Scheme:	St. Leonards PSC		
Contributory Factor to Upper Bound	**% Factor Contributes**	**% Factor Contributes after mitigation**	**Explanation for rate of mitigation**
Progress with Planning Approval	4	2	Previous consent given but new application required.
Other Regulatory	4	4	
Depth of surveying of site/ground information	3	3	Full survey of conditions, site services and topographics will be undertaken.
Detail of design	4	3	1:200s and key 1:50s to be done.
Innovative project/design (i.e. has this type of project/design been undertaken before)	3	2	Standard project similar to many primary care / resource centre schemes.
Design complexity	4	2	Not complex but will need to fit with wider site development and existing surgery on site.
Likely variations from Standard Contract	2	1	
Design Team capabilities	3	2	Some skills in team so JV arrangement proposed to mitigate risk and cost.
Contractors' capabilities (excluding design team covered above)	2	2	JV to control / procure.
Contractor Involvement	2	2	No involvement at this stage
Client capability and capacity (NB do not double count with design team capabilities)	6	4	There could be capacity problems if the project is delayed to overlap with Olympics construction projects.
Robustness of Output Specification	25	22	There will be clear definition of scope and extent of services.
Involvement of Stakeholders, including Public and Patient Involvement	5	3	Further consultation would be needed
Agreement to output specification by stakeholders	5	4	To be finalised at FBC stage
New service or traditional	3	2	Traditional
Local community consent	3	1	Stakeholder support is strong
Stable policy environment	20	17	In line with NHS C&H strategy to develop community and primary care services and offer choice to patients.
Likely competition in the market for the project	2	2	Land sales and construction market still reasonably buoyant in London.
TOTAL	**100**	**78**	

Note: Across all contributory factors, mitigation would be expected to be greater the greater the extent of risk quantification and risk management.

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London Ambulance Service: Overview

Overview

- In 2010/11 the LAS took 1.5 million calls, an increase in demand by 5%.
- Calls are received from London residents, commuters and visitors, and the once the patient needs have been assessed, an appropriate response to the need identified is dispatched.
- LAS care delivery are supported by clinical and performance targets.

Clinical Responses

- The LAS responds to patients in a number of different ways:
  - ✓ **Hear and treat:** At the point of call-taking, approx. 100,000 callers are identified as having a presentation that could be managed initially via telephone consultation by either a LAS or NHSDirect Clinician. Having completed the consultation, the majority of these calls are closed, with a small number being identified as needing an on-scene face-to-face clinician assessment.
  - ✓ **See and treat:** Approximately 31% of incidents that receive an on-scene assessment by a member of LAS staff receive treatment that enables the case to be completed at that point without conveyance to an Emergency Department. An increasing volume of these calls also now also result in an onward referral to local primary and community care services.
  - ✓ **See, treat and convey:** Patients are conveyed both to local Emergency Departments as well as specialist centres across London – this decision depends on the patient's presenting condition. As a pan-London stakeholder within local and hospital reconfigurations, we have been key in delivering large-scale change, improving health outcomes for major trauma, stroke and cardiac patients.

Ensuring High Quality Care

- The LAS has a number of internal strategies to ensure and maintain high quality care for our patients. This is done through a number of strategies:
  - ✓ Training of our staff
  - ✓ The development of clinical-decision making tools
  - ✓ Advanced clinical support for paramedics on the road and in our call centre

- ✓ Call back rates
- ✓ Complaints/incident reporting
- ✓ Collecting patient and stakeholder feedback
- ✓ The development of a quality dashboard

Performance

- The LAS Commissioners hold the service to account for a range of Key clinical performance indicators (KPIs) including the A8 target – attending 75% of category A (the most clinically serious calls) within 8mins
- Introduced in 11/12 – The Department of Health report monthly on National Ambulance Quality Indicators which measure 11 clinical quality for all Ambulance Trusts in England

Our challenges

- Increasing category A demand.
- Planned events:
  - ✓ The LAS attend over 100 planned events each year (e.g. football matches, Notting Hill Carnival)
  - ✓ In 2012/13 provision of ambulance care during the Olympics is a top priority.
- Unplanned events:
- Responding to events such as the London riots
- Alcohol consumption in the capital

Meeting our challenges

- Access to our calls is through a call taking and triage system where we are able to deem the most appropriate operational response for each incident.
- Health professionals information provision and case management – the ability to share information to provide a more integrated service
- Patient transport and clinical transfers
- Event Management
- Emergency planning
- Alcohol recovery centre and 'booze bus'

Priorities for 2012

- Delivery of improved clinical outcomes for patients against the new national ambulance outcome framework
- Delivery of Olympic Bid commitments for the LAS, including business-as-usual service delivery for all NHS patients
- Significant QIPP schemes across London focusing on improving urgent care to deliver savings and improving quality for patients
- Implementation of the 111 programme across London
- LAS achieving Foundation Trust status with associated flexibilities, whilst delivering the Cost Improvement Plan
- Ensuring a safe transition to the new NHS commissioning structures

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East London and the City

NHE East London and the City **Cover paper for OSCs**

Title of Report:	Proposed NHS East London and the City Commissioning Policy: Assisted Conception Policy for Sub-fertility
Author(s): **Date finalised:**	Anna Stewart – Associate Director, Technical Contracting, NHS ELC Commissioning Support Service Maggie Harding, Locum Public Health Consultant, NHS ELC Commissioning Support Service 7 March 2012
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NHS East London and the City Commissioning Policy: Assisted Conception for Sub-Fertility

1. Introduction and context

NHS East London and the City inherited the current assisted conception policy from the North East London Specialist Commissioning Group. The NICE 2004 guideline is currently being updated to take account of evidence published in the intervening seven years and the revised version is anticipated during 2012; the local NHS East London and the City policy will need to be reviewed when the new guidance is published.

NICE Clinical Guidelines are not binding on commissioners unlike technology appraisals: they are recommendations made by NICE to the NHS and have no mandatory funding requirement.

The Department of Health reminded PCTs in January 2011 of the existing NICE Clinical Guideline. The legal context to the decision making is set out in section 6 of this paper, and NHS ELC Clinical Commissioning Groups (CCGs) and the Clinical Commissioning Committee were aware of this guidance when considering and approving this proposed new policy.

This paper sets out the:

- process that has been involved in revising the clinical criteria for assisted conception services;
- detailed changes to the existing policy and the reasons for them;
- responses from two public engagement seminar events to these changes
- legal context in relation to surrogacy and advice on public consultation

2. Process of review of the access criteria

In January 2011, East London and the City GP Commissioners proposed a reduction in the number of IVF cycles commissioned, and recommended that NHS East London and the City should move from funding three locally defined cycles of IVF to two.

Since then there has been extensive clinical engagement with both tertiary care specialists and lead GPs from across the cluster. The initially proposed policy revisions were modified by the Transitional GP Commissioning Board in May 2011 and version three of the policy was subject, on the advice of the ELC LINks chairs, to a public engagement process to test public reaction and to have an opportunity to talk through the clinical complexity of the proposed changes.

3. Rationale for changes to the existing policy

The revised policy sets out three significant changes to the existing policy and a number of new criteria. These are set out in detail below:

3.1 Change to two fresh cycles

The current North East London wide policy defines a local cycle as transfer of either a fresh or frozen embryo. The NICE definition of a cycle is one fresh followed by up to two frozen embryo(s). This distinction was not widely understood. This means that

the three current North East London defined cycles may only be equivalent to one NICE defined cycle.

The proposal as set out in the policy is to fund two fresh cycles: couples would have the choice to self-fund freezing of any additional embryos produced as part of the fresh cycle for use at a later date.

The evidence shows that fresh embryo transfers generally result in a 10% higher chance of pregnancy than frozen embryo transfers.

3.2 Inclusion of surgical sperm retrieval

Clinicians identified the anomaly that some men with azoospermia due to vas dysfunction were required to self fund surgical sperm retrieval because it was not included in the tertiary infertility service contract. This was inequitable as NHS ELC routinely funds egg retrieval for women with tubal dysfunction. The new NHS ELC policy redresses this for an estimated fifty men per year.

3.3 Equity considerations

The policy makes clear that the aim of NHS funding is to treat infertility. If this can be demonstrated the policy would apply equally to single women, female same-sex couples and heterosexual couples.

3.4. New or modified criteria

Criterion	Current policy	This policy	Rationale
GP Registration	The couple have at least one year registration with a GP attached to a primary care trust based within NEL	Couples or single women, resident in City and Hackney, Newham or Tower Hamlets and registered with an NHS East London and the City (ELC) GP for the previous 12 months **OR** Both partners must be continuously resident in the UK for the past 1 year AND entitled to planned NHS treatment AND the female partner has been registered with a GP in NHS ELC for the previous 12 months	Provider trusts are now looking more closely at this and have discovered several couples where this criterion does not apply.
Duration of unexplained sub-fertility	The couple has 2 years of unexplained infertility or one year of diagnosed sub-fertility within the current relationship	'unexplained infertility' is defined as failure to conceive after frequent unprotected sexual intercourse for two years in couples of reproductive age where the female partner is less than 36 years of age, or 1 year where the female partner is 36 years or older.	This may help reduce the number of IFR requests for funding assisted conception for women over 40 years of age.
Woman's BMI	Between 19.0 and 29.9 kg/m^2	Between 19.0 and 29.9 kg/m^2 for the 6 months prior to starting IVF treatment	To demonstrate stability of the BMI
Age of the male partner	Not in current policy	Treatment should start before the male partner's 55^{th} birthday	• the age related risk of deteriorating sperm quality and increasing risk of DNA fragmentation • equity between heterosexual couples and female same sex couples/

			single women whose HFEA regulated sperm donors have an upper age limit of 55 years for known donors: unknown donors have an upper age limit of 45 years
Previous treatment	Couples have had less than three previous NHS-funded IVF cycles leading to embryo transfer.	Couples/single women will not be funded if they have already had three or more previous fresh cycles of IVF/ICSI (irrespective of how these were funded) Previously untreated couples/single women or with a single self funded cycle will be eligible for two NHS ELC fresh funded IVF/ICSI cycles Those with two previous self funded cycles will be eligible for a single fresh cycle	This is intended not to deter or disadvantage couples from self funding in the first instance. Similar distinctions between the number of NHS funded and the total of NHS and self funded cycles apply in other areas including North West London. It in no way implies that NHS ELC considers 3 cycles 'an optimal care package'
Parental smoking	Not in current policy	Where couples smoke, only those who agree to, and take part in, a supportive programme of smoking cessation will be accepted on the IVF treatment waiting list, and should be non-smoking at the time of treatment	This is for the welfare of the child

3.5. Clarifications

The following exclusions to the policy apply:

a) The policy relates only to treatment for sub-fertility.

The following areas that use IVF/IUI technology will require a specific addendum to the policy:

- for pre-implantation genetic diagnosis (PGD)
- as part of a viral transmission risk reduction programme, gamete/embryo storage
- storage of sperm, embryos or oocytes prior to potentially sterilising cancer treatments

Current clinical practice for patients or couples in these categories will continue unless or until we have agreed this new addendum to the policy

b) IVF which is intended for a surrogate mother, as surrogacy is not commissioned by NHS ELC due to the complex medico-legal considerations

Clarification added as a result of public engagement:

c) The cycle number criterion is per person rather than per couple: discussion identified that this was very unlikely to increase demand as the probability of couples changing a partner for this reason were low

3.6. Criteria which are unchanged

- Donor eggs or donor sperm will not be funded (on the grounds of affordability), though IVF using self funded eggs or sperm will be funded if all other criteria are met
- The couple should have no living children within the current relationship and not more than four between them from previous unions
- Neither partner will have previously undergone a sterilisation procedure

4. The Public Engagement Process

This is detailed in appendix 2.

4.1 In summary:

- Two public engagement events were held in October – one in Newham and one in the City – which all four LINks were asked to publicise to their members. PALS teams at both BLT and the Homerton which provide assisted conception services in ELC were asked to publicise the events within their trusts

- The Newham session was well attended, with a diverse group of just under ten consultees present, the City session was attended by the LINk chair for the City

- Overall there was a good understanding in both groups of the difficult choices needed to balance NHS affordability with equity and effectiveness for individuals and couples. The debate was around where these lines should be drawn.

4.2 Areas of contention were:

- *Cycle number:* this was
  - Contentious in the City: the consultee wanted to move to three NICE defined cycles across the board.
  - Newham understood our need to make hard choices and on balance supported both recommendations

- *Surrogacy*
  - This generated debate in both groups: overall Newham considered the recommendation reasonable; the argument was made in City that this should be funded on the grounds that it constituted preferential treatment for disadvantaged groups provided there was no risk of legal liability to NHS ELC.
  - Infertility specialists additionally noted that shortage of surrogates in the UK meant that there could be significant applications for treatment within the EU as a result, and this may raise even more issues around 'expenses' and legal liability

- *Age of male partner*
  - In Newham of those who felt strongly the view was roughly split half and half. The City consultee was against the recommendation

4.3. All other changes were supported

5. The Clinical Commissioning Committee discussed and agreed to recommend to the Board the following:

5.1 *That NHS ELC fund two fresh IVF or ICSI cycles*
The move from three locally defined to two fresh cycles will result in a modest estimated annual cost reduction, based on 2010/11, prices of £290k which will offset the cost pressures of the proposed policy changes including surgical sperm retrieval; equitable access to infertility services for single women and same sex female couples and other small changes.

This will mean that, with the present exceptions to this policy (in 3.5.a) NHS ELC will not routinely fund freezing or storage of embryos, sperm or oocytes and this exclusion is made explicit in the policy.

5.2. *That NHS ELC do not fund surrogacy or IVF to assist surrogacy*
Legal advice is that this is primarily a legal issue rather than one of policy and therefore not a subject for public engagement. The current policy is silent on this issue and therefore it is not a substantial change to the existing policy.

5.3. *That NHS ELC include the criterion of an upper male age limit*

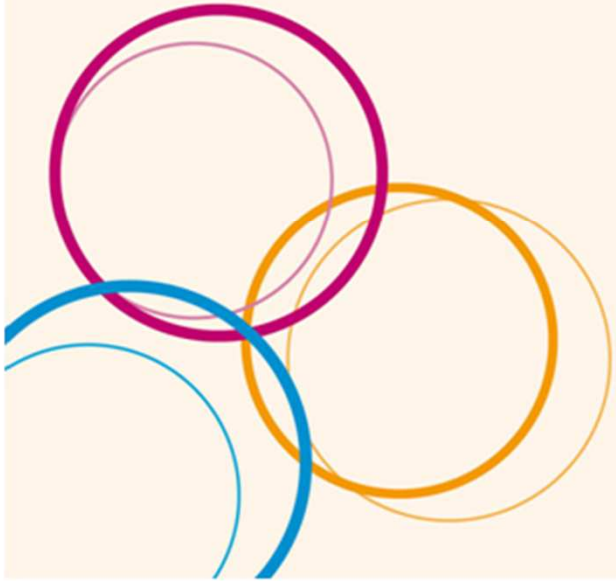
6. The legal context

6.1 The extent of the public engagement was discussed at the City and Hackney CCG Executive meeting. The advice is that the engagement described above should meet NHS East London and the City's obligations under s.242 of the NHS Action 2006 which sets out an obligation to consult on decisions that will impact on the provision or operation of services provided, as taken as a whole the changes being proposed do not constitute a substantial change to existing policy. Views are being sought from the four local authority OCSs.

East London and the City

Feedback on Public Engagement Meetings

East London and the City – Assisted Conception Policy



Anna Stewart – Associate Director, Technical Contracting

Engagement undertaken

- Following discussion with the four LINks in East London and the City about the proposed changes, they advised us to hold two seminars to discuss in more detail and test out views on potential changes to our Assisted Conception policy
- Two seminars were held in October – one in Newham and one in the City – which all four LINks were asked to publicise to their members. PALS teams at both BLT and the Homerton which provide assisted conception services in ELC were asked to publicise the events within the trusts.
- The seminars were attended by the public health consultant who had led the development of the policy, AD within PCP as the lead commissioner for the work, and a consultant from either HUH or BLT, they were supported by the ELC engagement team.
- The Newham session was well attended, with a diverse group of just under ten consultees present, the City session was attended the LINk chair for the City.
- Overall there was a good understanding in both groups of the difficult choices needed to balance cost and efficacy for individuals. The debate was around where these lines should be drawn.
- Both events were positive engagement sessions and can be drawn on a model for future discussions.

Overview of feedback from the engagement events

Cycle number

Proposed change: fund two fresh locally defined cycles (rather than three locally defined cycles as at present), self-funded cycles would be reflected in the number of NHS cycles funded

Contentious in the City: the consultee wanted to move to three NICE defined cycles across the board.

Newham understood our need to make hard choices and on balance supported both recommendations

Cycle number per person or per couple

This came up in discussion and had not been made explicit in the policy. Both City and Newham argued it should be per couple which would potentially make an individual eligible for more than 2 cycles with different partners, though infertility specialists considered that this situation would be rare. Recommend that this is reflected in the policy.

Single women

Proposed change: to explicitly include single women and same sex couples if infertility could be demonstrated.

Both engagement events agreed we needed specifically to include them. Newham raised the issue of whether they should be given choice to freeze oocytes rather than embryos but agreed that patient choice had its limits and 'banking' frozen oocytes should not be funded except where the woman faced imminent treatment for cancer.

BMI

Proposed change: ensure the woman can demonstrate she is stable at the BMI range in the guidance for six months before treatment.

Change agreed as non-contentious

Age of male partner

Proposed change: to introduce an upper age limit for the male partner of 55 years

This was a point of significant discussion: in Newham of those who felt strongly the view was roughly split half and half. The City consultee was against the recommendation

Overview of feedback from the engagement events (cont...)

Parental smoking

Proposed change: to recommend that both partners have accessed stop smoking services before treatment.

This was supported by both groups

Surrogacy

Proposed change: to make explicit in the policy that IVF with a view to surrogacy would not be funded

This generated debate in both groups: overall Newham considered the recommendation reasonable; the argument was made in City that this should be funded on the grounds that it constituted preferential treatment for disadvantaged groups provided there was no risk of legal liability to NHS ELC.

Infertility specialists additionally noted that shortage of surrogates in the UK meant that there could be significant applications for treatment within the EU as a result, and this may raise even more issues around 'expenses' and legal liability

Inclusion of surgical sperm retrieval

Proposed change: this is an anomaly in the current policy and proposed that this is included in standard funded

This was universally supported

Duration of unexplained fertility

In discussion at City it was noted that NICE actually recommended duration 12 months for women 35+ and 24 months for younger women. This seems sensible and our recommendation is that the policy is changed to reflect this

City of London LINk

Leaving Hospital

City LINk report

September 2010 - January 2012

Leaving Hospital

A report by the City of London Local Involvement Network

Contents:

1) Introduction and Background Information

How the LINk works:

The City of London LINk (Local Involvement Network) is a community network, to discover what local people think about health and social care and find ways of working with services to improve the way care is experienced.

To help decide what the LINk will look into, a log of issues is kept, which combines: concerns raised by the community; topics raised in reports and investigations; issues discussed by people arranging and providing care and any urgent or arising matters. A Steering Group of elected LINk members then prioritises these issues and plans how the LINk will use its resources to make a difference.

Looking into Leaving Hospital:

The Steering Group found many issues related to people leaving hospital and how their care was followed-up. To take this forward, a LINk group was formed to look at ways of gathering more information and think about how to address these issues. The "Patient Handover and Co-ordinated Care" group met regularly and created a plan to find out more: from patients, their families and carers; from people involved in planning and providing care; and by visiting a hospital to see what happens as people prepare to leave hospital.

2) Community Feedback

Finding out people's views:

To make sure many different people could share their views with the LINk, a variety of different ways of collecting information were set up:

- A Leaving Hospital questionnaire was created (please see appendix II)

This was sent to all LINk members, voluntary and community groups in the City of London and given to people as they attended events and visited hospital. A prize draw for £50 Waitrose vouchers encouraged people to return their forms. The LINk was careful to reassure people, their personal information and details of their experiences would be kept confidential.

- Leaving Hospital information stalls were set up

The group held displays and information stalls at local events, such as the Older People's Reference Group Annual Event and on hospital sites, including the Royal London and Barts

hospitals. People were happy to pick up information about the project from these stalls and discuss their experiences with the LINk.

- Using existing information and sources

As well as the information already collected in the issue log and through LINk meetings, the group looked at other sources, such as the Care Quality Commission's Survey of Adult Inpatients and reports from Barts and the London PALS (Patient Advice and Liaison Service)

People's Experiences:

People expressed a wide range of views and different experiences of leaving hospital, many praising the work of dedicated staff and rating the treatment and care received as "excellent", "9 out of 10" and "gold star".

However, where issues did arise, it seemed people were reliant on relatives, friends and carers to step in – or felt they only received appropriate care as they were able to "self-advocate" or stand up for themselves.

It is clear a lack of information prevented some patients and their carers, to access support and after-care that would have helped them through this process.

The feedback below has been arranged under general headings, which are taken from the Leaving Hospital questionnaire.

Assessments and checking people will be ok leaving hospital

Everyone is entitled to an assessment on leaving hospital, to see whether the NHS or local authority can provide ongoing care services and to look at other options, such as arranging alternative care[1].

The LINk received varied feedback on this – several people said they were not aware of their rights to an assessment and that this would have been very helpful. Others received assessments but only once they had returned home, one lady waiting six weeks, by which time she had fallen many times. Another patient reported being inappropriately assessed as "mobile", whilst in reality their ability to wash and clothe themselves was severely restricted.

Three people commented on their lack of capacity to request or adequately take part in an assessment process at that time.

Occupational and Physiotherapists were often praised for their help, even when it was felt other issues had not been assessed properly. Other respondents reported being supported by many people, with one exclaiming "the doctors and nurses helped me greatly"

Recommendations:

- Information to be made easily available on assessments and how to request one
- Social services available on site (or easily contactable) and as far as possible, present at assessments
- Information to be made easily available to people on where to go if they do not agree with their assessment or feel they do not have capacity (for example: PALS, advocacy services)

Transport

[1] Hospital discharge arrangements, factsheet 37, Age UK, p. 12

People accessing the Patient Transport Service were generally satisfied. However, one person described waiting six hours for a specific vehicle, which had become delayed. Another issue raised involved carers not being able to travel with patients.

It was often expected that relatives would make arrangements for patients to travel home, resulting in large parking expenses in some instances. In one case, an older, vulnerable person was returned home by the transport service without checks first being made about their carer's whereabouts.

Recommendations:

- Checklists to be displayed on wards and Patient Transport areas, to remind staff to check practical considerations (eg. the patient has their house keys; the family or carer is expecting the patient to return home etc.)

Information on medication and who to contact with concerns after leaving

People were happy with the information they received on how to take medication, or could find on the packaging. Delays at the hospital pharmacy were noted. Most people were also confident they knew who to contact with concerns, although one person stated: "my friend lives alone…and is very afraid she will fall or collapse and not be able to contact anyone"

Recommendations:

- Information on telecare and other services to be made widely available

Follow-up support: arranging and receiving care

1) Information on follow-up care

Many comments related to the lack of information available on follow-up care of all kinds and how support could be accessed. Typical remarks included: "[I] didn't know what services were available, how to find information or how to access them".

More specifically, one issue involved a lack of information on convalescence homes and a response that only unrealistically expensive homecare options had been offered. Language barriers were also cited as a problem.

2) Arranging follow-up care

People were happy that appointments were made for hospital visits but rarely for follow-up care in the community. This was often left to relatives or friends to arrange, with suggestions that staff were too busy to deal with this and communication between different hospitals and services was a major problem. One patient felt she did not have the capacity to co-ordinate follow-up care for herself and described feeling "deserted and very low". On the other hand, one service-user reported: "I..have a social worker who is always ready to intervene on my behalf, if occasion demands it"

3) Receiving follow-up care:

A large variety of comments were received about follow-up care, with some describing services as "brilliant", "excellent" or "very good" and others raising particular problems. A common theme was the assumption that friends or family would provide ongoing care, where this was often not possible.

Specific issues raised included: a lack of support with direct payments; no response from social services when issues were raised; a high number of hospital appointments cancelled; and low skill-level staff not in a position to provide appropriate care.

Recommendations:

- Information on care and support available to people on leaving hospital is vital and needs to be made accessible to patients, carers, relatives and friends – to ensure practical solutions and informed decisions can be reached

Patient dignity and relationship with staff

Where several people felt they had been "treated with courtesy and respect", commenting that staff were "kind and pleasant" and "very caring", others reported being "pretty much ignored", "treated poorly" or believed staff were too busy to be friendly. Two specific problems related to older people suffering indignity on mixed wards.

Recommendations:

- Awareness campaign around the Dignity Code
- Review of patient experiences of mixed wards

Involved in decision making

Generally speaking, people were content they had been involved, in situations where they felt in a position to comment – several people preferred to hand responsibility for decisions to staff. It was mentioned that relatives and friends could be more included in decision making processes and that it was not always possible to talk to a doctor of find out when this would be possible.

Other thoughts and suggestions collected by the LINk:

- Combine Citizens Advice and discharge services
- Make services more personal, make sure staff have time to interact with patients and relatives
- Give people their own budget to design care
- Roll-out the temporary after-care service via the hospital until homecare services can be put in place
- All agencies, nationalities and groups working in care should share good practice and where possible meet

3) Care Staff perspectives

The LINk group was interested in finding out about the reality of providing care and support for people as they leave hospital and is very grateful to staff from the City of London Corporation Adult Social Care department and Barts and the London NHS Trust for sharing their thoughts and experiences. Staff talked through their experience of how the discharge process works[2] and described issues that sometimes occur.

Communication between different organisations

Many of the problems happen because of difficulties in communication between staff from hospitals and services which may be located in many different organisations and areas.

[2] See appendix 2: Discharge Process flowchart (from a discussion with Adult Social Care)

For example:

- patients are sometimes referred to services in the wrong social services authority or Primary Care catchment area, causing delays, funding disputes and missed assessments
- homecare cannot be arranged when no notice is given or services are closing, for example: when patients are discharged on Friday afternoons
- it is sometimes difficult to communicate the urgency of situations to external staff

Staff recognised that communication was often very good due to personal contacts made over time, rather than secure systems in place between organisations.

Recommendations:

- All staff to be trained on how boundaries, between both local authorities and Primary Care Trusts, affect how services can be accessed
- Social services to have a presence in hospitals

Mental Health

Mental health issues are often missed, in medical records and at assessment, as this is not the main reason why a patient has been admitted to hospital. It is often only recognised if staff are able to discuss care with relatives, friends or carers. The high incidence of dementia among City residents known to social services means sufferers are not in a position to give accurate information when they are admitted to hospital.

Recommendations:

- Mental Health to be considered in all assessments
- Awareness raising among staff around mental health issues

Staffing and capacity issues

Concern was expressed at the high turn-over of staff and shortages of staff, staff time and resources. When staff are constantly changing, it becomes more difficult to establish relationships between different services and raise awareness of processes and good practice (such as the Dignity Code). The lack of staff time is hampered by time consuming forms (for example: the continuing care form) and constant pressures, for example: to free up beds.

Recommendations:

- Trust to review recruitment processes
- Trust to investigate reasons for high staff turnover and review staff support, induction and ongoing training

3) Observing Care

In order to monitor services, the LINk has statutory powers to "Enter and View" premises where care is given. Having contacted the Care Quality Commission, which regularly inspects hospitals, the LINk group arranged to visit the Royal London Hospital. As well as observing care on the Older People's ward and talking to patients, visitors and staff, the group looked at patient feedback mechanisms and the PALS office.

Observations and conversations on the ward

Members or the LINk (Authorised Representatives) raised a few concerns following observations and discussions on the ward, which relate to issues and recommendations above.

One elderly patient was left in an undignified position in full view of other patients for several minutes; the daughter of another patient was struggling to navigate the complicated discharge system and arrange follow-up care, with little information to hand. Staff also mentioned problems with lengthy paper work, complicated systems and Multi-Disciplinary Panels causing delays in the discharge process and passing referrals back and forth between different departments.

Patient Realtime Feedback Machines
Realtime Feedback Machines provide the opportunity for patients and visitors to offer their views on an interactive screen, at the time of their visit. This is useful for collecting people's opinions on services, although the LINk representatives mentioned a few points which could be looked into. These included: a lack of hand-wash near the machines; difficulty in accessing the machines in a small space, particularly for those with mobility issues; complicated language used and no option of different languages.

PALS office and site issues
The Patient Advice and Liaison Service provides: information on NHS services; help to deal with concerns and complaints and listens to patient feedback. The LINk representatives commented that the PALS office is placed prominently in the reception area of the Royal London Hospital but also felt that it seemed unapproachable, with a seemingly locked door. Another site issue mentioned was the lack of signs in languages other than English, apart from in reception.[3]

Recommendations:

- Signs and Realtime Feedback software to be provided in different languages
- Realtime Feedback Machines to be placed in more accessible areas, with handwash accessible
- Efforts be made to make the PALS office more approachable

5) Next steps

The LINk is keen to make sure the experiences and views expressed in this report can be used to improve care.

City LINk
Having identified access to information as a key issue, the LINk hopes to produce a leaflet for patients, carers and other visitors, to raise awareness of the support available to people on leaving hospital and how they can access these services in the City of London and local areas. Funding is being sought to publish and distribute this leaflet.

Statutory Partners
The LINk will distribute this report to key statutory partners and ask that they consider the recommendations and respond with an action plan to address the issues raised, with support from the LINk, as possible.

The LINk would like to thank everyone who took part in this project: as LINk group members; by commenting on their experiences or as staff facilitating information sharing and activities.

[3] See Appendix I, comments from PALS at Barts and the London NHS Trust

For more information on the work of the City LINk or to share your views, please contact the LINk team on: 020 7535 0496 / jpurcell@citycomm.org.uk / City LINk, 37 Chapel Street, London NW1 5DP

Or visit the website: www.cityoflondonlink.org.uk

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6) Appendices

Appendix I: Comments from Statutory Providers on this report

The report was circulated to Statutory Partners for comment on issues relating to factual accuracy. Barts and the London NHS Trust kindly provided the flowing feedback relating to the Patient Advice and Liaison Service:

"Please note that access to the PALS office is available through an intercom system in order to ensure the safety of the staff particularly when they are female staff working in the office alone. The PALS office has now moved to the new building and continues to be easily accessible through an intercom system.

Evidence has shown that providing surveys in different languages on the RTF machines does not necessarily improve engagement and feedback. We are creating a variety of ways that patients can give us feedback about the services to suit different communication needs and preferences. These include out patient comment cards, and Tell Matron cards. The work will develop further with the implementation of the patient experience strategy."

Appendix II: Questionnaire (unformatted)

Leaving Hospital

We would like to hear about your experiences to find out how leaving hospital can be made easier for everyone.

You can answer thes s about things you think are important – ld names or details th

We will always keep your thoughts anonymous

If you would like help filling out this form or to let us know what

you think, please contact the City LINk on 020 7535 0496

Have you, a friend or relative recently left hospital?

If so, were you happy that:

Someone made sure that you could cope at home?

You were able to get home safely?

You had the medication you needed and knew how to take it?

You knew who to contact – and how - if you were worried or if something went wrong?

At home, were you happy that:

You had everything you needed?

You received the follow-up care you needed?

In general, how did you feel treated by staff?

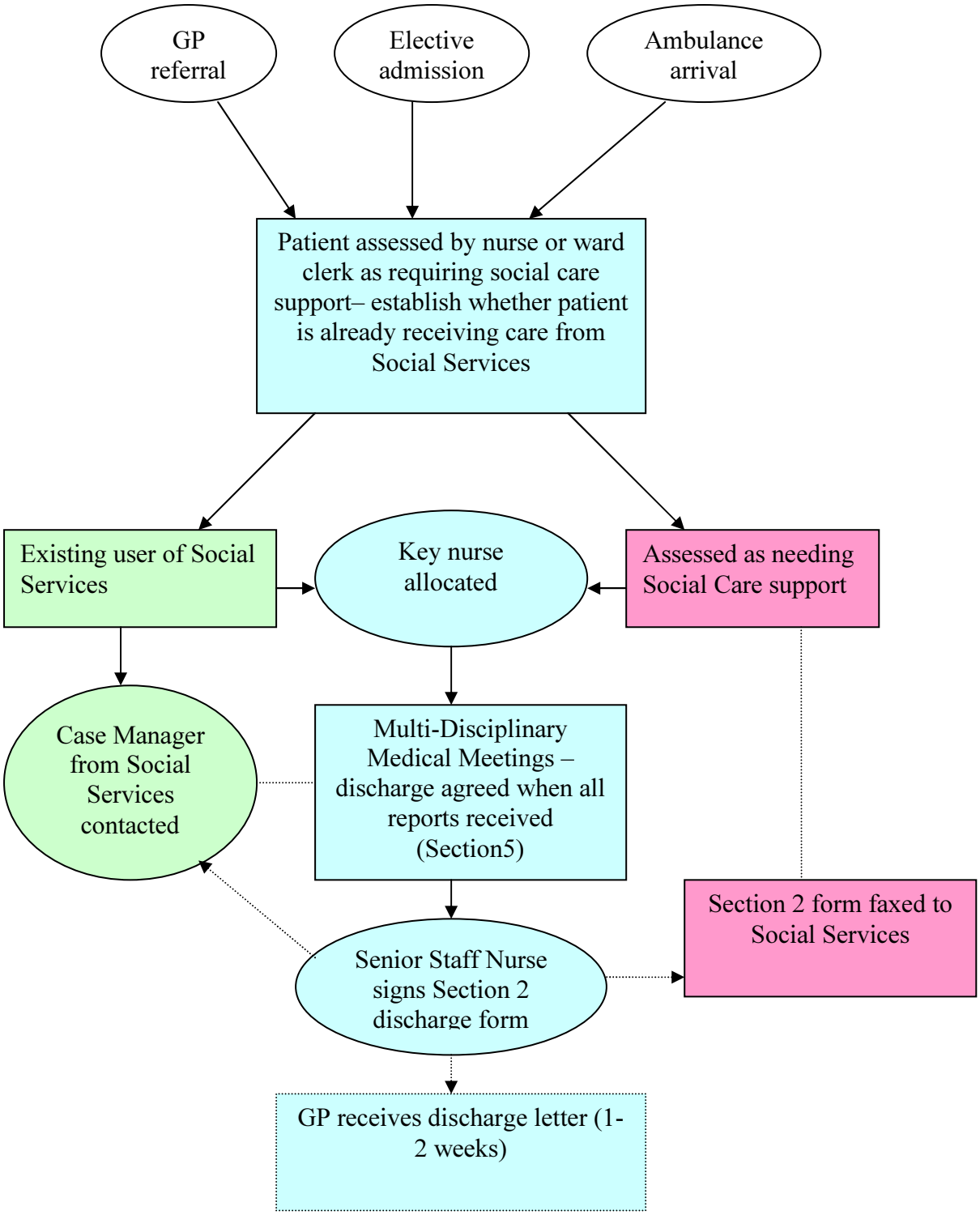
Did you feel involved in decisions and able to have your say?

How could this experience have been improved?

These are just general headings. Please feel free to tell us your story or make other suggestions here:

Thank you for your help!

Appendix III: Discharge Process diagram


GP referral
Elective admission
Ambulance arrival
Patient assessed by nurse or ward clerk as requiring social care support– establish whether patient is already receiving care from Social Services
Existing user of Social Services
Key nurse allocated
Assessed as needing Social Care support
Case Manager from Social Services contacted
Multi-Disciplinary Medical Meetings – discharge agreed when all reports received (Section5)
Section 2 form faxed to Social Services
Senior Staff Nurse signs Section 2 discharge form
GP receives discharge letter (1-2 weeks)

Insight into City Drinkers

Summary report

Alcohol use, attitudes, and options for addressing alcohol misuse in the City of London

January 2012

James Morris
Fizz Annand
Nick Southgate
Vince Wakfer

Contents

Project summary

This document is a summary report on the findings and recommendations of the ***Insight into City Drinkers*** project.

The report was commissioned by the City of London Substance Misuse Partnership to gain an insight into the prevalence and nature of alcohol consumption among city workers and identify segments within the community of City workers who can, and should, be targeted with public health information about risks associated with consuming alcohol.

For the purpose of the report, we have defined alcohol misuse as those identified as drinking at 'increasing' or 'higher risk' levels as identified by a validated screening tool. Alcohol misuse in itself does not infer 'problematic' drinking, though those drinking at higher risk levels are likely to be experiencing harms including possible dependency.

Further explanation of alcohol misuse and the terms used in this report can be found on page 7.

As a summary report, this document *excludes* chapters in the full report:

- About the City of London
- Methodology
- Literature review
- Psychographic segmentation
- References
- Appendix (Survey template)

For the full report or further information about the project please contact:

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CITY OF LONDON SUBSTANCE MISUSE PARTNERSHIP

Reducing the impact of drug and alcohol misuse in the square mile

Executive Summary

'City Drinkers'

For the purpose of the research, 'City Drinkers' were defined as:

Any person who frequents the City of London for work, business, education or training purposes including students and residents, and are therefore likely to drink alcohol or be aware of alcohol use and some of its perceived or actual impacts in the Square Mile.

Key findings

This report explores the nature, prevalence, and attitudes towards alcohol misuse amongst 'City Drinkers'. Using these findings it provides recommendations to inform possible actions to reduce alcohol-related harm in the Square Mile.

Results of the survey have conclusively found high levels of alcohol misuse ('increasing' or 'higher risk' drinking) when compared to both regional and national averages. The reasons for this are undoubtedly manifold and complex, but must be viewed within a wider context of both environmental and individual level determinants.

At an environmental level, it is known that the affordability and availability of alcohol has a direct relationship with consumption. Given the relative wealth of the City and its workforce, it is of little surprise that a significant number and variety of licensed premises exist to meet demand. 'Lunchtime drinking' plays a significant role, with many venue managers seemingly surprised or even shocked at its popularity, despite a reported decline over recent decades.

Entertaining clients has been identified as a key driver for much of the 'drinking culture' that many respondents identified. For others, the 'high pressure' or 'competitive' nature of City roles may also be understandable triggers for excessive or risk taking behaviours. City Drinking has most likely become engrained in a culture where alcohol has become more 'normalised' than elsewhere, and where drinking is often viewed as integral to success, de-stressing, socialising and bonding with colleagues or clients.

Key findings

- Nationally around one in four people (24.2%) drink at increasing or higher risk levels. Amongst the sample of City Drinkers (n=740) the figure was closer to one in two (47.6%).
- 33.4% of City Drinkers are at an increased risk of alcohol-related harm, compared to 20.4% in the general population. These drinkers are not yet necessarily experiencing alcohol-related harms, but are increasing their risk of health and social problems.

- 12.9% of City Drinkers are drinking at a higher risk level compared to 3.8% in the national population, or 2.8% as the London average. Higher risk drinkers are already experiencing alcohol-related harms and many have some level of alcohol dependency.
- City Drinkers have significantly higher consumption and harm than the national average and even more so than the London average, which ranks as the lowest of the 7 English regions. These findings emphasise the unique profile of City Drinkers in contrast to London averages of high ethnic diversity and inequalities.
- Accounting for the significant higher levels of alcohol misuse overall amongst the City Drinkers sample, variations in age, ethnicity and gender for alcohol misusers are overall broadly reflective of national profiles (i.e. white, young men highest misusers).
- National figures show men and those in employment, particularly those in managerial or professional roles, drink more than other adults. Given the profile of the City as a largely male and managerial/professional workforce, this may in part account for higher levels of alcohol misuse.
- Alcohol misuse in the City may in part also be attributed to a complex range of factors such as higher average wealth, high pressured or risk based work environments, a culture of entertaining clients and high use public transport.
- Alcohol misuse amongst both male (56.2%) and female (34.1%) City Drinkers is considerably higher than national averages (33.2% men and 15.7% women). Women in the City may in part drink more because they have been influenced by a wider 'social norm' of heavy drinking in the City.
- Financial, business or professional services have the highest level of alcohol misuse (53.5%) by employment sector compared to public services (40.5%) as the lowest. The financial/business sector may be having an impact on other sectors by 'norming' higher levels of alcohol misuse.
- Highest levels of alcohol misuse exist amongst middle managers and general office roles who appear to drink more heavily ('binge drinking') on either two or three nights of the week – most commonly on Thursdays and Fridays.
- Lowest levels of alcohol misuse exist amongst senior managers - however they appeared to drink 'less but more often' in comparison with others. In fact senior managers were most likely to drink four or more times per week, though also most likely to drink only 1 to 2 units (and most likely to drink at home or with a meal).

- Alcohol-related problems in the City may be disproportionately social rather than health harms compared to national averages. Health-related problems were less reported than social or behavioural related problems (e.g. injury or remorse).
- Drinking by location shows that alcohol misuse is strongly linked to drinking in pubs and at work events in the City. Frequency of drinking in the City is a key indicator of alcohol misuse.
- Home drinking, although the most frequent of all locations, showed lowest levels of associated alcohol misuse. No significant correlation between home and City drinking was found.
- Administrative role's consumption was the lowest overall, with both low consumption and low frequency of drinking. However alcohol problems (indicated by AUDIT score) were slightly higher than senior managers who drank more, suggestive of health inequality factors - i.e lower socio-economic groups overall drink less but experience greater levels of harm.
- 'Segments' of City Drinkers have been identified for targetting messages and interventions to reduce alcohol misuse. Segments utlise the known attitudes and beliefs of City Drinkers to identify which messages they are most likely to respond to.

Key recommendations

It is imperative that the context and environmental factors surrounding City Drinkers are recognised when considering responses.

Whilst there is a strong case for individual level interventions to be targeted at City Drinkers, a sustained cultural shift towards achieving lower levels of alcohol misuse will rely upon progress in addressing environmental and wider health determinants. Organisations must be encouraged to go further in recognising both the potentially damaging impact of alcohol misuse and the benefits to be accrued from addressing it.

In practice, this means progress on promoting workforce health and wellbeing, addressing health inequalities, and effective policy and support for those who find themselves facing an alcohol problem.

Alongside this, interventions for at-risk City Drinkers will have greater efficacy and a further chance of achieving lasting change. Risky drinkers will benefit from information that ensures they realise the possible negative health, social or work impacts. Targeting messages and interventions to identified 'segments' of City Drinkers will be essential in changing individual attitudes and behaviours – together these approaches can deliver the necessary medium to long term change in the current 'City drinking culture'.

Recommendations from the report are tabled from page 35

Introduction

The World Health Organization (WHO) outlines two main drinking patterns that determine the likelihood of alcohol-related harm. Firstly, the frequency of heavy alcohol consumption per drinking episode, commonly known as 'binge drinking'. In the UK, 'binge drinking' is defined as drinking double the recommended guidelines on any single occasion, but others have rejected this approach and instead described it as a social behaviour - namely drinking with the intention of getting drunk.

Secondly, our lifetime volume of consumption is a key determinant in the development of alcohol problems. With alcohol at least 60% more affordable and far more widely available than 30 years ago, the amount we drink has increased proportionately.

As a result, alcohol-related harms have been steadily rising, with annual alcohol-related hospital admissions surpassing one million per year in 2010. These harms, combined with the social, criminal and other impacts are costing the economy at least £21 billion per year. Over £6 billion of these costs are associated with the workplace such as absenteeism, sickness, accidents and injuries or damaged work relations.

Less than a decade ago the first national alcohol harm reduction strategy was released, prompting action to develop and implement effective approaches. What is clear is that no single intervention can work alone, and population level determinants such as price, availability and marketing play key roles. Such issues are hotly political, whilst driving investment in local alcohol treatment and prevention has remained an uphill struggle.

However progress has been made with well-evidenced approaches to identify and support at-risk drinkers. Many of these people are simply drinking more than they realise, or have not considered the level of risk and potential benefits of cutting down. Providing such drinkers with simple advice and information can be highly cost effective.

Those drinking at 'higher risk' levels, who are already experiencing harm or dependency, typically need more intensive behavioural therapies or assisted withdrawal. However the significant majority of higher risk drinkers do not need intensive treatment and, perhaps contrary to popular opinion, are typically 'regular' people with jobs, families but often stressful lives.

This report recognises the complex reasons why people drink and the need for careful insights to understand these. The recommendations made reflect the evidence for approaches that offer the greatest chance to reduce harms amongst City Drinkers. Whilst acknowledging the complex challenges facing implementation, it is clear that addressing alcohol misuse not only benefits individuals and communities, but also businesses and the economy to which the City plays such a central role.

Alcohol misuse and population level drinking

Identifying 'at-risk', harmful and dependent drinking

The research aimed to identify the prevalence of alcohol misuse amongst City Drinkers to enable the comparison of the sample to national and regional averages. The most effective and universally recognised approach for identifying alcohol misuse is known as the Alcohol Use Disorders Identification Test (AUDIT), a validated health screening tool developed by the World Health Organisation. Completing the full 10 question AUDIT identifies respondents into one of four main categories:

AUDIT SCORE	LAY CATEGORY	MEDICAL CATEGORY	COMMENT / SUMMARY
0-7	Lower risk	Lower risk	Includes abstainers – unlikely to experience alcohol-related harm
8-15	Increasing risk	Hazardous	Drinking above the guidelines therefore increasing the individuals risk of alcohol-related health or social problems
16-19	Higher Risk	Harmful	Regularly drinking (on most days) at least twice the recommended guidelines. Already likely to be experiencing alcohol-related harms
20+	Possible dependence	Possible dependence	Dependence may be mild, moderate or severe. Loosely defined as a strong desire to drink and/or difficulty controlling alcohol use

For the purposes of this report, we will use the 'risk' terminology to describe the two main categories of alcohol misuse, though equivalent 'hazardous' or 'harmful' may also be used where citing other reports. It should be noted that those with alcohol dependence are also included as 'Higher risk'/harmful drinkers where not separately specified.

AUDIT was used as the primary tool for gathering insight into City Drinkers as it provides an accurate indication of alcohol misuse factoring in consumption and social or behavioural indicators of misuse.

Although AUDIT is the most accurate tool for identifying main categories of alcohol misuse, it is not a tool for specifically identifying dependence or severity of dependence. Specific tools are available for this purpose though were not utilised in this research as AUDIT gives a sufficient indication of likely dependence (a score of 20+). Most cases of dependence (84%) are mild in severity. Mild dependence is typically characterised by

primarily psychosocial rather than physiological factors i.e. would not require medically assisted withdrawal.

‘Binge drinking’

‘Binge drinking’ has been defined as drinking twice the recommended guidelines on one occasion – that is 6 or more units for a woman or 8 or more for a man. Although explored as one question within the AUDIT, looking at ‘binge drinking’ in isolation can be unhelpful. For instance many lower risk drinkers will ‘binge drink’ occasionally, but overall their consumption means they are unlikely to experience harm. Using risk terminology and looking at frequency and volume of consumption are therefore more suitable.

Existing insight into City Drinkers

The full report details existing information or data that provides insight into City Drinkers. In summary, key existing information includes:

- Limited data previously available on City Drinkers, mainly due to City Drinkers largely made up of the 340,000 daytime working population
- A 2001 Workforce Travel Census identified where City workers commuted from. The largest group came from the county of Essex, with 34,726 people commuting each week day, followed by the London Borough of Wandsworth (13,935)
- There are around 700 licensed venues in the City of London; around 400 of these are bars, pubs or clubs. The remainder are privately licensed venues.
- Alcohol-related assaults make up over half of all assaults in the City, although a small decline in total offences is shown since 2007. Alcohol-related assaults peak in Quarter 3 which includes the festive season.
- Although overall crime rates are low, Anti-Social Behaviour (ASB) is reported as a problem. 61% of issues raised by the community are linked to the Night Time Economy (NTE) and include noise linked to licensed premises, 'drunk and rowdy behaviour', urination in the streets and violence.
- Ambulance data for alcohol-related call outs shows 20-29 as the highest age profile, calls are highest on Thursdays, Fridays and Saturdays. Peak times for callouts are between 8pm and midnight, then midnight to 4am.
- Bishopsgate, which includes the area around Liverpool Street Station, stands out as the highest ward for alcohol-related ambulance call outs. The second highest area is Walbrook which includes the area around Bank and Mansion House.
- The City of London Adult Well-Being Strategy and Action Plan for 2009/12 cites figures indicating low levels of alcohol misuse amongst residents although local services indicate a hidden picture of alcohol problems amongst residents. Homeless populations also have high levels of substance misuse.
- An insight into City Smokers, a group likely to be closely linked to City Drinkers, found smoking was closely linked to stress. The report suggested anti-smoking messages were a turn off as City Smokers did not like to be told what to do. However they are competitive so messages that challenge them to do something have potential.

Results: surveys response and alcohol use

Alcohol misuse amongst City Drinkers sample

Alcohol misuse was identified amongst the sample using the Alcohol Use Disorders Identification Test (AUDIT). AUDIT provides a scoring range of 0-40. Scores in the 0-7 range indicate lower risk drinking, whereas scores above 8 indicate alcohol misuse as either increasing or higher risk drinking. AUDIT scores above 20 were classed as alcohol dependence as a category of alcohol misuse.

Alcohol misuse here is defined as drinking that is either 'increasing risk', 'higher risk', or 'dependent' based on relevant AUDIT scores.

AUDIT scores: alcohol misuse

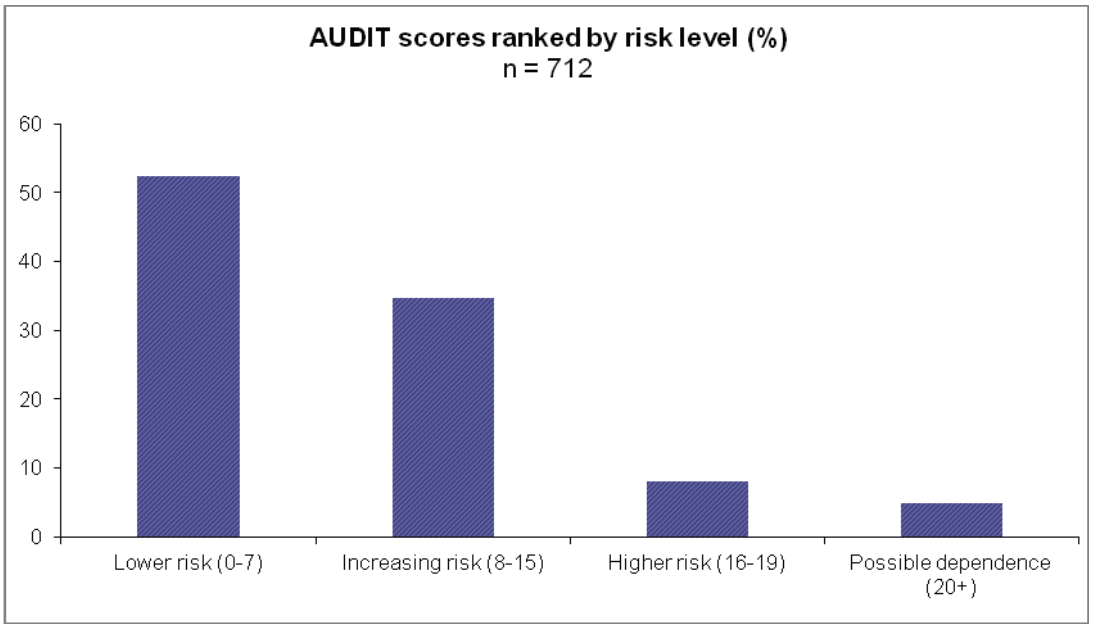
AUDIT scores gathered from the survey results show 52.4% of City Drinkers are at 'lower risk' of alcohol-related harms. These drinkers are likely to be drinking within or close to the recommended guidelines, including at least 2 alcohol free days per week. Some of these drinkers are abstinent.

34.7% of City Drinkers are at 'increasing risk' of alcohol-related harms based on their answers. This means they are increasing their risk of a range of health, social or work problems as a result of their drinking, though may not yet be experiencing harm.

12.9% of City Drinkers at drinking at a 'higher risk' level, 4.9% of whom are possibly alcohol dependent. Those drinking at higher risk levels are almost certainly experiencing either health or social harms as a result of their drinking, including many with mild dependence.

The average AUDIT score for all City Drinker responses (n=712) was 8.1 out of a possible 40. This includes 0 scores indicating abstainers (7.7%).

Figure 1: Levels of alcohol use and misuse amongst City Drinkers sample

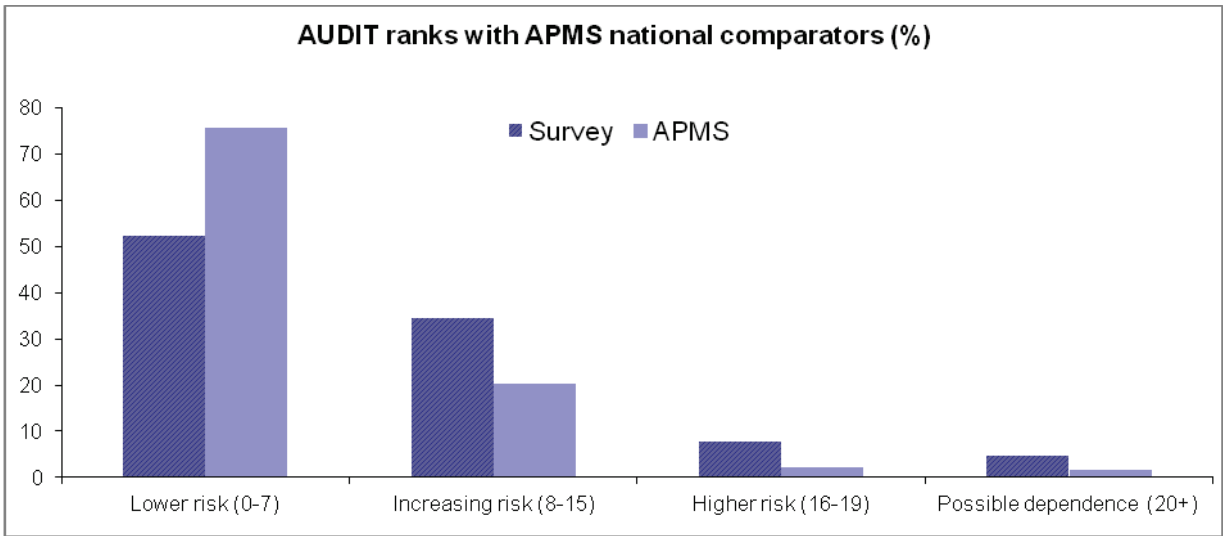


AUDIT scores: City Drinkers Vs national averages

The 2007 Adult Psychiatric Morbidity Survey (APMS) is the best indicator of national level alcohol misuse. APMS also used AUDIT scores (n=7,384) to identify alcohol misuse, identifying 20.4% of APMS sample drinking at 'increasing risk levels, and 3.8% drinking at higher risk (1.6% possible dependence).

Directly comparing City Drinker's AUDIT scores with the national level based on APMS, there are significantly higher levels of alcohol misuse within the City. Whereas in the general population around 24.2% of adults are alcohol misusers, the City Drinkers sample indicates 47.6% are alcohol misusers (increasing or higher risk drinkers).

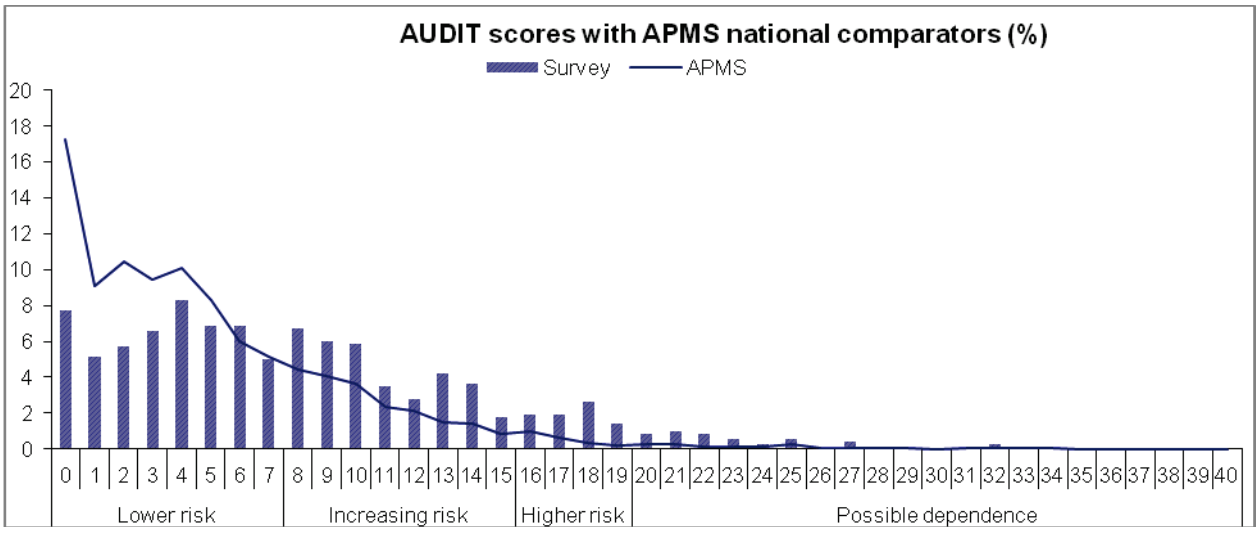
Figure 2: City Drinker's alcohol misuse Vs APMS national prevalence



City Drinkers average (mean) AUDIT score was 8.1 versus 5 in APMS. This represents a significant difference with average City AUDIT score indicitive of alcohol misuse rather than a national average of lower risk drinking.

It can be seen that City Drinker's responses were above the APMS results for all AUDIT scores indicating alcohol misuse.

Figure 3: City Drinker's AUDIT scores Vs APMS AUDIT scores



AUDIT scores: City Drinkers Vs regional prevalence

Of further note is that the London regional average (LAPE profiles[1]) for alcohol misuse is lower than the national APMS levels.

Alcohol misuse	National average	London average	COL average
Percentage of the population aged 16 years and over who report engaging in increasing risk drinking*	**20.1%**	**18.8%**	**33.4%**
Percentage of the population aged 16 years and over who report engaging in higher risk drinking^	**3.8%**	**2.8%**	**12.4%**
*(% of adults aged 16 or over with an AUDIT score of 8-15	APMS 2007	NWPHO	City Drinkers Insight
^(% of adults aged 16 or over with an AUDIT score of 16-40			

Reasons for regional variations are not commonly asserted though lower prevalence of alcohol misuse in London is believed in part to be attributable to higher levels of abstainers as a result of larger ethnic/cultural communities where alcohol consumption rates are much lower (or as a result under-reported).

Of course the results of the 'Insight into City Drinkers' proves that regional or indeed national generalisations about prevalence can be misleading given complex and diverse drinking cohorts within.

AUDIT scores: age, ethnicity and gender

Despite significantly elevated levels of alcohol misuse amongst the City Drinkers sample, profiles of age, ethnicity and gender for alcohol misusers are broadly proportionate to national APMS figures. That is gender, age and ethnicity differences amongst the sample are indicative of national differences.

The significance however of a disproportionately male population of City Drinkers has been considered, but figures weighted for gender inequality still showed high overall alcohol misuse of 44.9% compared to the un-weighted survey figure of 47.6%.

Alcohol misuse amongst male (56.2%) and female (34.1%) City Drinkers is considerably higher than national averages (33.2% men and 15.7% women).

[1] Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in increasing/higher risk drinking, Local Alcohol Profiles for England, www.lape.org.uk

Figure 4: male Vs female City Drinkers alcohol misuse (%)

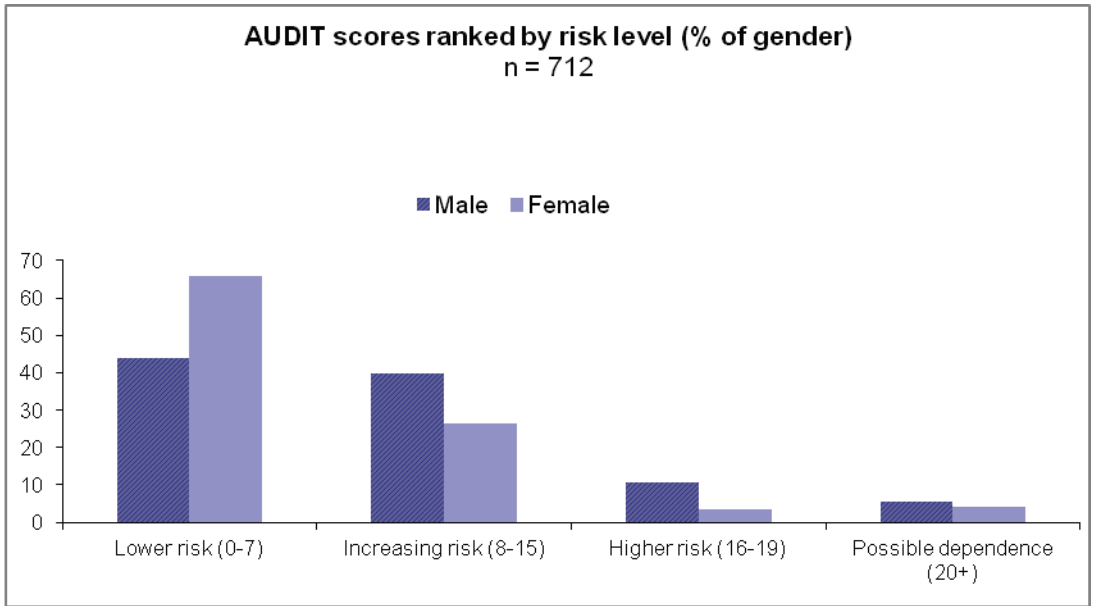


Figure 5: Increasing and higher risk City Drinkers by age and gender (%)

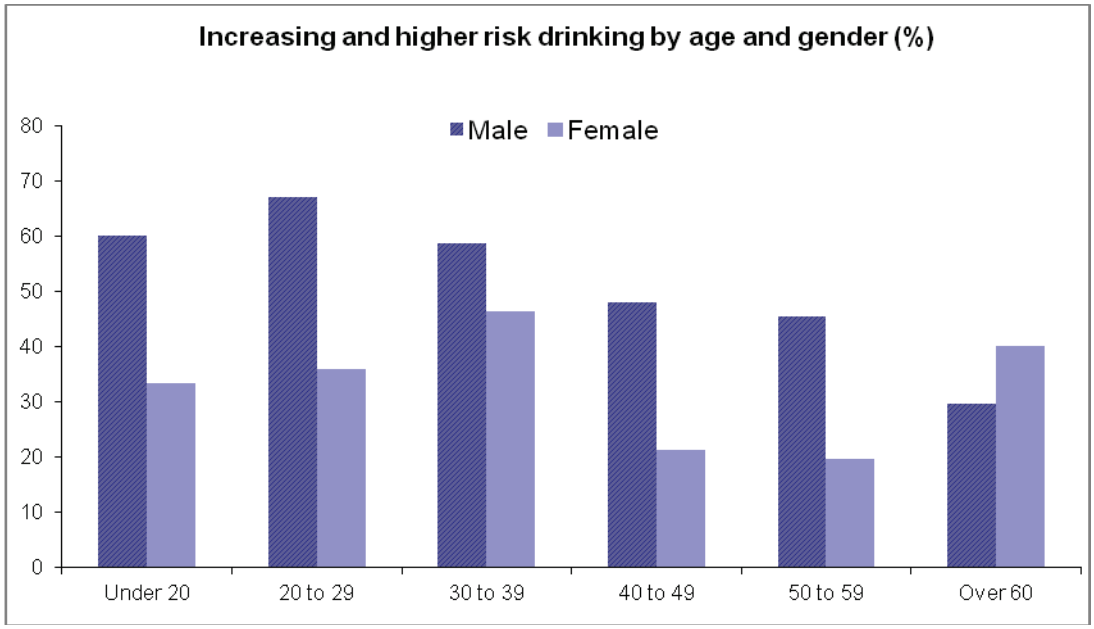
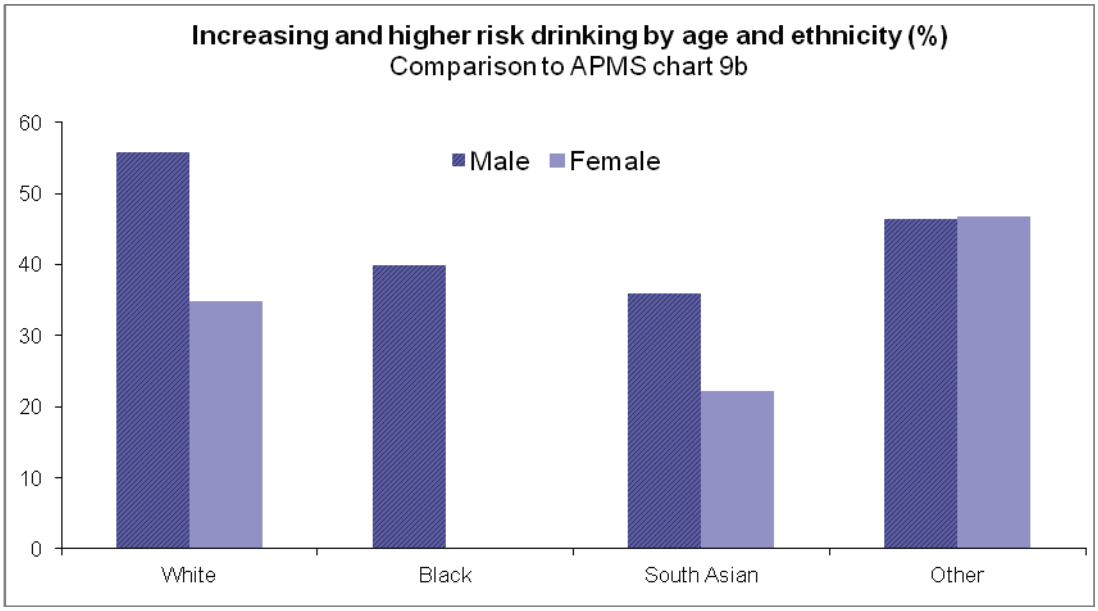


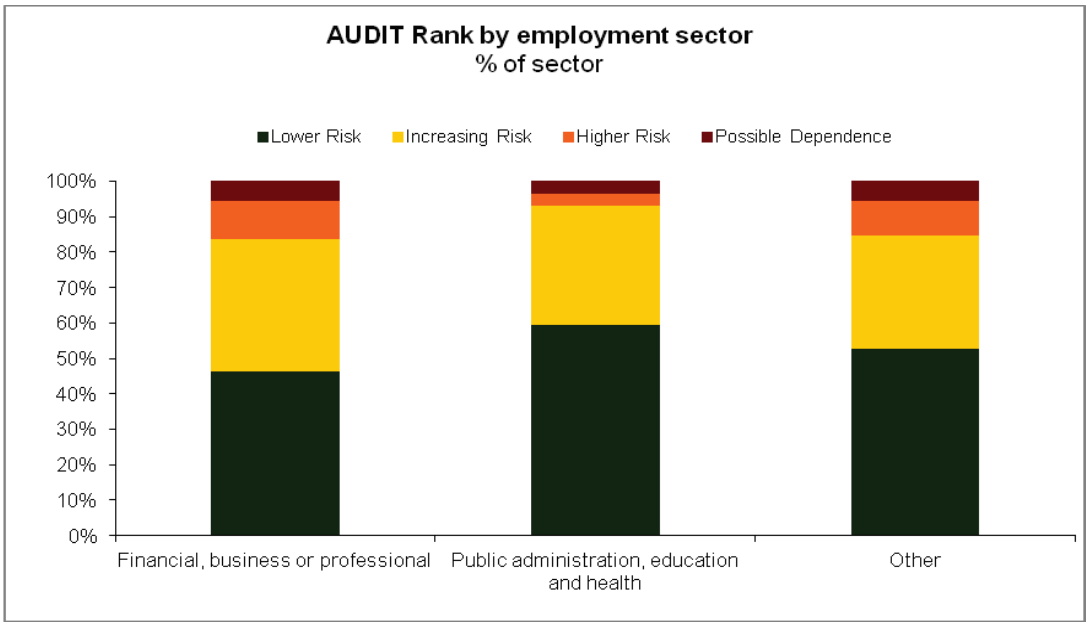
Figure 6: Increasing and higher risk City Drinkers by gender and ethnicity (%)



AUDIT scores: employment sector

Financial, business or professional services have the highest level of alcohol misuse (53.5%) by employment sector, compared with public services (40.5%) or 'other' (47.4%). This indicates that although the financial and private sector may be leading a culture of alcohol misuse, it may be having an influential impact on other sectors by 'norming' higher levels of alcohol misuse.

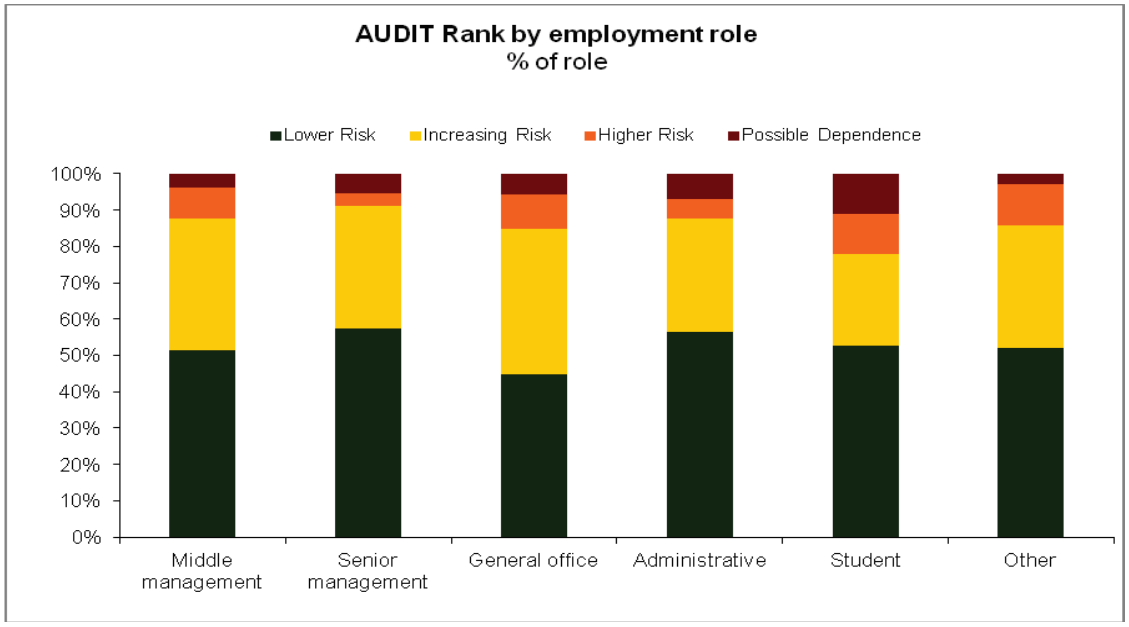
Figure 7: Alcohol misuse by employment sector



AUDIT scores: job role

The highest levels of alcohol misuse by role was amongst 'general office function' (55.2%), followed by 'middle management' (48.6%). The lowest levels of alcohol misuse were identified amongst senior management (42.5%) and administrative roles (43.4%), though these figures are still strikingly high compared to national prevalence (24.2%).

Figure 8: Alcohol misuse by role



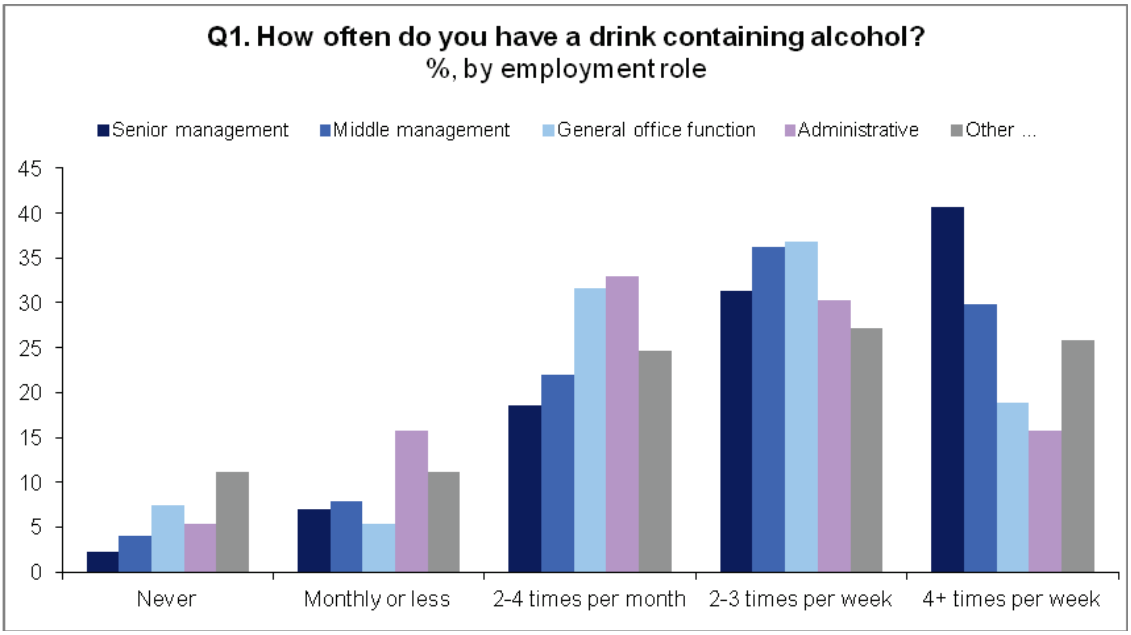
Frequency of drinking

Questions 1 to 3 of the AUDIT are consumption based, determining the frequency and amount of typical drinking. AUDIT question 1 (How often do you have a drink containing alcohol) identified frequency of drinking.

Interestingly, senior managers were most likely to score on the highest frequency measure - four or more times per week (40.7%). Given senior managers ranked lowest for indicative alcohol misuse, this would suggest a more drinking 'little and often' and a lower occurrence of heavy episodic ('binge') drinking. However, given the still high rates of alcohol misuse amongst senior managers, 'less but often' would be a more apt description.

Administrative roles, also lower than most roles for alcohol misuse, were conversely the least likely to drink daily (four or more times per week). This indicates a correlation between seniority of role and frequency of drinking.

Figure 9: Frequency of alcohol consumption (any) by employment role



Assuming a correlation between age and senior management, this may be corroborated by frequency of drinking by age, with those in the 50-59 range most likely to drink four or more times per week (34.7%) against the average (25.6%) for all roles.

Volume of consumption on single occasion

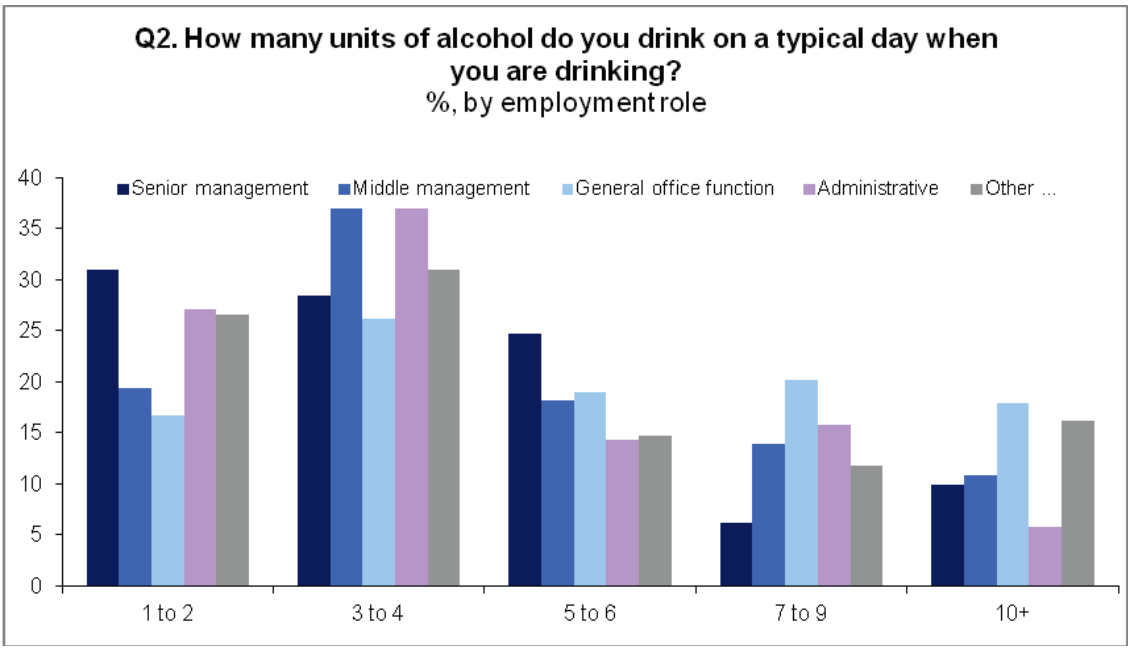
AUDIT question 2 identifies units consumed on a typical drinking day, and AUDIT question 3 identifies frequency of drinking twice the daily recommended guidelines[2] on a single occasion ('binge' drinking).

General office roles were mostly likely to drink 10 or more units or 7-9 units on any single occasion. Senior managers and administrative roles were least likely to drink 10 or more units on a typical occasion and most likely to drink only 1 or 2 units.

As suggested above, senior managers and older City Drinkers appear to be drinking 'less but often' in comparison with other roles, whilst administrative roles are least likely to drink often (4 or more times per week) and least likely to exceed the recommended guidelines.

Given the overall level of consumption in the City, exceeding the guidelines itself is not a robust indicator or alcohol misuse or heavier binge drinking. Units per occasion (AUDIT question 2) may therefore warrant further attention than exceeding the guidelines (AUDIT question 3).

Figure 10: Volume of consumption on typical drinking day by role



[2] 2-3 units per day for a woman and 3-4 units per day for a man. However at least 2 alcohol free days are still advised

Binge drinking shows a strong correlation with alcohol misuse prevalence, with 39.3% of general office functions and 33.7% of middle managers indicating binge drinking 2 or 3 times per week.

Higher levels of binge drinking/alcohol misuse are also correlated to age, where there is a clear decline in binge drinking amongst older age groups (for the highest two levels of typical drinking day consumption of 7-9 or 10+ units).

Figure 11: Volume of consumption on typical drinking day by age

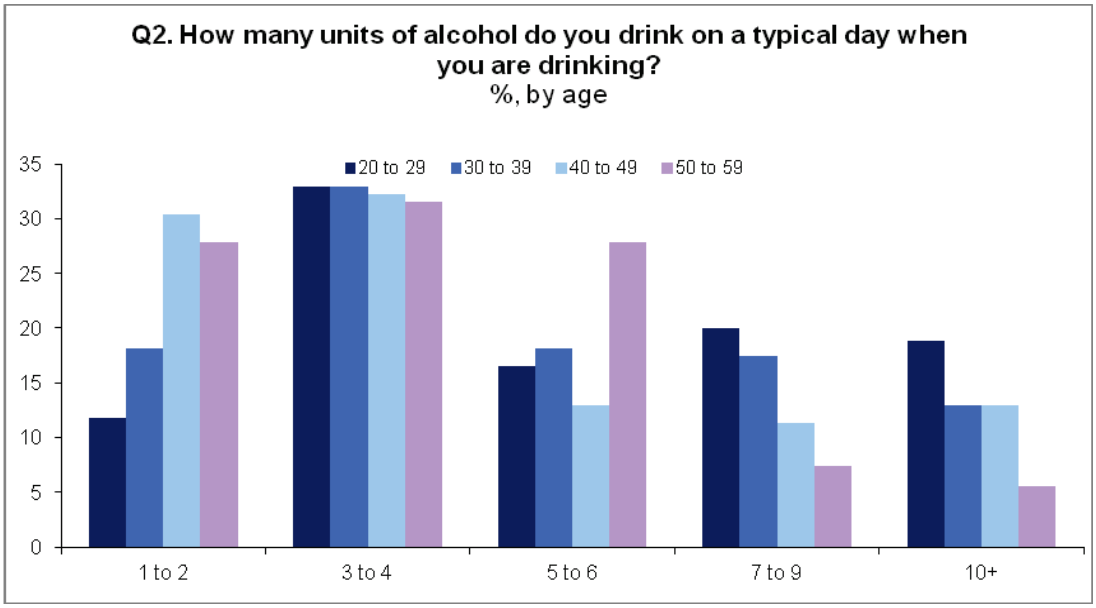
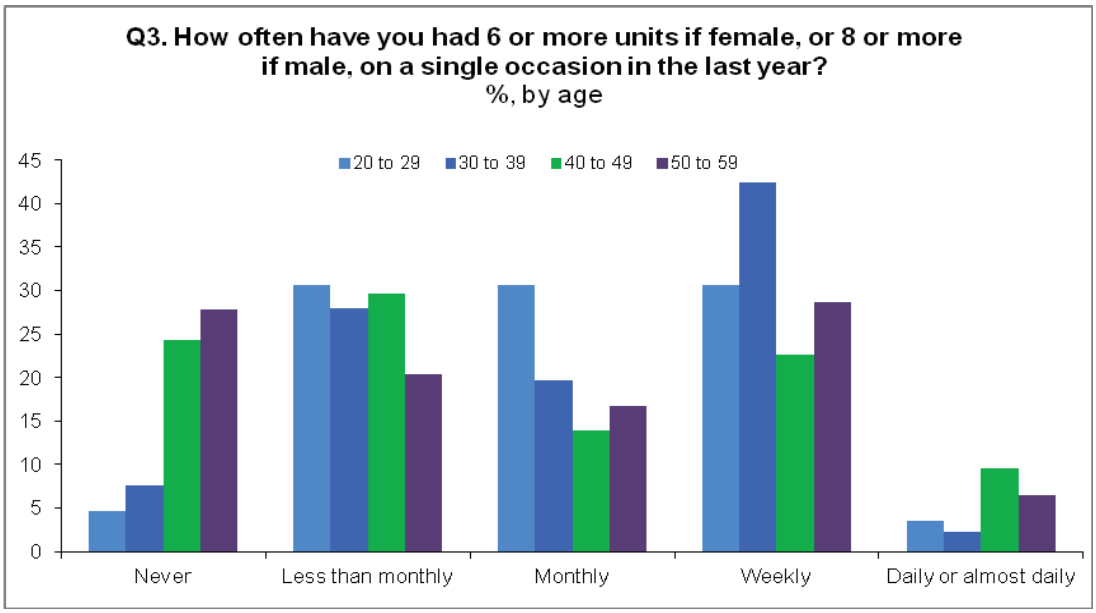


Figure 12: Drinking more than twice the recommended guidelines per occasion (binge drinking) by role



Alcohol misuse, 'binge drinking' and social harms

'Binge drinking', technically defined as drinking twice the recommended guidelines on any single occasion, should also be reflected on as social behaviour such as drinking with the intention of getting drunk[3]. Consumption associated with binge drinking may therefore way exceed the recommended guidelines, with the AUDIT only measuring 10 or more units as the highest option per occasion.

The correlation between binge drinking and alcohol misuse in the City indicates that higher levels of alcohol-related harm amongst City Drinkers (as indicated by AUDIT questions 4-10) are more closely related to weekly binge drinking occasions rather than 'less but often' drinking seen amongst senior managers and older City Drinkers.

This would be consistent with alcohol-hospital admissions data that shows although those in managerial and professional roles drink most often, and are most likely to exceed the guidelines when they do drink, those from lower socio-economic groups suffer high levels of alcohol related health harm[4]. In this respect, alcohol-related problems in the City may be disproportionately social rather than health harms compared to national averages.

Although no national comparators are available to test prevalence of social Vs health harms amongst alcohol misusers, some simple comparisons of AUDIT questions 4-10 suggests social harms may be elevated. For example AUDIT questions relating to behaviour or social impacts scored far higher than those related to health harms or dependence symptoms.

The highest number of 'never' responses were for health impacts: needing an alcoholic drink in the morning (97.2% never); not able to stop drinking once started (80.6% never) and relative, friend or doctor showing concern (79.6%). Those with the lowest number of 'never' responses were social or behavioural: unable to remember what happened the night before (62.8% never); a feeling of guilt or remorse after drinking (64.7% never) and you or somebody else injured as a result of your drinking (77%).

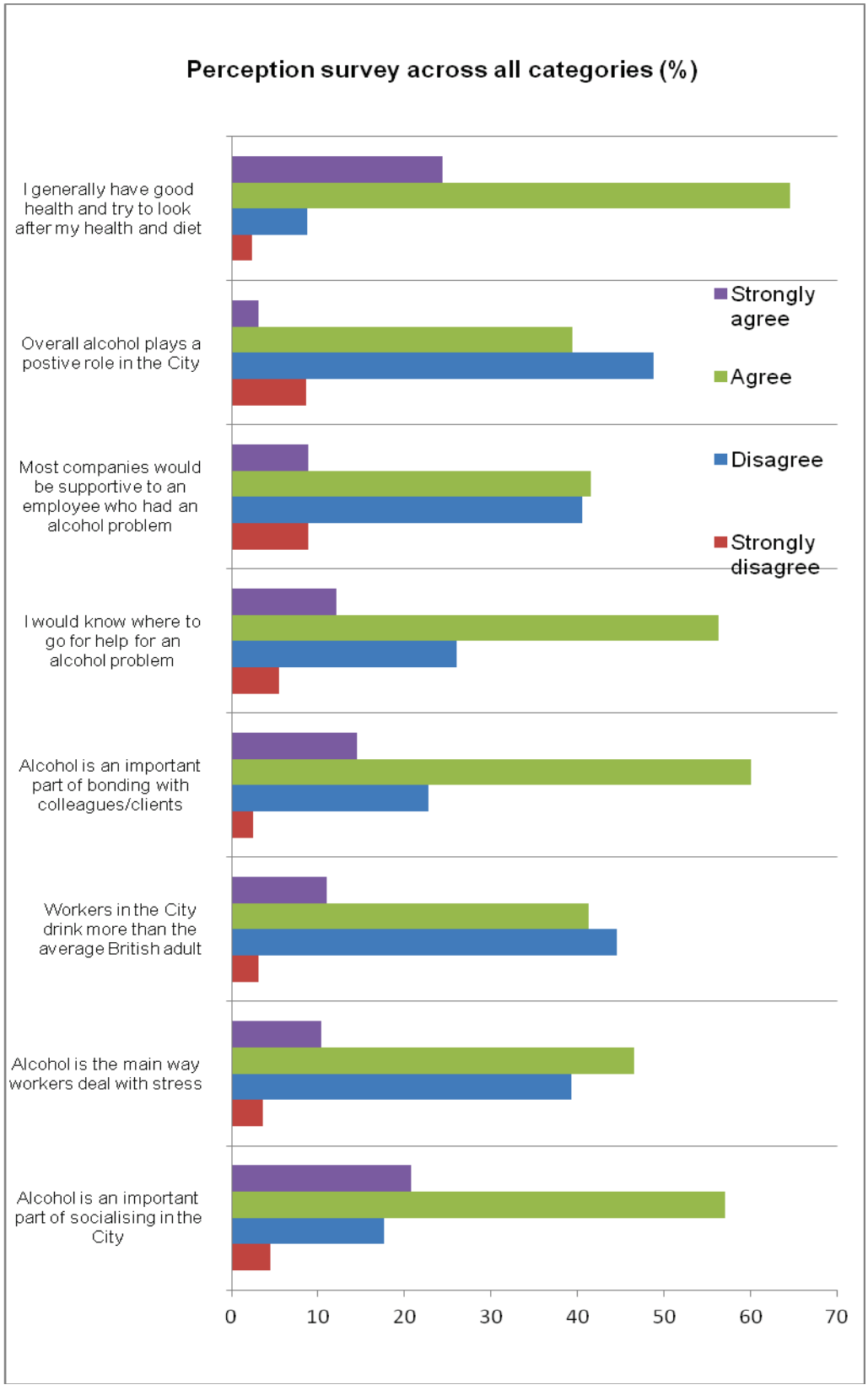
City Drinker's perceptions of alcohol use, health and drinking

City Drinkers' attitudes and perceptions of alcohol's role in the City and their own health and attitudes were taken to ascertain an overall profile of key perceptions and allow potential correlation of attitudes to alcohol use.

[3] A Demos 2011 report 'Under the influence: what we know about binge drinking' explores binge drinking as a more social behaviour

[4] 2009, Dept of Health, *Alcohol Social Marketing toolkit for England'*

Figure 13: City Drinker's perceptions of alcohol use and issues in the City

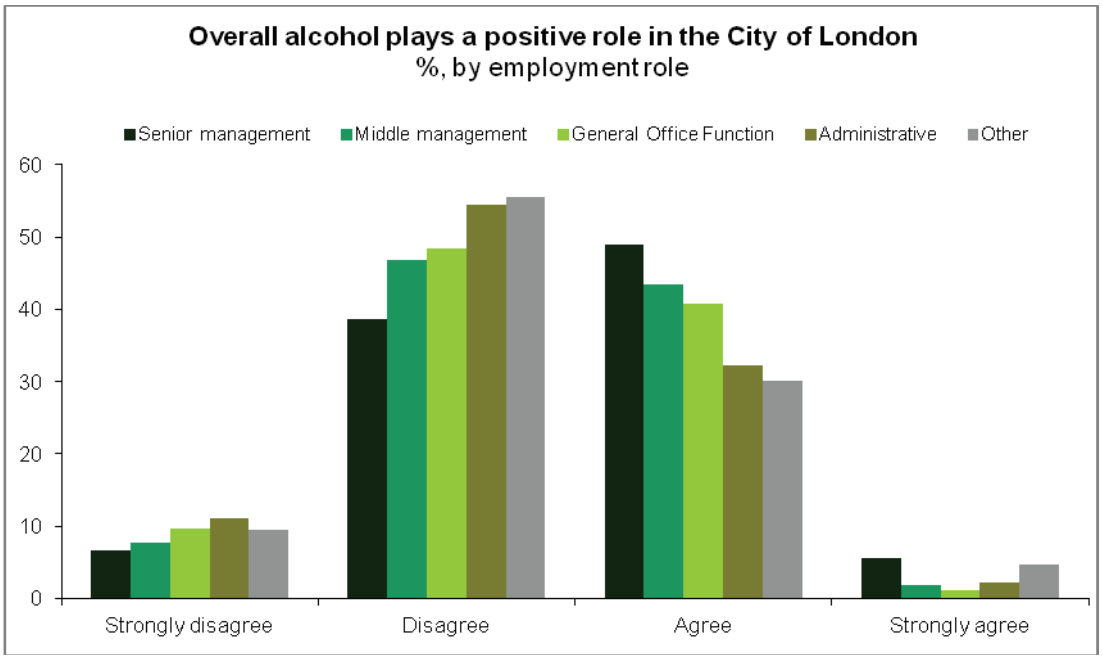


Perception questions were mainly used for the purpose of identifying segments of City Drinkers based on their attitudes and beliefs. However some key observations are worth noting:

- 78% of respondents agreed or strongly agreed that alcohol was an important part of socialising within the city.
- 49% of respondents disagreed that overall alcohol plays a positive role in the City, with 40% agreeing.
- 57% of respondents felt alcohol was the main way workers in the City dealt with stress, with 43% disagreeing.
- A very even split occurred between whether people felt companies would be supportive to an employee with an alcohol problem - 42% agreeing versus 41% disagreed.

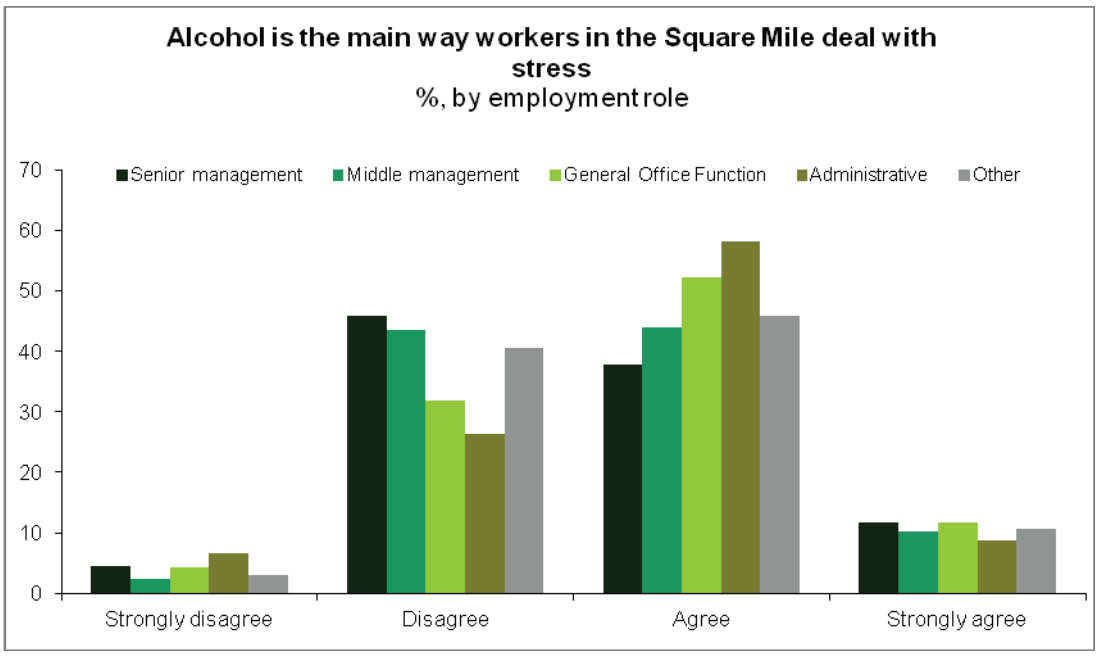
However some analysis of the perception data by role appears to corroborate previous observations. A correlation between role seniority and a positive view of alcohol is apparent.

Figure 14: Perception of alcohol in the City by role



When assessing whether alcohol is viewed as the main way workers in the City deal with stress (a negative view of alcohol), again role seniority indicated a more positive perception of alcohol's role in the City:

Figure 15: Perceptions of stress and alcohol by role

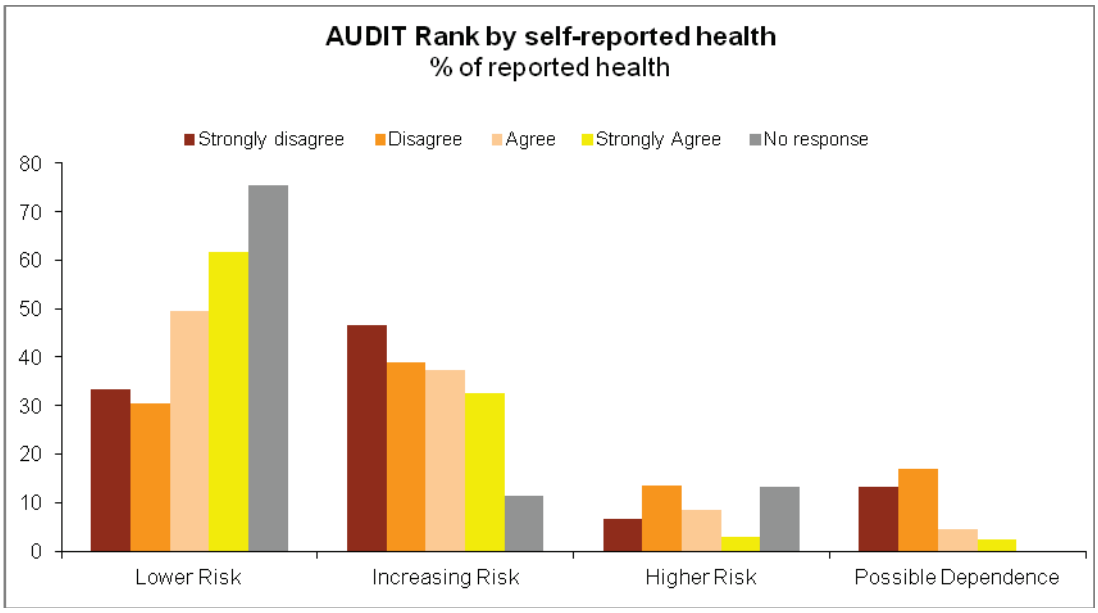


A link between higher alcohol misuse/'binge drinking' and negative views of alcohol amongst less senior roles could be indicative of an awareness of the harms caused by their alcohol misuse. In addition, an awareness of the possible negitive cues for binge drinking in the first place (such as stress). In contrast, more senior roles, who indicate lower alcohol-related problems and "less but often" drinking patterns are likely to be experiencing more of the positives and less of the shorter term negatives of alcohol conumption (such as accident, injury or regret).

Alcohol misuse Vs self-reported health

A correlation between those reporting looking after their health and diet and lower risk drinking was apparent, suggesting higher risk drinkers may be aware of their consumption's negative effects, or as an indicator of less healthy lifestyles. However increasing risk drinkers have relatively high perception of looking after their health, suggesting they are unaware of their drinking's potential or actual impact.

Figure 16: alcohol misuse by self reported good health

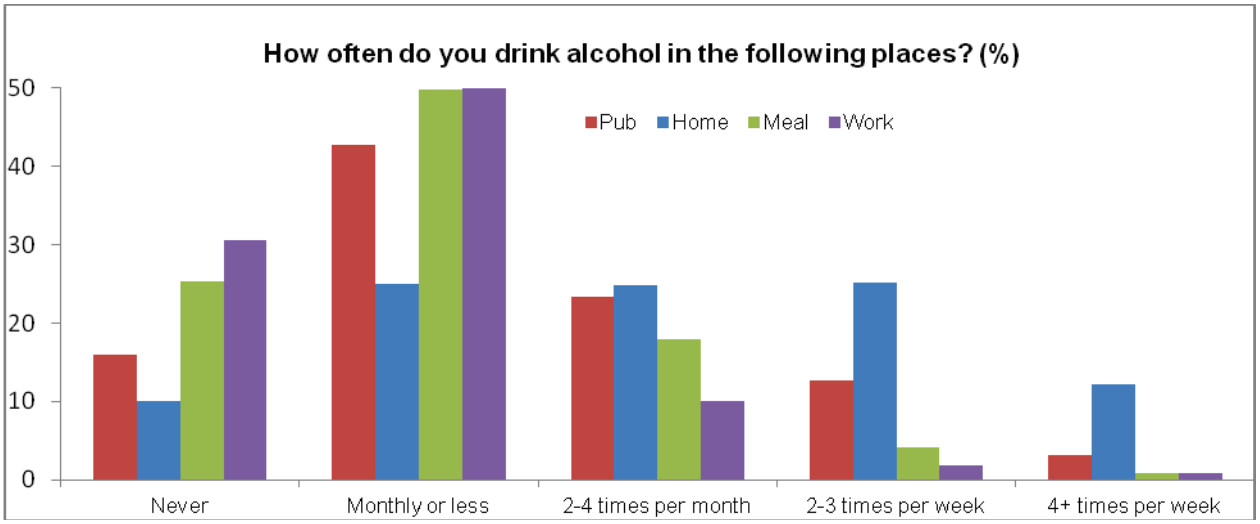


Drinking locations

In line with a national trend over recent decades, overall consumption, particularly linked to frequency of consumption, has shifted from on licensed premises to home drinking. A 2009 Alcohol Concern survey identified the most common reasons for home drinking as 'to unwind', convenience and it being cheaper.

Amongst all City Drinkers, home drinking appears the most frequent place of consumption overall, particularly for those drinking weekly or near daily.

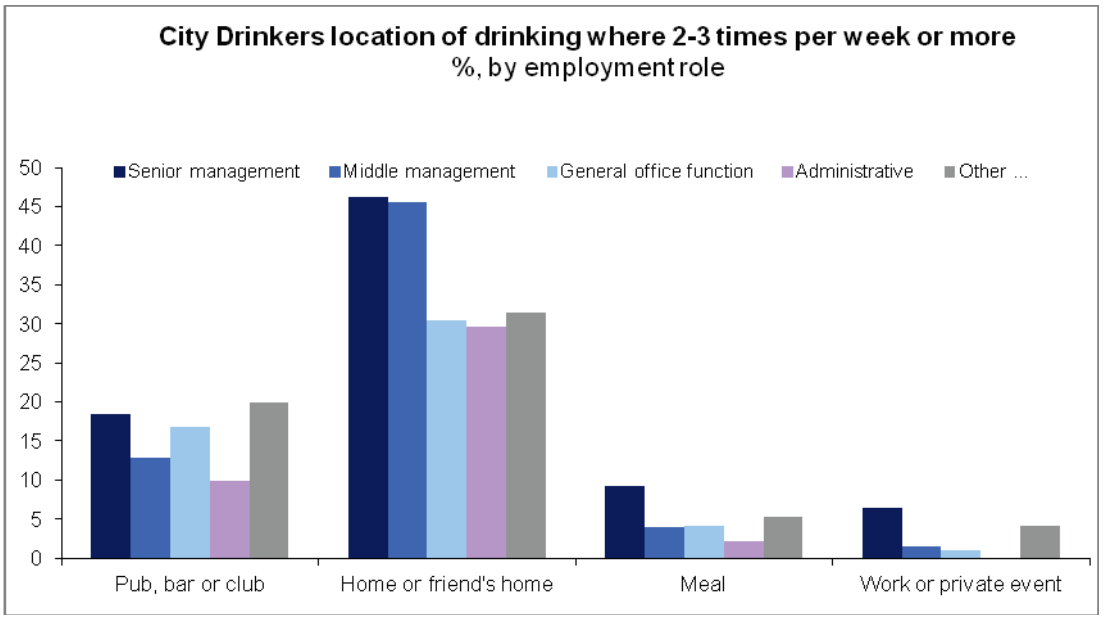
Figure 17: frequency of drinking by location



Responses that identified drinking in any location 2-3 times a week or more are shown below by role. Not surprisingly, senior managers were most likely to drink most frequently across all settings. Home drinking amongst all management roles is notably high, offering potential exploration for home drinking as a target for those drinking most frequently.

Interestingly though 'general office function' roles, who report highest alcohol misuse, showed lower home drinking frequency than management roles. Separate analysis[5] also showed no direct correlation between those that drank at home more regularly and those frequently drinking in the City.

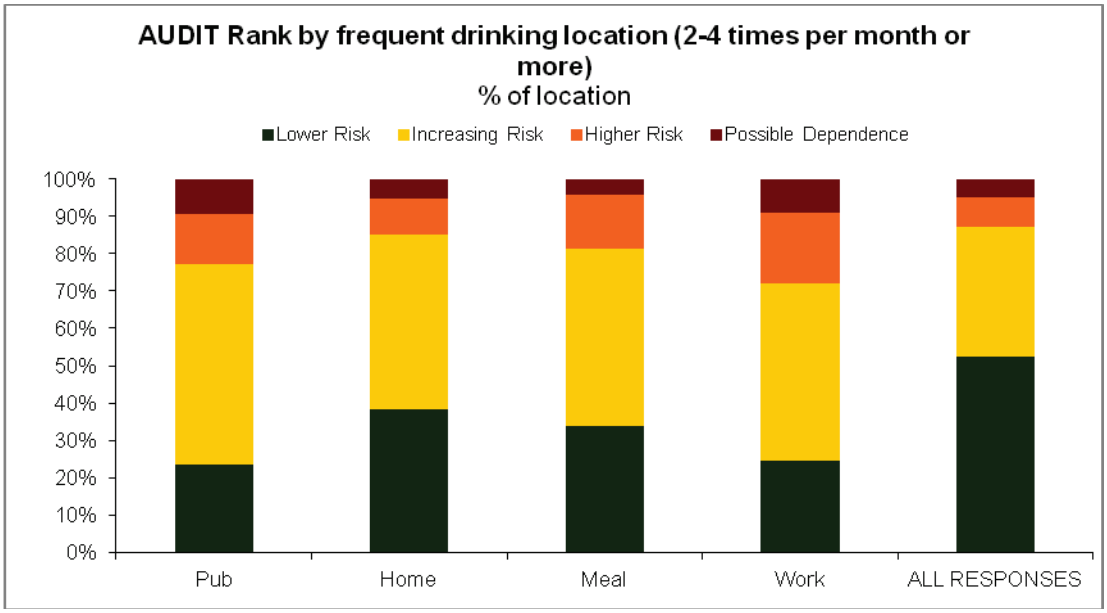
Figure 18: frequency of drinking by locations amongst regular City Drinkers



Importantly, when looking at risk levels amongst those frequently drinking at different locations, those drinking in pub settings or at work events were significantly more likely to be alcohol misusers. This would suggest that alcohol misuse amongst City Drinkers is significantly driven by drinking done in the City rather than at home.

[5] No significant correlation between those who drink at home more regularly and those who drink in the City; r^2 value = 0.066

Figure 19: Alcohol misuse (AUDIT rank) by drinking location



Average AUDIT scores significantly increased in line with frequency of City drinking when the sample is divided into three groups:

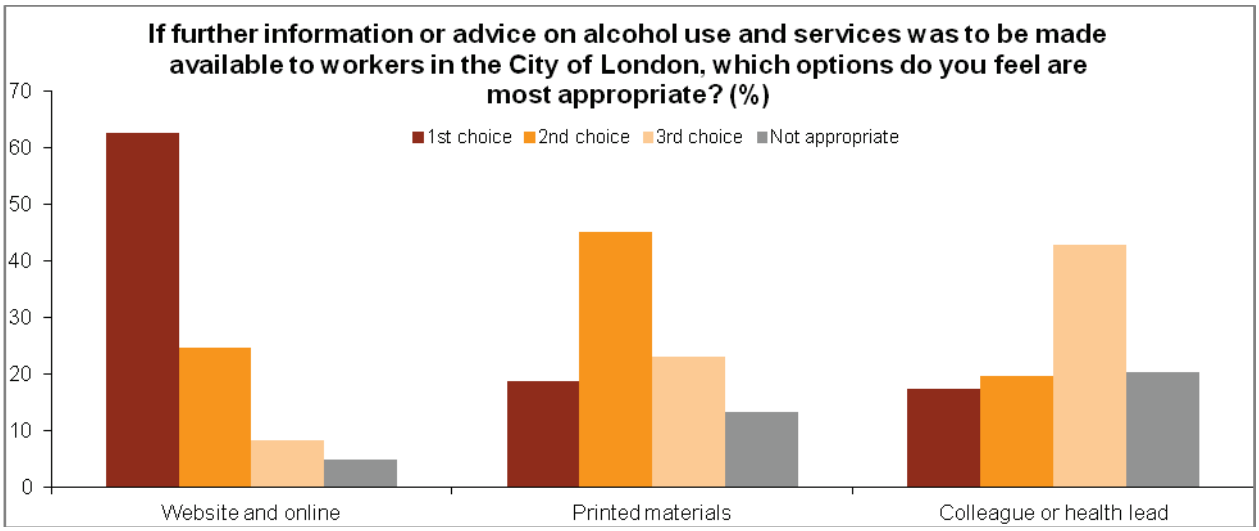
City drinking frequency	Average AUDIT score
Never drink in the City (n=206)	5.510
Sometimes drink in the City (n=375)	8.795
Often drink in the City (n=93)	12.404

The role of pub or work event drinking in the City is therefore of particular relevance to alcohol misuse. Home drinking appears to be an important part of drinking for many City Drinkers, but is not an indicator of alcohol misuse. However the longer term health impacts and risk of dependency of regular home drinking should not be overlooked.

Preferences for further information or advice

A significant preference for website and online resources was apparent as noted within qualitative feedback.

Figure 20: preference for alcohol-related information to be made available



Survey validity: confidence and statistical significance

The survey collected the responses of 740 people (526 online and 214 in street-based surveys). The results above describe the collected responses directly (unless otherwise stated for weighting purposes).

The size of the survey suggests that general confidence intervals of 3.6% can be assumed at a confidence level of 95%, although intervals will increase for different segmentations of data. These confidence levels can be considered positive given an estimated 2 in 1000 population tested based on a 339,000 population estimate.

The results have not been tested for statistical significance due to limitations of the project, and although some testing could be carried out, this may not prove conclusive or relevant for this type of research.

Postcode data

376 (51%) of respondents volunteered partial postcode information. While not detailed enough for hotspot analysis, this data could be used at a summary borough or county of residence level, which may shed greater light on the behaviour of City drinkers (for example, differing levels of alcohol use in different areas, whether those drinking after work in the City live closer or further from work, etc). GIS (mapping) technology could be performed for this purpose, but meaningful results can also be gained from simple descriptive statistics. This work was beyond the capacity of the project but could be explored.

Results: qualitative analysis and interviews

The survey design allowed for comments on City drinking culture and drinking in general. Most respondents felt there was a specific City drinking culture and most felt this had negative associations with health and social issues. The identified drinking culture was commonly described as 'blokey' and 'competitive'. Those who felt uncomfortable with the drinking culture were disproportionately, but not exclusively, female and non-white.

Some expressed disappointment at the lack of alternative non-alcohol focussed activities after work to provide opportunities for bonding, stress relief or socialising. Others highlighted the link between drug use and other problematic behaviours.

Positive comments about the drinking culture reflected views that drinking promoted team bonding and building relations with clients, relieved work stress and allowed escapism from 'pointless' jobs. Some felt that drinking occasions were where 'grace and favour' was earned and assisted career progress. Reasons for the existence of the drinking culture ranged from stress relief, peer pressure and escapism. Significantly, some felt that company practices actually encouraged excessive drinking.

Although drinking at lunchtime was reportedly less common than in previous years or decades, venue managers were surprised at the amount and frequency of drinking and the money spent at lunchtimes. They also expressed shock at customer's ability to go back to work and perform after lunchtime drinking sessions. Midweek evening drinking had become more popular, with Thursday now being seen as 'the new Friday'. However venue managers felt alcohol-related problems in the premises were rarely an issue and the City police and crime reduction partnerships were regarded as excellent.

Conclusion

Prevalence of alcohol misuse amongst City Drinkers has been shown to be a significant issue, having a considerable impact on both individual's health and social functioning and the overall performance of their organisations. Levels of alcohol misuse within the City may be amongst the highest studied within any specific sample in the UK.

However when considering the social and environmental factors at play in the City, these findings should come as no surprise. It is well known that the affordability and availability of alcohol are key determinants in consumption, neither of which are likely to be barriers to City Drinkers. In addition, the typical profile for alcohol misuse amongst adults is essentially that of the average young City worker who may be prone to a competitive 'work hard, drink hard' attitude.

This report has identified key characteristics of alcohol misuse and its likely cues within the City. General office roles, as a less senior and younger profile of City Drinker, are evidently the key driving force behind high levels of alcohol misuse in the City. Their drinking is defined by heavy occasion binge drinking, typically or most enthusiastically taking place on Thursdays and Fridays. General office roles and those aged 20-29 are significantly more likely to drink 10 or more units of alcohol on a typical drinking occasion than any other role.

With increasing age and seniority of role though, a 'less but more often' approach to drinking becomes apparent. Although senior managers or those aged 50-59 are most likely to drink 4 or more times per week, they are also most likely to drink within the 'lower risk' guidelines. Management roles are more likely to drink frequently at home or with a meal in the City. Logically, common sense reasons are that senior roles and older City Drinkers tend to have more responsibility within organisations, are more likely to entertain clients and more likely to have family or other responsibilities that discourage drunkenness.

With seniority of role, older age and lower alcohol misuse, the perceptions of alcohol use become more positive. In contrast, younger less senior roles are more likely to perceive alcohol negatively and cite drinking as the main way to deal with stress. With greater alcohol misuse comes a greater awareness of the negative effects, and perhaps also awareness of the negative cues that lead to binge drinking.

Giving in to 'binge drinking'?

Although in many ways a flawed concept, binge drinking may be the simplest way to characterise alcohol misuse within the City - but more within a social or behavioural framework rather than the official consumption definition. Drinking more than twice the recommended guidelines on a single occasion is possibly unhelpful as a national

definition. Arguably it is even less so in the City where overall consumption is higher and 'less but more often' drinkers are often drinking at or over the guidelines. Despite this they have significantly lower prevalence of alcohol misuse than those City binge drinkers driving alcohol misuse in the Square Mile.

Binge drinking amongst City Drinkers is therefore best characterised by heavy single occasion consumption[6], motivated by social or behavioural factors such as the desire to get drunk or unwind. This is not to say that those not drinking within this 'City binge drinking' definition are not alcohol misusers, more that they are not the driving force behind alcohol misuse and associated problems in the City.

A 2011 report by Demos exploring binge drinking also rejected the use of the official definition based on consumption. Demos characterised binge drinking as "young adults that drink to extreme excess, often in an intentionally reckless and very public way, putting themselves and others at risk of harm." This definition fits the profile driving alcohol misuse within the City, but a key aim of this report was to break down such profiles and identify segments to target messages or interventions that will lead to behaviour change.

Targeting 'segments'

As the segmentation analysis has shown, younger, less senior City binge drinkers driving alcohol misuse within the City are not themselves a homogenous group. Nonetheless, an increasing 'awareness' of the negative impacts of alcohol misuse comes with greater immersion within the culture. Close to one third of the sample are drinking at increasing or higher risk levels and show potential to engage with suitable messages based on their attitudes.

However, a significant proportion also show positive attitudes towards alcohol despite their alcohol misuse and being immersed in the City drinking culture. These individuals will be harder to engage via communications and are more likely to require a stronger intervention such as Identification and Brief Advice delivered by a healthcare or other professional. In general terms, 'higher risk' drinkers (12.9% of the sample) typically require more structured interventions or treatment to help address dependence.

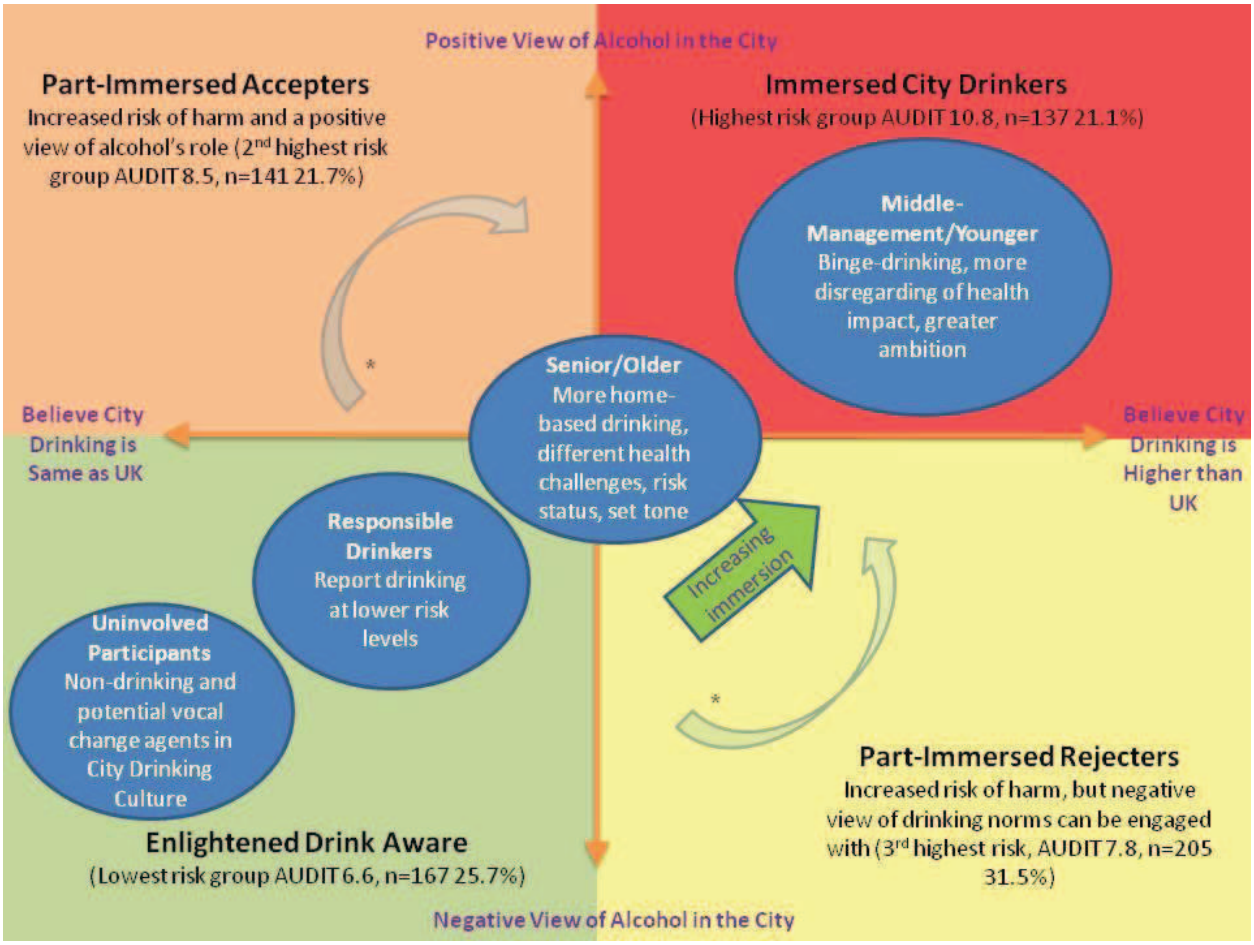
Nonetheless, a significant sample of City drinkers can be targeted with relatively low cost messages to support behaviour change. Both binge drinkers with high levels of alcohol misuse and 'less but often' drinkers who are still placing their longer term health at risk will often be unaware of their drinking's impact. Reaching out to these drinkers

[6] Heavy single occasion consumption here implies drinking significantly above double the recommended guidelines (many City Drinkers will drink double the guidelines but not be characteristic of binge drinking as defined here)

through a variety of media with appropriately targeted messages will help them to reflect on their drinking and identify steps to help them cut down.

Chart: Segmentation of City Drinkers

With increased 'immersion' in the City Drinking culture – that is greater levels of alcohol misuse – comes a greater level of awareness of associated negative factors. However some who are immersed are also hold a positive view of alcohol and are therefore 'accepters'. 'Accepters' may be less responsive to health messages and require more innovative approaches, for instance appealing to their desire for professional advancement as a lever for drinking less. However 'part-immersed rejecters' – those at-risk but with a negative view of alcohol use in the City- will be receptive to targeted health or social impact messaging.



*Arrows represent that City Drinkers are not bound or static within the segments. Attitudes, alcohol use and other influencing factors are constantly shifting so segmentation should not be entirely viewed as an exact science.

Reducing alcohol misuse in the City

As emphasised throughout this report, no single intervention can make a significant or lasting change to the high levels of alcohol misuse that form the harmful City drinking culture. To make a sustainable impact, a range of environmental and organisational

changes will need to take place. Ranging from robust licensing policy to leadership and commitment from employers, a clear message from the top will help to confront and change the drinking culture.

Alongside this, individual level action to delivering messages and interventions to alcohol misusers within the City can start to reduce the significant negative impacts. These must be delivered by carefully planned and well-informed strategies. To change a complex and engrained culture will require innovation, for instance through empowering assets such as lower risk drinkers or abstainers to challenge the drinking 'norms'.

Given the level of alcohol misuse and environmental determinants that have embedded a problematic City drinking culture, a commitment to sustained action on alcohol misuse within the Substance Misuse Partnership will need to be the key driving force for this change.

	Recommendation	Rationale	Likely impact	Resource implication	Examples
1.	***Social Marketing approaches for City Drinkers***				
1.1	**An alcohol communications strategy based on City Drinkers Insights**	• An alcohol communications or 'social marketing' strategy should be employed in order to: ○ Help at-risk City Drinkers make informed decisions about their alcohol use ○ Motivate at-risk City Drinkers to reduce their alcohol use ○ Target specific segments as identified with appropriate messages ○ Reach out to City Drinkers through a variety of channels ○ Utilise potential levers for change such as 'social norms' approaches	Communications strategies vary from ineffective to potentially powerful and cost-effective ways to change behaviour. However few alcohol-related social marketing campaigns can be conclusively shown to have achieved long term behaviour change alone. A carefully developed and comprehensive strategy should play a key role in reducing alcohol misuse in the City	Dependent on scope, reach and scale of strategy. Delivery of a strategy could range from several to hundreds of thousands of pounds	National level social marketing activity includes 'Know Your Limits', 'Alcohol Effects' and now 'Change4Life' activity. 15 local campaigns can be found under the 'local initiatives' section of the Alcohol Learning Centre and other examples from www.thensmc.com
1.2	**Secondary alcohol information**	• Accurate core alcohol awareness information (units and lower risk consumption) to support recommendation 1.1 and those choosing to reduce their consumption	Basic alcohol information alone is unlikely to lead to behaviour change, but forms an important part of decision making when other motivators or interventions are employed	Dependent on methods of delivery but generally low-cost and free resources available, especially web based	Web resources such as www.nhs.uk/drinking and a variety of printed materials. 24 hour free phone information line (Drinkline 0800712 8282)
1.3	**Mobilise lower risk City Workers to facilitate**	• Lower-risk drinkers could be mobilised by employers or local health and well-	Not evaluated as a specific alcohol approach but such	Dependent on specific initiatives	

	Recommendation	Rationale	Likely impact	Resource implication	Examples
	non-drinking cues	being initiatives. For example to ensure the provision of no or low alcohol drinks, or facilitate alternative activities to the 'default' drinking times	'nudge' approaches have sufficient recognition within behaviour change policy	but instigating them alone could take sufficient time to build buy-in	
1.4	**Promotion of web-based information and resources for City Drinkers**	• Disseminating web-based messages and resources (such as online drinks trackers or self-assessment tools) will support objectives of 1.1 and 1.2	As with alcohol communications in general, understanding of efficacy is limited. However some early evaluation of web-based interventions shows some effectiveness for certain segments	Many free web-based resources exist, including 'self-help' brief interventions approaches, forums	NHS Choices (www.nhs.uk/livewell/alcohol), Change4Life, Drinkaware
1.5	**Direct marketing of self-help booklet/materials**	• Those 'contemplating' or wanting to reduce their alcohol use will benefit from structured advice and strategies to cut down • A self-help booklet (Your Drinking and You) has a six-step plan shown to be effective	An evaluation of a direct-marketing project found the booklet 'was very effective, and efficient in terms of return on investment'	Producing the booklet itself is low cost however setting up mechanisms for allowing orders and delivery has resource implications	West Midlands self-help leaflet direct marketing evaluation
1.6	**Recognising the impact of alcohol and cocaine use**	• Cocaine use is associated with alcohol misuse and linked to increased health and social risks • Awareness around these risks and further consequences such as criminal or ecological impacts may reduce use	No specific evaluation of cocaine awareness on alcohol use	As per 1.1/1.2	Cocaine campaigns such as national FRANK messages. Some local examples of combined alcohol and cocaine messages

	Recommendation	Rationale	Likely impact	Resource implication	Examples
2.	***Alcohol treatment and interventions***				
2.1	**Identification and Brief Advice targeted to City Drinkers**	• Identification and Brief Advice (IBA) is the most cost-effective behavioural intervention for reducing at-risk but non-dependent drinking • Reaching a significant number of City Drinkers with IBA would be the single most effective individual level intervention • Opportunities for IBA exist such as through Occupational Health contacts, return to work interviews, health and wellbeing initiatives etc	Hundreds of international studies have shown IBA to be effective in reducing alcohol misuse. Although the workplace is relatively untested as a setting, IBA works as long as is delivered in line with key principles. IBA is called for by the Department of Health, NICE and the World Health Organization (WHO)	National efforts are being made to ensure health and social care roles routinely deliver IBA. Initiatives to instigate IBA in workplace settings would need funding/resources to cover engagement, training, policy development etc	The Alcohol Academy delivered a feasibility study into workplace IBA and found opportunities did exist. Some other International studies have explored workplace IBA in various forms
2.2	**Web-based interventions for City Drinkers**	• A small but growing evidence base suggested that structured interventions, including brief intervention and IBA, peer support are effective • More interactive resources are being developed and promoted	Some segments appear receptive to web-based interventions, although traditional treatment and intervention approaches are certainly still required	Dependent upon the intervention and reach. Some resources are free (see 1.4) but more sophisticated versions may cost £10k upwards	NHS Choices (www.nhs.uk/livewell/alcohol) offers free online self-assessment and tools, though www.dontbottleitup.org.uk has been launched at a starting cost of £10k
2.3	**Action-research into opportunistic street based IBA**	• City Drinkers were surprisingly amenable to discussing their alcohol use as part of the street research • Street based IBA could be a key opportunity to achieve 2.1 and could be	Some initial studies have shown street based IBA to be effective	Due to the relatively limited training required for delivering IBA, street-based IBA	An unpublished Brazilian trial into street based IBA has been shown to be effective

	Recommendation	Rationale	Likely impact	Resource implication	Examples
		a pioneering approach to alcohol harm reduction		itself could be relatively low cost. However full evaluation would add significant costs	
2.4	**Access to treatment and peer support groups**	• Improving uptake of treatment and peer support to reduce alcohol misuse/problems • Addressing access barriers, particularly to City Drinkers who may face particular barriers such as working hours and stigma, could significantly increase engagement • This includes access to both structured treatment and mutual aid or peer support/aftercare	Alcohol treatment is proven to be cost-effective. The 2005 UKATT trial found that for every £1 spent on alcohol treatment, £5 would be saved in wider public sector costs	Structured treatment has significant resource implications for commissioners although mutual-aid groups – which are also effective for supporting recovery – should be low or cost free	Alcohol treatment guidelines, examples and costing tools are all set out in NICE CG115. Mutual aid groups such as AA, SMART Recovery or Moderation Management
3.	***Alcohol workplace policy***				
3.1	**Action to encourage the development of alcohol workplace policies**	• Workplace environments and other factors play a significant role in influencing alcohol use at work - workplace policy and action can play a crucial role in reducing misuse • Alcohol misuse significantly impacts the workplace though absenteeism, poor performance, damaged relationships/ morale, long term sickness etc. • Organisations could be incentivised or encouraged to develop changes or	The impacts of alcohol misuse on the workplace cost the economy around £6.4 billion per year. Reducing alcohol misuse has been shown to increase employee health and wellbeing and can directly impact the performance of organisations.	Dependent on action taken, though simple workplace alcohol policy can be developed with sufficient organisational buy-in	Some companies, such as BT have made impressive health and wellbeing efforts across the workforce. However few have taken specific action or attention to alcohol, though

	Recommendation	Rationale	Likely impact	Resource implication	Examples
		initiatives to address workplace environment or other factors linked to alcohol misuse			examples of good policy and practice exist
3.2	**Commission or instigate workplace alcohol & health 'packages'**	• Workplace activity can include alcohol awareness raising and health and wellbeing for all employees, targeted IBA and support for at-risk drinkers, and appropriate support and referral for dependent drinkers • Offering commissioned packages to employers may be the most direct way to affect workplace change	As above. Although there are no full cost-benefit models of comprehensive alcohol workplace packages, a recent report by the London School of Economics calculated a return on investment of 9-1 for a comprehensive workplace-based health promotion and well-being programme	Dependent on scale of action taken. Simple training and policy development could be commissioned at relatively low cost per organisation.	The Alcohol Academy supported some local authorities to develop packages, and other organisations and providers are also developing work in this area
4.	***Further recommendations***				
4.1	**Wider development of positive and alternative activities**	• Many City workers may drink as the 'default' option. Improving options for City Drinkers to engage in other activities that fulfil social or other criteria could reduce alcohol misuse	There appear no direct studies looking at the availability of alternative/positive activities in comparable groups. Some studies into students engaging in other activities have mixed findings, perhaps not surprisingly since involvement in sports has been linked to misuse	Dependent on scope of work, though some low cost initiatives to encourage exercise or engage in existing schemes could be developed	
4.2	**Integrate alcohol and health and wellbeing projects within the**	• Addressing alcohol misuse can be challenging, particularly amongst those segments that may be resistant to alcohol messaging/interventions. Health	Improving Health and Wellbeing has clear evidence base for workplace settings. However there is at present		Wide range of initiatives or projects promoting

	Recommendation	Rationale	Likely impact	Resource implication	Examples
	workforce	and Wellbeing approaches offer a more acceptable way to change behaviour	little recognition of alcohol in particularly within such programmes		workplace health, including the Responsibility Deal
4.3	**Compare consumption based alcohol data**	• Further alcohol related data gathered through forthcoming/future studies could add to the City Drinkers insight			
4.4	**Wider work to reduce determinants of alcohol harm and ill health**	• It must be recognised that reducing an overall culture of alcohol misuse cannot be achieved by any single action. A sustained and multi-component strategy that recognises the key determinants of alcohol misuse must be employed	'Multi-component' approaches are identified as necessary to achieve population (not individual) level alcohol harm reduction	Dependent on scope of work	WHO strategy guidance for European states. A 2006 review was also carried out by Middlesex University
4.5	**Further possible research and analysis into City Drinkers**	• Further insights or exploration into City Drinkers could be useful for further work to reduce alcohol misuse in the City • Analysis of postcode data, further development of psychographic segments, or testing of other data or observations could be considered		Dependent on scope of work	

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