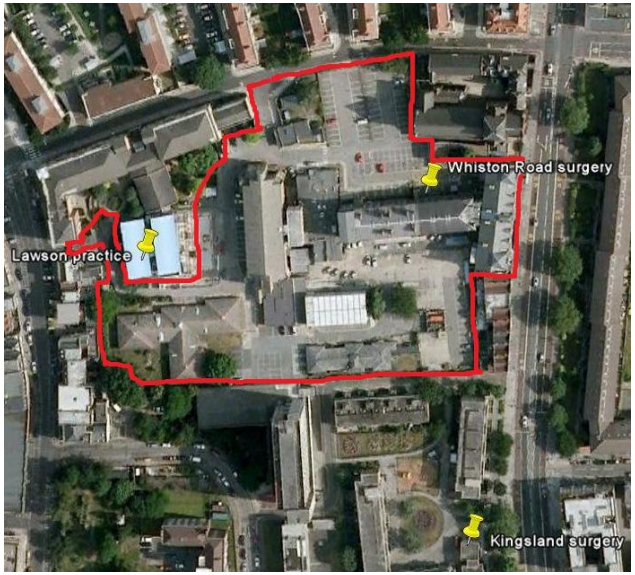
BETTER SERVICES FOR ALL AT A REDEVELOPED ST.LEONARDS

Outline Business Case



NHS

North East London and the City

healthquantum
driving change in healthcare

Draft 2.0

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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
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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, subject 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

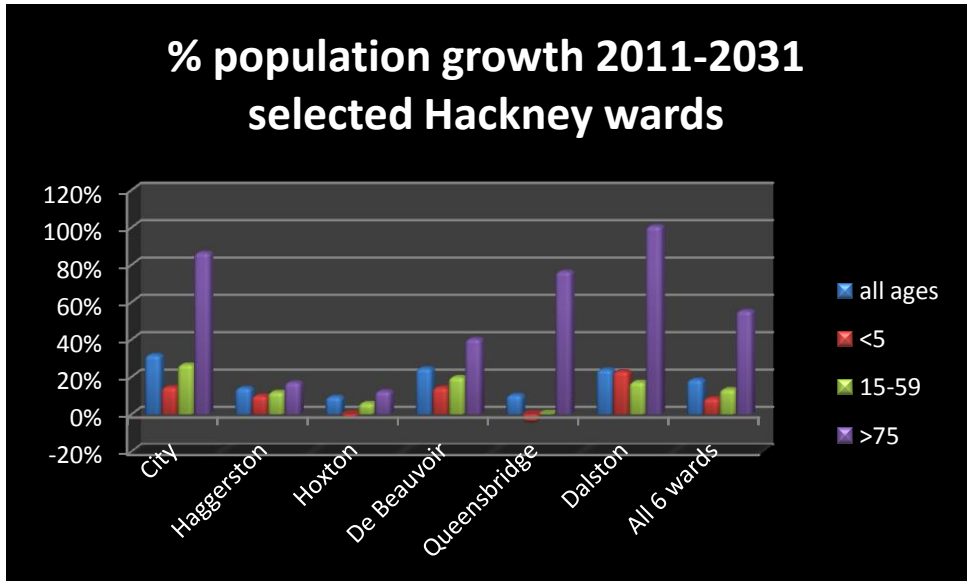
The most recent population projections from the GLA take account of the long-term prospects for housing availability in the area as defined by the 2009 Strategic Housing Land Availability Assessment for London[5]. The availability of housing is a core constraint on migration in an inner city area.

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.

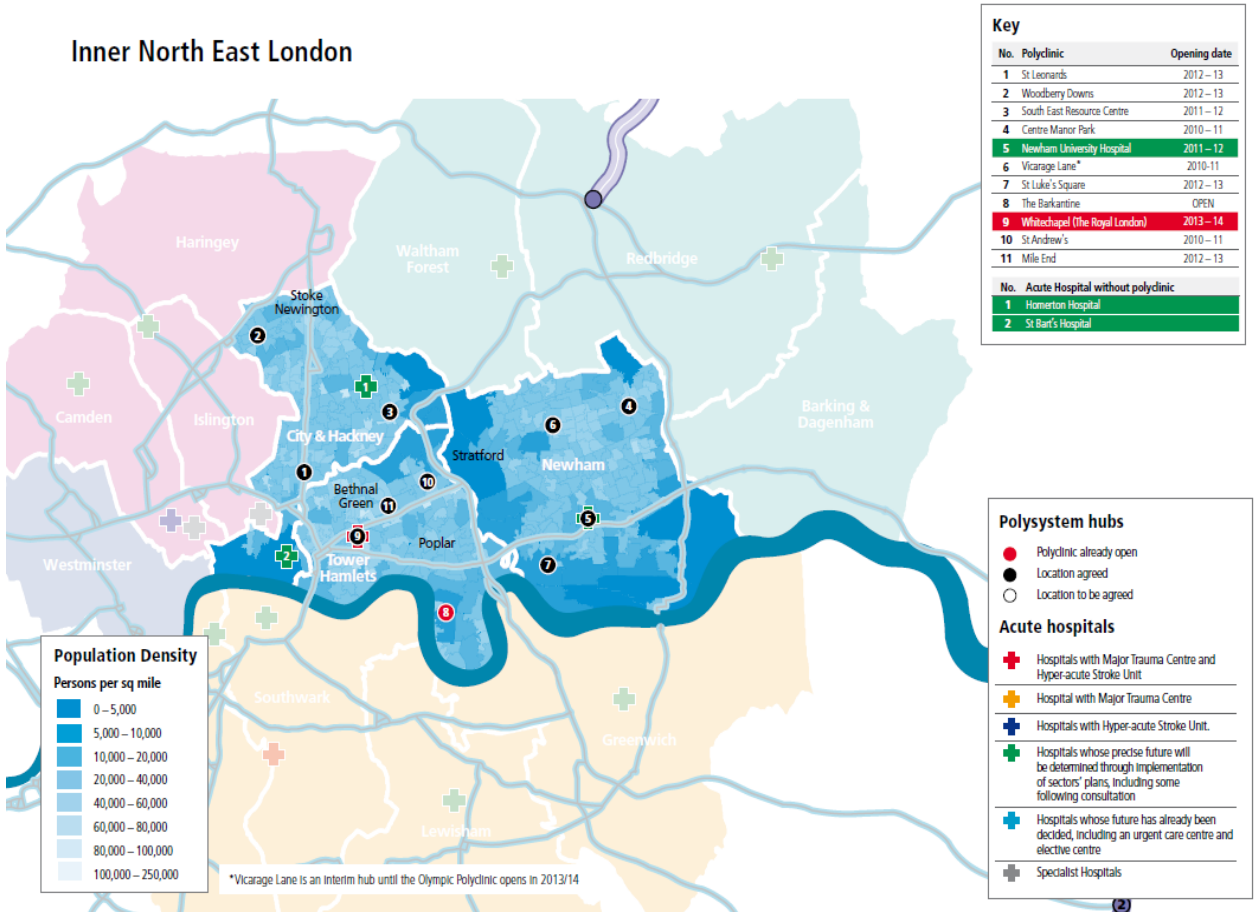
[4] Mayhew l, Harper G, Waples S: *Counting Hackney's population using administrative data – an analysis of change between 2007 and 2011*. Mayhew Harper Associates, 2011.
[5] Mayor of London: The London Strategic Housing Land Availability Assessment and Housing Capacity Study 2009, GLA 2009.

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
Haringey
Waltham Forest
Redbridge
Stoke Newington
Camden
Islington
City & Hackney
Stratford
Newham
Barking & Dagenham
Bethnal Green
Poplar
Tower Hamlets
Westminster
Southwark
Greenwich
Lewisham
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 Whitechapel (The Royal London) 2013 – 14
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
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

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.

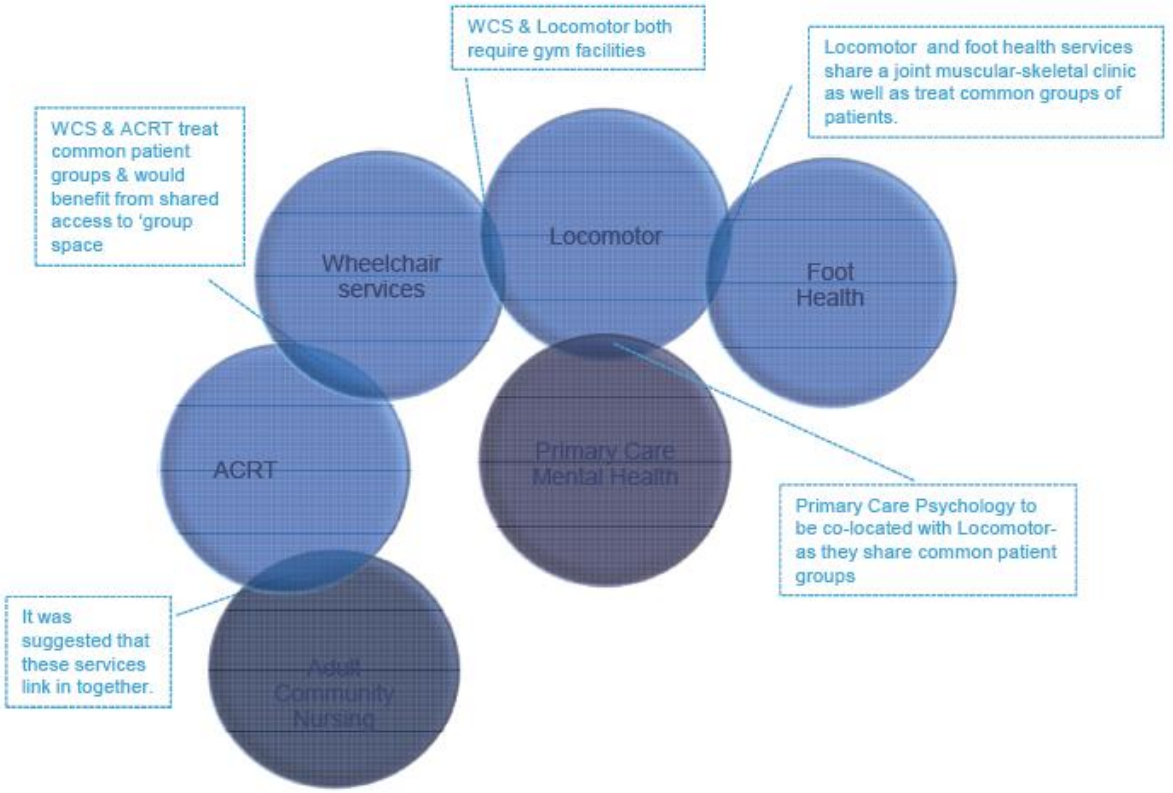
The general conclusion from the discussions was that there is a case for a number of the adult community services in particular to be accommodated in 3 centres which could be regarded as hubs. There will be further work on this concept and the potential locations with GP commissioners and the Homerton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

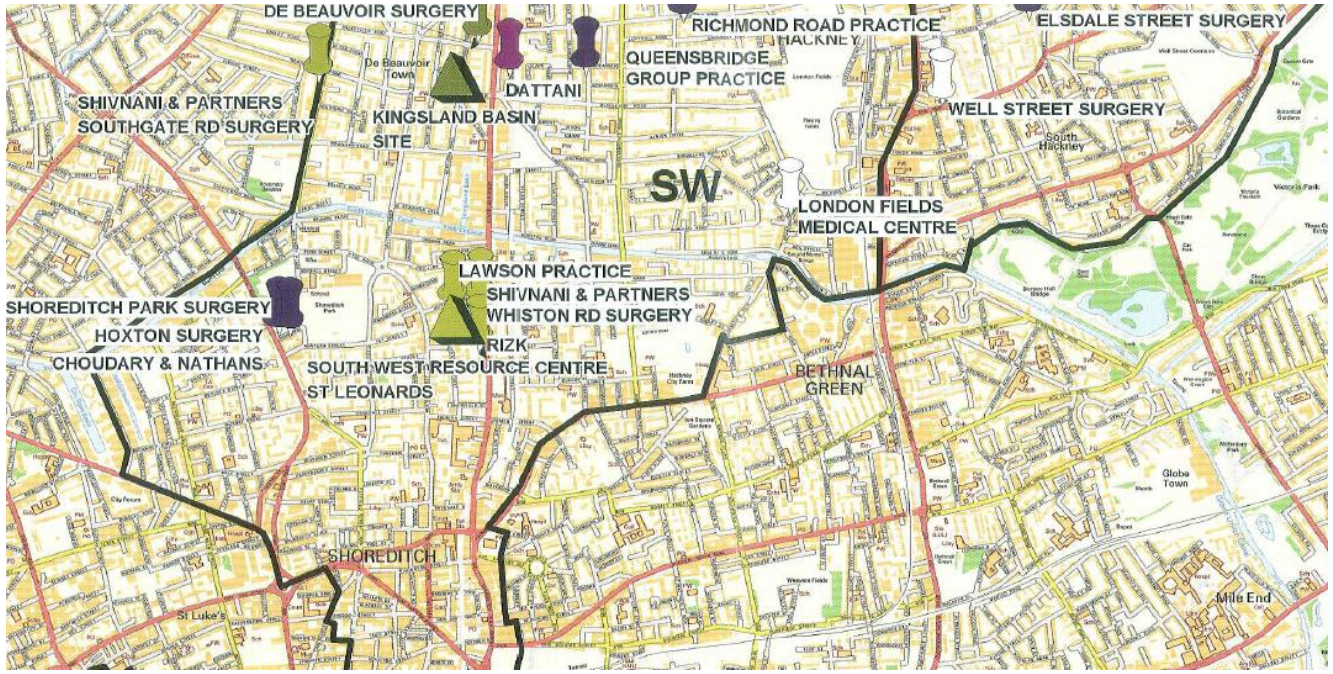


Agreement has also been reached on the level at which it is sensible to provide services. In other words which services are best delivered at Borough level or in exceptional cases supra-Borough? Which services because of critical mass need to be provided at no more than 2 or 3 centres? Finally, how are 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.

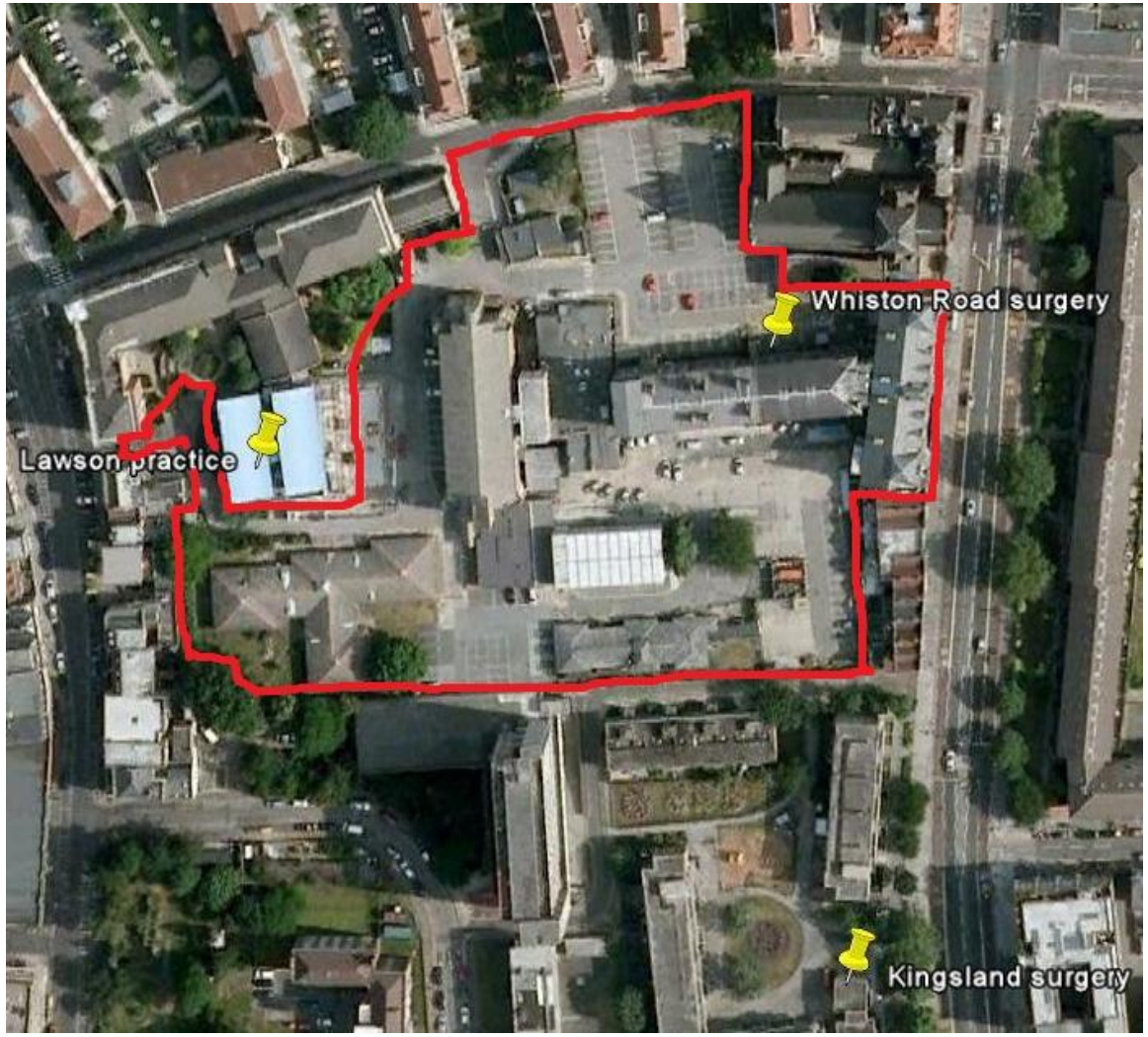
The nearby Kingsland practice is a small single handed practice which can either be co-located in the resource centre or whose patients can choose to re-register with either the Lawson or Southgate practices. The following map shows the location of current practices in the vicinity of St. Leonard's Hospital:



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:

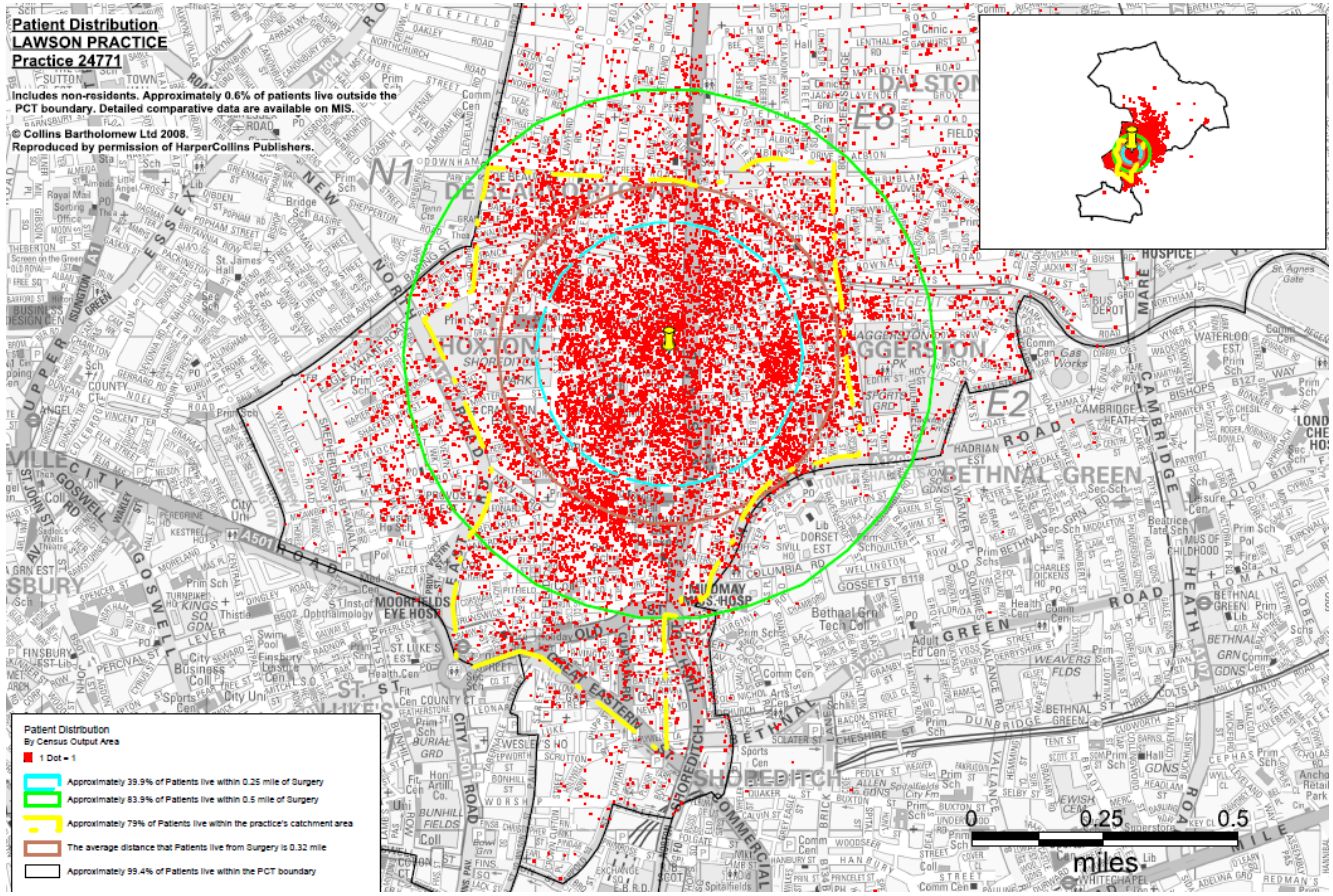


- Lawson practice: modern building, recently extended with 11,000 registered patients

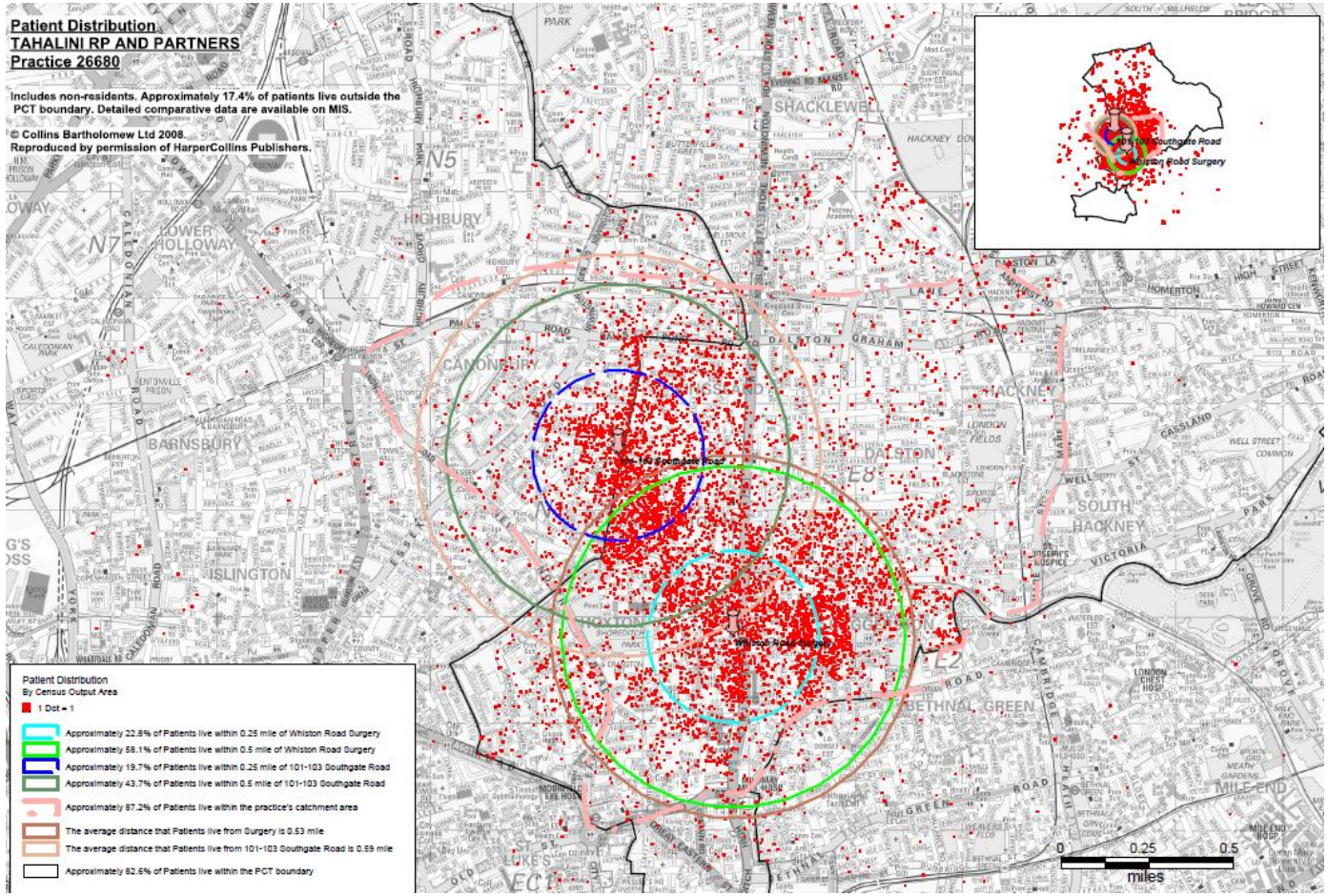
- Whiston Road in poor accommodation with 5,000 patients registered here, compared to 1,900 at its sister surgery in Southgate Road

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

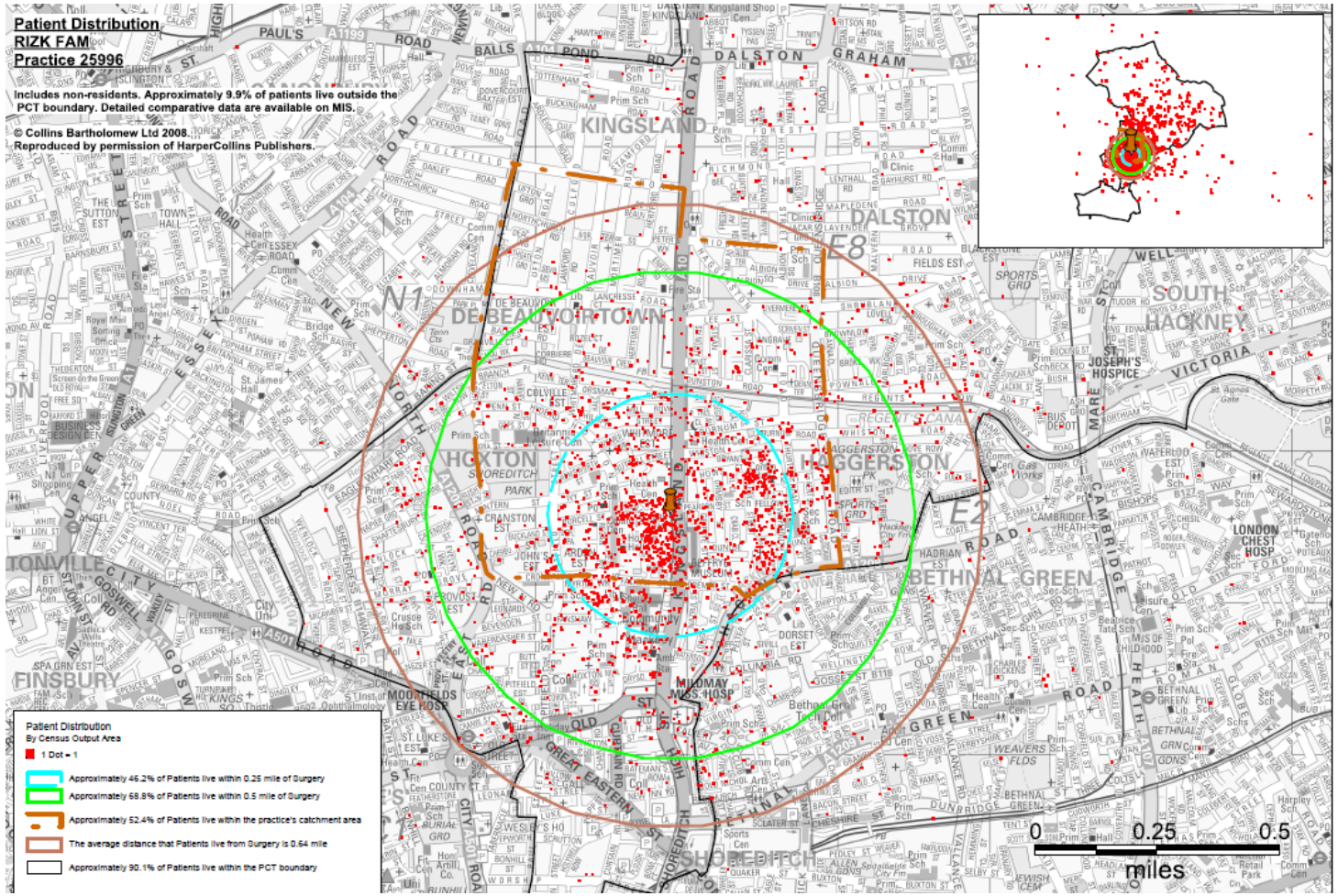
The followings maps show the distribution of patients for each surgery with a red dot representing one patient. The first shows how local the patients are in the Lawson practice with 84% of patients living within half a mile of the surgery and less than 1% living outside NELC boundary.



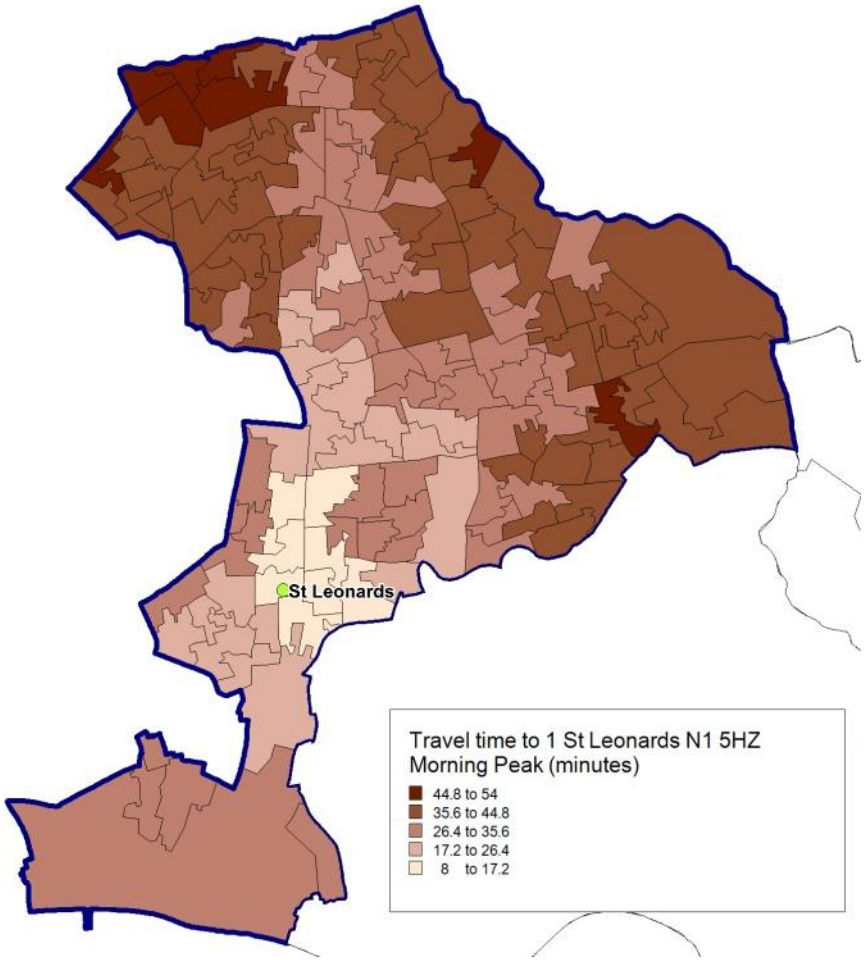
The next map shows the distribution of patients for the practice located on the two sites at Southlands Road and at Whiston on the St. Leonard's site. There is, in marked contrast to that of the Lawson practice, a far greater geographic spread of patients with only 44% of patients registered at Southlands 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.

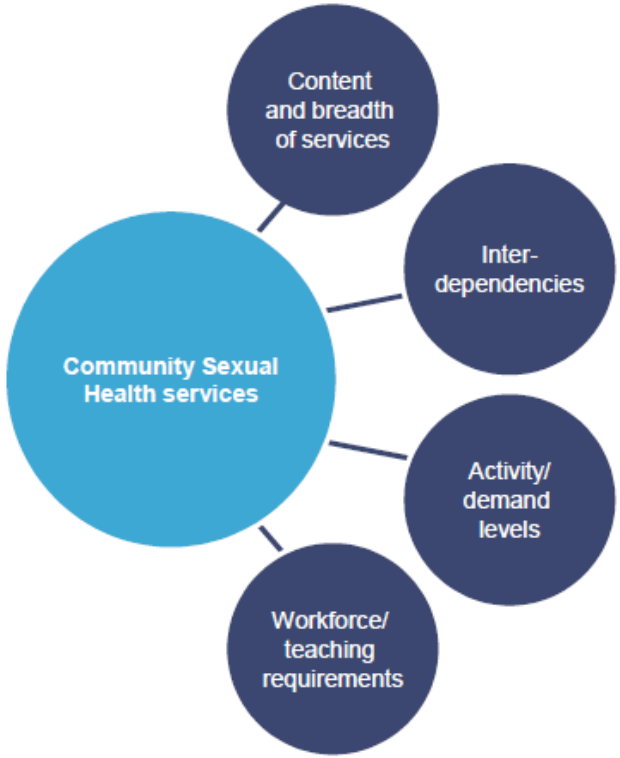
It was also agreed that practice activity should continue for people happy to access the service in this way.

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:

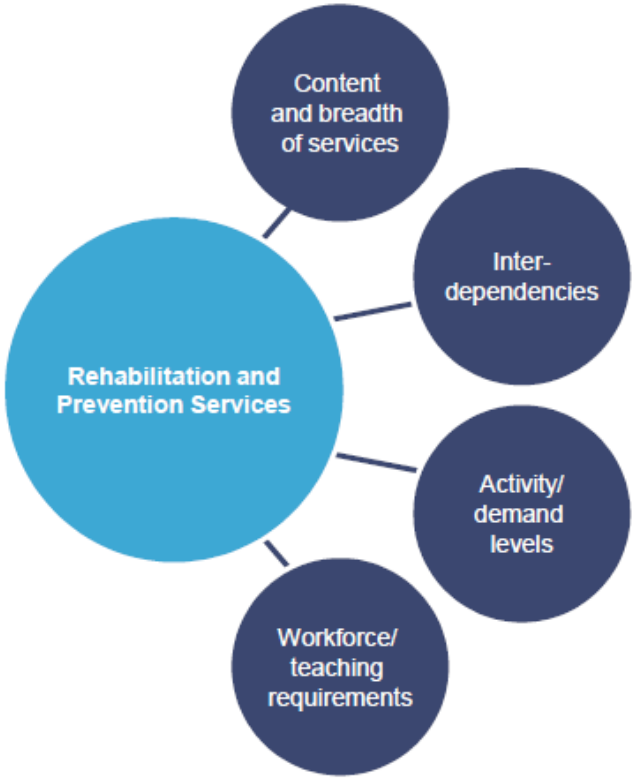
- Case for co-locating locomotor and foot health - currently share a joint muscular-skeletal clinic and treat common patient groups
- Benefits of co-location include easier and more efficient to manage service such staff supervision and resource planning, reduced travel time between sites and staff development 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

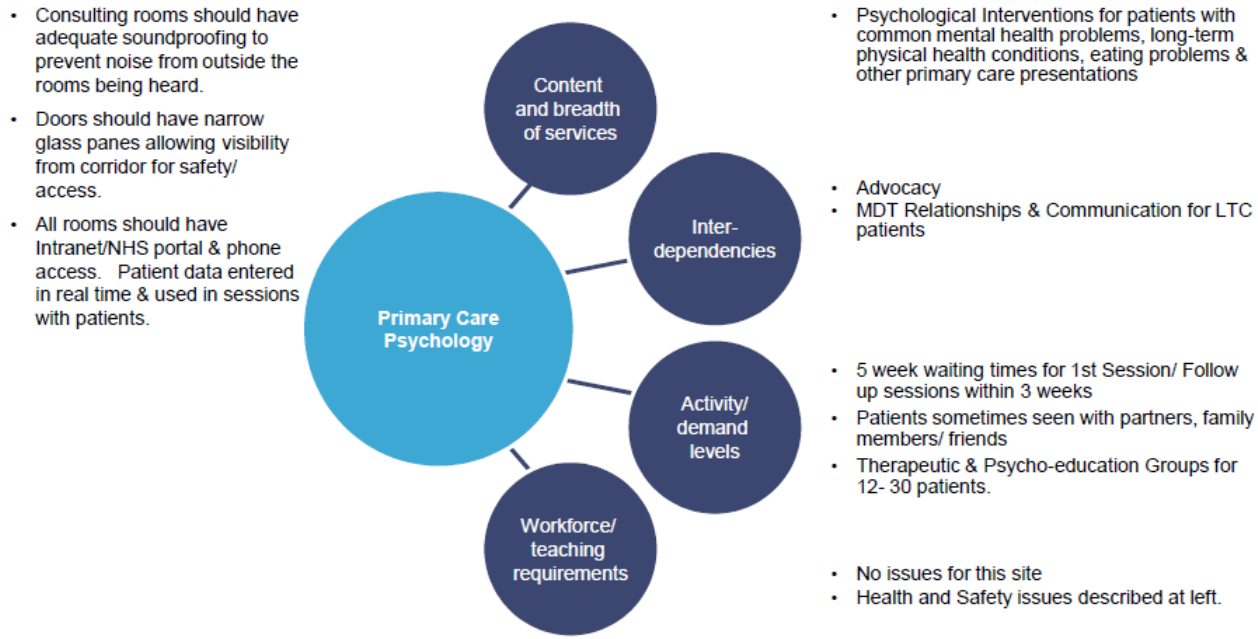
- All services take students; group and 121 and rooms in close proximity
- Space for 121s and supervision - discharge
- Access to PCs for data entry etc

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

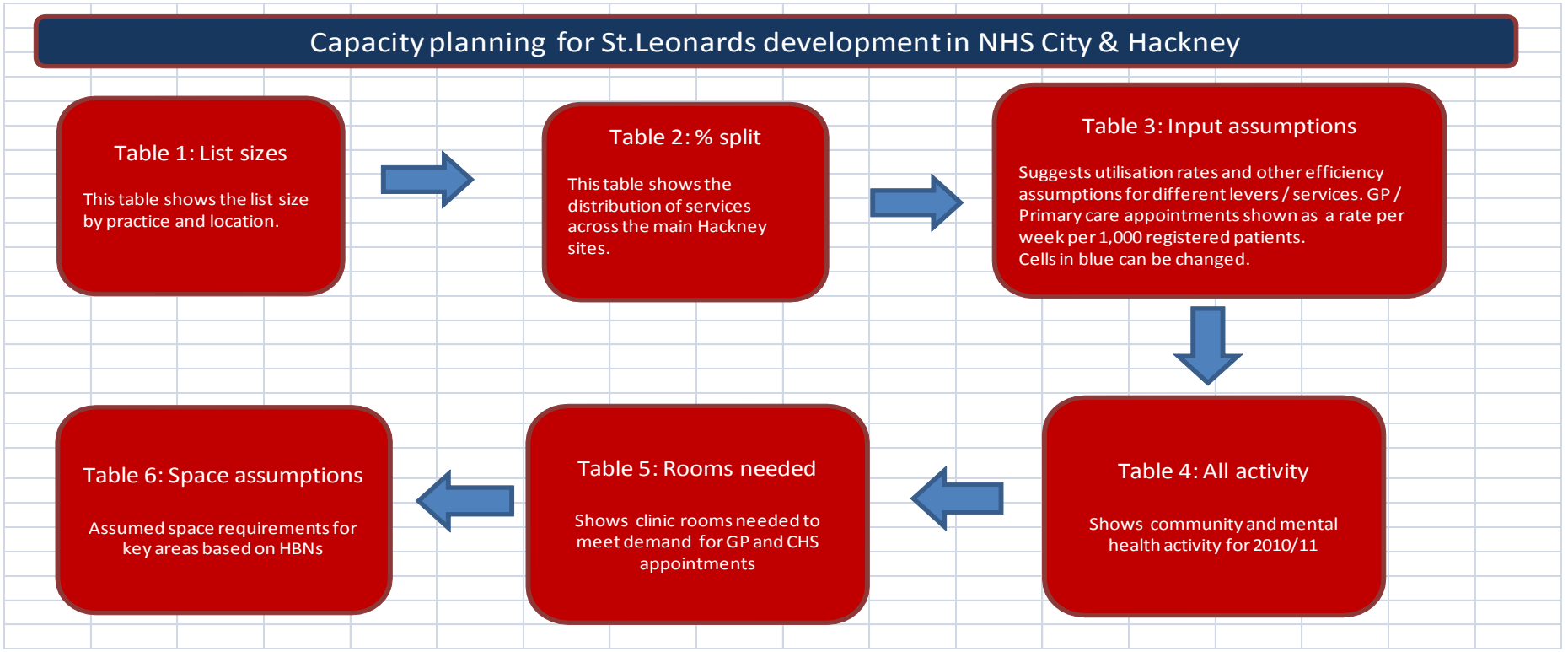
Breast cancer screening services in City and Hackney are currently provided by the Central and East London Breast Screening Service (CELBSS) in the form of two mobile units. These units have a limited lifespan of approximately seven years, which will soon come to an end in December 2011.

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 aupported 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

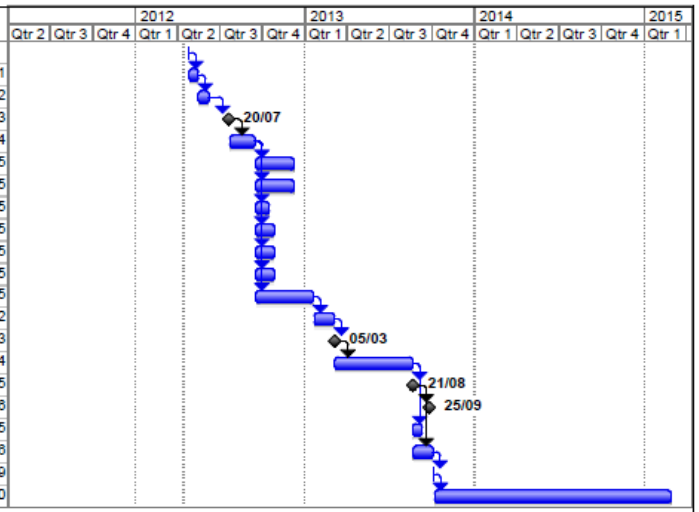
NELC has already identified clear responsibility for taking the project forward by designating David Butcher as the Project Director. There will need to be a project manager and a Senior Responsible Owner who should be a Trust Board director.

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



Project: St.Leonards timeline rev2
Date: Thu 12/04/12

Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline

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 m²	Quantity	Total area m²		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 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**	Authorised for issue	
Position			Project Director
Address			
		Date	
Telephone			

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					
Choose 1 category		**X**			
Length of Build	< 2 years		0.50%	0	
	2 to 4 years	x	2.00%		2.00%
	Over 4 years		5.00%	0	
Choose 1 category					
Number of phases	1 or 2 Phases		0.50%	0	
	3 or 4 Phases	x	2.00%		2.00%
	More than 4 Phases		5.00%	0	
Choose 1 Category					
Number of sites involved (i.e. before and after change)	Single site*	x	2.00%		2.00%
	2 Site		2.00%	0	
	More than 2 site		5.00%	0	
* Single site means new build is on same site as existing facilities					
Location					
Choose 1 Category					
Newsite - Green field	New build		3%	0	
Newsite - Brown Field	New Build		8%	0	
Existing site	New Build	x	5%		5.00%
	or				
Existing site	Less than 15% refurb		6%	0	
Existing site	15% - 50% refurb		10%	0	
Existing site	Over 50% refurb		16%	0	
					11.00%

Scope of scheme					
Choose 1 category		**X**			
Facilities Management	Hard FM only or no FM		0.00%	0	
	Hard and soft FM	x	2.00%		2.00%
Choose 1 category					
Equipment	Group 1 & 2 only		0.50%	0	
	major Medical equipment		1.50%	0	
	All equipment included	x	5.00%		5.00%
Choose 1 category					
IT	No IT implications		0.00%	0	
	Infrastructure	x	1.50%		1.50%
	Infrastructure & systems		5.00%	0	
Choose more than 1 category if applicable					
External Stakeholders	1 or 2 local NHS organisations	x	1.00%		1.00%
	3 or more NHS organisations		4.00%	0	
	Universities/Private/Voluntary sector/Local government		8.00%	0	
Service changes - relates to service delivery e.g NSF's					
Choose 1 category					
Stable environment, i.e. no change to service			5%	0	
Identified changes not quantified		x	10%		10.00%
Longer time frame service changes			20%	0	

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.