White City Health and Care Centre
Full Business Case
Hammersmith and Fulham Primary Care Trust

Revised 4 November 2010
1 Executive summary

1.1 Basis of the approval required

This business case is seeking approval from NHS London for the construction of a Health and Social Care Centre at White City under an Internal Repairing and Insuring Lease by Building Better Health Ltd on behalf of NHS Hammersmith and Fulham. This approval is subject to:

- confirmation of the £9m contribution to the capital costs of the scheme through a competitive procurement process
- confirmation that the legal agreements necessary for the development have been reached
- confirmation that the final design of the building meets the PCT’s requirements

The PCT intends to submit these final pieces of evidence to NHS London in Feb 2011.

1.2 Summary of the Business Case

The White City Health and Social Care Centre is planned for the area of Hammersmith and Fulham with the greatest health need and currently the poorest access to quality health services. Section 2.4.2 below sets out the health challenges faced by the residents of White City including a high level of childhood obesity and poor control of long term conditions. Despite having high levels of health need, the north of the Borough is poorly served by primary health services. This means that care is often provided through hospitals on an emergency basis. Primary care services which are available in the north of the Borough are fragmented and delivered from poor premises – the White City Health and Care Centre would replace a number of below-standard GP premises.

Providing the care in this way rather than through pro-active high quality primary care is expensive, and leads to worse health outcomes and ultimately lower life expectancy.

NHS Hammersmith and Fulham has developed an integrated model of service for its residents which has been praised as fulfilling the strategic requirements of the NHS. However, there is no current site in this area of the Borough capable of delivering an integrated model. The PCT is proposing a new build designed by Rogers Stirk Harbour which:

- brings together health and social care, reflecting the integrated commissioning arrangements between the Borough and the Local Authority, and making the most of increasingly scarce resources to deliver maximum impact
- includes a range of residential accommodation under the management of Notting Hill Housing Association
- responds to the physical environment of the building including the adjacent park
- provides a new landmark building in White City

The capital costs of the new centre will be funded from already realised commissioning savings and receipts from the sale of existing poor quality assets. The recurrent costs of the new building is less than the running costs of the old buildings, and in addition it is expected the new service model will release savings – the scope of these will be assessed as the new model of care is implemented.
The development supports and is supported by a programme of transformation of primary and community care. This has already delivered major pathway redesign in unscheduled care, musculo-skeletal conditions (MSK), Respiratory and Diabetes. The current focus of the programme is on integrated support to keep people out of hospital and is considering the Integrated Care Pilot with Imperial College Hospital NHS Trust as a delivery vehicle for improved services for the frail elderly and people living with diabetes.

Primary care improvements in the area are ongoing with new GP and dental services utilising a temporary base at the Canberra Health Centre in the White City area. The intention is that these services move to the new build once complete. The planning permission for the temporary Centre has been given for a maximum of five years, meaning this cannot be a long-term solution.

The programme is led by our fledgling GP commissioning consortia which are fully supportive both of the transformation programme and the Business Case.

The proposed contractual route for the White City Health and Social Care Centre is an Internal Repairing and Insuring (IRI) Lease, provided by the PCT’s LIFT partner Building Better Health. The lease is funded through a £9m plus VAT payment on completion of the building and a small annual rental. Construction of the shell and core of the building is currently being procured by Fundco. Fit-out and maintenance services will be provided by Fundco through the LIFT partnering agreement.

Bevan Brittan has provided advice on the procurement route, and considers that the risk of challenge to the shell and core construction contract is low. This risk, plus other implications of the procurement route, has been incorporated into an economic analysis shown at section 3.7.3. This shows that the IRI lease route is clearly better value for money than the LIFT contracting approach.

Financial and legal close is expected by 28 February 2011, with the building completed by the end of March 2013.
2 The Strategic Case

2.1 Introduction

This Full Business Case (FBC) is for the provision of a Health and Care Centre at White City.

The FBC has been prepared using the agreed standards and format for business cases, as set out in HM Treasury’s Green Book: Appraisal and Evaluation for Central Government, and is based on the Office of Government Commerce’s Five Case Model, which comprises the following key components:

- the strategic case section: sets out the case for change, together with the supporting investment objectives for the scheme
- the economic case section: demonstrates that the PCT has selected the most economically advantageous offer, which best meets the existing and future needs of the service and optimises value for money (VFM)
- the commercial case section: sets out the content of the proposed deal
- the financial case section: confirms funding arrangements, affordability and the effect on the balance sheet of the PCT
- the management case section: details the plans for the successful delivery of the scheme to cost, time and quality

This section describes how the scheme fits within the existing business strategies of NHS Hammersmith and Fulham and makes the case for change, in terms of the existing and future operational needs.

The process by which the PCT has progressed the White City development since its approval as a Stage 1 LIFT case, and the reason for changing the procurement route to an IRI lease, are set out in the Economic Case in Section 3 below.

2.2 Organisational overview

Hammersmith and Fulham is a relatively small, but densely populated, inner London Borough with a population of 191,879 in 2010/11. The residents are young with 45% in their 20s and 30s, are highly mobile and live in small households with 40% being single person households. 10% are lone parents; of the children 37% live in low income homes. Ethnically only 22% of the residents are from non white backgrounds and the borough displays extremes of wealth lacking the traditional middle income residents. There are pockets of deprivation across the patch with the North (White City area) generally more deprived.

The health of residents in the borough is generally improving with increased life expectancy in line with national rates. However there is a marked and increasing gap between the best and worst off areas with a twenty minute bus ride north taking nearly eight years off male life expectancy.

The PCTs residents demonstrate higher than national rates of childhood obesity, child tooth decay, alcohol and drug misuse, mental health problems, HIV, TB, excess winter deaths, emergency admissions for older people and the highest nursing home admission rate in London. Local uptake of screening and prevention services is improving but still below national averages. Deprivation is one of the strongest factors in determining ill health with deprived families in public housing a priority.

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1 From Department of Health figures, March 2010
Residents in the north experience a wide variation in quality and accessibility to primary care and higher levels of heart disease, respiratory disease, teenage pregnancy, diabetes and depression than the rest of the PCT.

The PCT has shown progress towards improving health and improving access, notably with its early polyclinic success. It has polyclinics with unscheduled care centres and new GP surgeries at both Charing Cross (in the South) and Hammersmith Hospital (in the north). The Hammersmith site has allowed more than 70% of A&E attenders to be seen in the Primary Care facility, which is quicker and leads to better patient satisfaction and reduced hospital admissions. The GP surgery has been slow to register new patients however2. Moving the care to the heart of the social housing area in the North, at Canberra Primary School, has shown accelerated registrations - 15% greater3 with 12% being previously unregistered people.

2.3 The PCT’s strategy

The diagram below summarises the PCT’s strategic plan.

The four strategic goals have been shaped by several years of engagement with local residents, clinicians and other partners. They reflect national priorities such as patient choice, timely access to care, a shift to provide care in more convenient settings and a greater focus on supporting people to live healthy lives. The goals also address specific local needs identified in the PCT’s Joint Strategic Needs Assessment.

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2 1,400 over north and south sites in a full year; average of 117 monthly with a footfall of over 1,200 patients each week
3 averaging 134 monthly with no footfall for other reasons
A main focus of the PCT’s plan is the creation of polysystems. In 2009, it opened London’s first Accident & Emergency (A&E) based polyclinics. The polyclinics have shown that primary care doctors and nurses can more effectively help almost 70% of the people who walk into A&E departments.

In July 2010 the Department of Health published the White Paper Equity and Excellence: Liberating the NHS. This document is built around a number of key themes:

• putting patients and public first
• improving healthcare outcomes
• autonomy, accountability and democratic legitimacy
• cutting bureaucracy and improving efficiency

The PCT has reviewed its polysystem policy against the requirements of the White Paper and the following table shows how it will help to implement Equity and Excellence.

Table 1: Polysystem contribution to implementing the White Paper

<table>
<thead>
<tr>
<th>White Paper theme</th>
<th>Effect of polysystem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Putting patients and public first</td>
<td><strong>Redesign of clinical services</strong> - clinicians across secondary, primary and community care together with partners from social care will design the optimal pathways to support their patients; services will be based around the needs of the patient, providing the support or treatment they need from the most appropriate locations</td>
</tr>
<tr>
<td></td>
<td><strong>Increase in capacity and capability in primary and community care</strong> to extend the services available outside hospital - more doctors, nurses and therapists will be employed across primary and community services meaning an extended range of care available to patients without having to be referred to hospital</td>
</tr>
<tr>
<td>Improving healthcare outcomes</td>
<td><strong>Improvement of prevention and early detection for those most at risk</strong> - more resources will be put into preventing ill-health; keeping people disease free and supporting those with long-term conditions to keep symptoms under control and for those most at risk, services will be responsive to individual needs and prevent conditions reaching crisis point</td>
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<tr>
<td></td>
<td><strong>Creation of integrated teams</strong> offering patients a simple holistic service - integration will occur between secondary and community health services and across health and social care boundaries</td>
</tr>
<tr>
<td>Autonomy, accountability and democratic legitimacy</td>
<td><strong>Supports GPs as commissioners</strong> enabling commissioning decisions to be taken as close to the patient as possible. Provides the opportunity for GP commissioners to create the services their patients require to keep out of hospital/stay healthy</td>
</tr>
<tr>
<td>White Paper theme</td>
<td>Effect of polysystem</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cutting bureaucracy and improving efficiency</td>
<td>• Greater efficiency and better use of resources - more efficiently designed services will reduce the administrative burden on clinicians, allowing them to spend more time with patients, reducing the duplication that currently exists across primary and secondary care will release resources to be reinvested elsewhere and developing modern energy efficient buildings supporting larger clinical teams will also allow the sharing of management and back office functions</td>
</tr>
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The table below describes how the White City development fits with the Secretary of State’s four tests:

Table 2: Effect of the White City polysystem on the Secretary of State’s four tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Effect of polysystem</th>
</tr>
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</table>
| Patient, public and local authority engagement  | • Section 6.3 of this business case sets out the process of public and patient engagement that the PCT has carried out over several years - the service model to be implemented at White City has been developed in consultation with the public  
  • The White City health and social care centre has been developed jointly by the PCT and the Borough and will house integrated care teams |
| GP support                                      | • The shadow GP commissioning groups in Hammersmith and Fulham have given their support to the creation of polysystems in the Borough |
| Clinical outcomes                               | • The integrated holistic service to be provided at White City will improve clinical outcomes as described in Section 2.7 below |
| Patient choice                                  | • The White City health and social care centre will provide additional services as set out in section 2.7 below  
  • Local residents have expressed a strong wish to be able to access health care in the White City locality |

2.3.1 The PCT as a Commissioner

The PCT created a joint executive management team across the Primary Care Trust and local Council in April 2009, and has integrated all children’s and adults health and social care commissioning in order to build effective polysystems and maximise the productivity gains in community health and care services. With new PCT cluster arrangements coming into place all three PCTs in the Inner North West London are committed to increasingly aligned commissioning with LA partners with the experience of NHS Hammersmith and Fulham providing a model to build upon.
2.3.2 Provider Services

There are 30 general practices in the borough, ranging in size from single-handed doctors to teams of 20+. One practice is based in our two current polyclinic sites, one in the interim site in White City. The quality and range of services varies considerably across practices and the current geographical spread means our more deprived areas in the North are under-served.

There are 26 dental practices with NHS contracts and 40 community pharmacies in the borough.

Imperial College Healthcare NHS Trust delivers services from two sites within the PCT; Charing Cross and Hammersmith, and from St Mary’s Hospital, just outside. Chelsea and Westminster Healthcare NHS Foundation Trust delivers about 30% of the PCT’s acute activity just outside the borough.

Central London Community Healthcare (an alliance of the community services of three primary care trusts) is the main provider of community nursing and therapy services. The majority of mental health services are provided by West London Mental Health NHS Trust.

A relatively small number of health services are commissioned from private providers, including Clinicenta (day case and out-of-hospital services) and InHealth (community diagnostics).

2.4 NHS Hammersmith and Fulham's Estate Strategy

The PCT’s estates strategy envisions two delivery hubs, supported by a number of larger health centres. These in turn will work with the remaining GP practices. The Southern hub is at Charing Cross Hospital and opened as a community services site, with GP surgery and Urgent Care Centre in a phased way from 2009. It is now fully open.

In the North the PCT has positioned the Urgent Care Centre at Hammersmith Hospital in the short term to address the unscheduled care need. There is no further space to expand at the Hammersmith site and the hospital is not as well serviced with transport options as the White City area. The greatest need and most significant health inequalities are in the North of the borough, around White City. The residents here have demonstrated a greater enthusiasm to access service on the White City estate as demonstrated by the GP registration pattern at the two new surgeries (one at Hammersmith Hospital and one in the White City Estate) and the extensive public consultation.

2.4.1 Background

The ability to make savings by moving health services closer to home depends completely on the success of transforming current delivery models for general practice, community services and social care. The capacity and role of general practice is central to this transformation. GPs will be the key decision makers in purchasing care and what they decide to purchase will be driven by what they are able to provide and deliver themselves.

There is much evidence to show that the current provision of general practice in White City and the surrounding area does not meet the high level of health need for this population and the existing composition is a long way from delivering the enhanced
proactive model of care needed to reverse rising secondary care costs by delivering care closer to home. This a population where over 50% of residents live in public housing with only 20% home ownership. In general this is a much younger population than across the rest of the borough with 30% of Hammersmith and Fulham children and teenagers growing up in its most deprived ward. Similarly there is a higher proportion of young families in this part of the borough and significantly there are twice as many lone parents with dependent children than for the rest of the borough. White City and Wormholt also have the highest proportion of black/black British residents and the highest proportion of Muslims.

Significant preparatory work has been carried out in partnership with the local population to understand their views on existing services and barriers to access and to establish the changes required to deliver health and social care services which will support improved access and result in better outcomes for the population both in the short and longer term.

2.4.2 Interim solutions

NHS Hammersmith and Fulham has developed a number of interim solutions to address issues of capacity, quality and access to primary care in the far north of the borough. The key developments have been:

- Hammersmith Centre for Health: the first hospital based polyclinic offering access to unscheduled care primary care 14 hours a day as well as the opportunity to register as a patient within the same facility
- Canberra Centre for Health: a PCTMS practice set up to address under-doctoring and offering the full range of general practice as well as access to a range of additional services geared to the particular needs of the local population

Both these services have been successful at meeting their specified objectives and have generated high levels of patient satisfaction but the future of both is limited by lack of space for further development, location and for Canberra by the temporary nature of the accommodation. Hammersmith Centre for Health has struggled to reach registration targets largely because the service is located north of the Westway (A40) which acts as a physical and psychological barrier for those living to the South of the dual carriageway. Canberra has registered an average of 100 patients a month since opening in January 2010 around 12% of whom were currently unregistered but the most significant proportion of new registrations are from patients currently registered elsewhere in the local area who are attracted by improved access and a patient focused healthcare team

There are a number of issues which have been highlighted as part of the early evaluation of service delivery at Canberra. These include;

- 40% of children registering at the practice being classified as obese
- high levels of poorly controlled childhood asthma particularly among the Somali population
- high levels of unmet health need among the homeless population who are now being registered at the practice and offered continuity of care often for the first time.
- poor access to primary mental health services
- reliance on unscheduled care provision for standard paediatric care

These and other emerging issues are being addressed by the Canberra team and opportunities for joint working with other local practices are being developed but the opportunity to embed change across the whole health economy relies on a more radical shift which would be led by the commissioning of the White City Health and Care Centre.
2.4.3 Case for Change

There are a number of factors which act as barriers to delivering the model of healthcare required by this population. With a shift to a model of proactive high quality integrated care services available in the community, health and social care spending on emergency and unscheduled interventions is likely to continue to rise without any positive impact on the health and well-being of the population. The key barriers are:

1. **Outdated premises that fail to comply with current access requirements and act as a deterrent to service improvement**

Six out of nine local practices are operating from premises which fall below minimum standards. Three meet minimum standards but do not have the capacity to meet full NHS requirements for primary care premises. Finding separate premises solutions for all these practices is challenging in Hammersmith and Fulham which is one of the most densely populated areas of the country. Separate premises solutions would also act to maintain isolated delivery of general practice rather than a federated or integrated model of care which would be supported by bringing a number of existing practices together within the proposed Centre.

2. **Wide variation in general practice quality**

The traditional model of general practice has not served high need communities such as White City well. GP practices in the north of the borough are more likely to be single handed or two partner practices with a smaller than average list size. Coupled with poor premises and a high proportion of patients with multiple risk factors it is not surprising that service quality varies widely and working practices are developed along a reactive rather than proactive care model.

It is widely understood by commissioners that patients registered at even the most poorly performing practices are unlikely to move either through loyalty, apathy or simply not knowing what good quality healthcare might look like. Simply improving comparison data will not fully address this issue and a more sustainable solution is to strengthen clinical leadership and standardise delivery pathways to ensure that all patients have access to equitable care.

3. **Lack of leadership to deliver a co-ordinated strategy**

Clinical leadership in White City has been strengthened to some extent by the services being delivered at Hammersmith and Canberra Centres for Health. However, these are relatively small contracts and the traditionally competitive model for delivering general practice means that there is some suspicion about new providers.

Tendering for the White City Health and Care Centre provides the opportunity to significantly strengthen clinical leadership by letting a contract which requires delivery of whole pathways of care for children, frail elderly and patients with long term conditions. This commissioning opportunity is likely to attract strong local multi-disciplinary bids with the capacity to make the step change necessary in White City.
4. Lack of space to accommodate shifts of services from secondary to primary healthcare settings

Without new space it is impossible to commission the additional primary care capacity needed to realise secondary care savings. At the moment there is simply not the space to build the teams of GPs, Practice Nurses and Healthcare Assistants who will be required to deliver proactive and systematic care to the significant number of patients in White City who will require this approach. The current model of delivery in White City depends on a large number of patients who never or rarely access primary care services. These are the patients currently using the Paediatric Ambulatory Care Unit in large numbers, repeat attending at the Hammersmith Hospital Unscheduled Care Centre or being admitted as emergencies for long term conditions that are poorly managed.

In addition to providing space for a proactive enhanced model of general practice additional space is also required to move consultant services into community settings. This is already happening with COPD and Diabetes but without the White City development the pace of this programme is likely to be affected particularly in the north of the borough where it is most needed.

5. Limited opportunity to co-locate services to support access and integrated working

While it is accepted that multi-disciplinary working can be supported by virtual networks of service providers and mutual access to records and care plans it is also important to understand the benefits of co-located services both for patients and service providers.

2.4.4 Harnessing local and national enablers for change

There are a number of local and national drivers for change which could be harnessed quickly in White City to prevent health inequalities widening by creating an integrated health and care system responsive to the local population and delivered along evidence based pathways. White City Health and Care Centre is essential for bringing these enablers together in a strategic approach which will achieve the twin objectives of reducing escalating costs and preventing another generation of children from White City entering adulthood with significantly reduced life chances. These drivers which need to be brought together are:

1. Local service redesign projects which were originally initiated by the London polysystem programme but remain central to the key health objectives of the new government. This change programme has been supported in Hammersmith and Fulham by health and LA management mergers resulting in close working between health and social care to deliver the Out of Hospital programme set out in the CSP. Although merger plans will inevitably be affected by NW London PCT clustering arrangements it is essential not to lose the momentum of developing shared service responses. The White City project offers the opportunity to stay focused on delivering a shared set of objectives to manage costs and quality in a joined up approach.

2. The North West London Integrated Care pilot which proposes to shift resources from secondary care to primary care to support a systematic planned care approach for patients based on risk stratification. While support for this work is not universal at this stage it seems important to reach broad agreement on how to explore the opportunities it highlights and to unlock the funding currently spent on avoidable non-elective admissions which is estimated to be a minimum of £5million for our patient population. The White City tender is an opportunity to bring all
partners to the table equally to develop a mutually acceptable plan for delivering integrated care to the residents of White City. The full engagement of General Practice is central to this process as they will be future commissioners as well as key providers within any pathway of care.

The principles of the IC project are clearly relevant to White City Including:

- bringing all partners to the table for a planned approach to transformation
- committing secondary care funding to pump prime transformation
- developing funding and incentives which support rather than work against integration
- identifying a shared culture and best practice
- agreeing governance and transfer of data

3. The transfer of commissioning to GP consortia is driving forward integrated working between local GPs both in terms of developing as future commissioners of services but also exploring cluster delivery models based on populations of 40,000 to 50,000 patients. GPs and their institutions (particularly the RCGP) are increasingly promoting a model of federated general practice to provide an enhanced model of care within existing budgets. White City offers an ideal opportunity to put this into practice and develop a model which has the potential to be adopted elsewhere. This should include:

- risk stratification of patients
- multi-disciplinary team working
- prevention programmes e.g. falls prevention
- systematic long term condition management including personalised care planning
- increased access to patient education
- funding flexibility for integrated health and social care packages
- access to expert advise to support patient care
- working to locally agreed care pathways
- sharing resources across practice boundaries
- integrated access to services in terms of location and appointment systems
- mutual access to patient records
- rapid response to prevent unnecessary hospital admission
- complex case management
- management of transitional arrangements
- enhanced practice nursing models

The White City Health and Care Centre is the key enabler for these new services and tackling the health inequalities in the North of the borough. It will enable the PCT to shift services and resources from acute settings to the community, reduce the variation in quality of GP services and deliver better value for money. The PCT has worked closely with the North West London sector to deliver services in a way that supports the plans for acute hospitals. The Unscheduled Care Centre which will move to the Health and Care centre is contracted for separately to acute services. No other services are affected by the move.

The Hammersmith Hospital site cannot develop further and provide all the services needed as it is confined to the old A&E department on the site with no other space that the Trust can release. This development will move the services from the hospital to the Health and Care centre, in the heart of the residential area of greatest deprivation.
2.5 Investment objectives

As set out in section 2.3 above, the PCT’s strategic objectives are to:

- enable and support health, independence and well-being
- give people more control of their own health and healthcare
- improve patient experience by offering timely and convenient access to quality, cost-effective care
- proactively tackle health inequalities

This project addresses the third and fourth objectives in particular, and the investment objectives for this project can be stated as:

- Objective 1: improving integration between health services and health and social care services
- Objective 2: improving primary care access
- Objective 3: improving service quality
- Objective 4: improving service productivity

2.6 Existing arrangements

Within the White City catchment area there are nine GP practices operating from their own premises. Six of these practices operate from premises that are below minimum standards and three meet minimum standards but do not meet the full standards for primary care premises. With the exception of the Bush Practice all practices have between one and three partners and there are a number of partners who are approaching retirement age.

The current configuration of General Practice and the premises restrictions means that the range of care provided in the North of the Borough is restricted. Fewer of the practices in the North offer a full range of Enhanced Services and the lack of capacity translates into some difficulties in registering with GP practices and accessing Primary Care. These difficulties appear to translate into higher than expected levels of attendance at A&E (particularly for children at the Ambulatory Care Service at Hammersmith Hospital), lower levels of elective activity, poorer management of chronic disease and (ultimately) higher mortality.

2.7 Service requirements

The White City Health and Care Centre is the key enabler to our shift of services from acute settings to the community, reduction in variation of quality of GP services and to enhanced health and well-being, with better value for money, in the North of the borough. We have worked closely with the North West London (NWL) sector to deliver our services in a way that support the plans for acute hospitals in the sector and delivers the polysystems requirements across the sector. NWL Sector Polyclinic plans include:

- pre-referral and pre-operative diagnostic work ups
- children’s centres
- end of life partnerships
- 55% of outpatient appointments within the community
- integrated MH services

These are all supported by the White City proposals.
The White City Health and Care Centre has been designed by an integrated health and Local Authority team with service user and provider input to ensure it delivers the local priorities. The Unscheduled Care Centre will relocate from the Hammersmith Hospital bringing this popular service closer to the residents who access it and allowing the Hammersmith to concentrate on planned acute care services. This will remain part of the primary care service and be joined by up to 9 other GP practices, allowing up to 50,000 local residents to keep their GP and also access general and specific primary care services current small GP partnerships are not able to deliver.

The generic clinical space planned into the Health and Care Centre will allow the provision of a flexible range of services dictated by residents’ needs and new service models. For the first time the co-location with social care will mean the PCT and local authority can share staff and resources and out-of-hospital support is currently being redesigned to integrate health and social teams and professional roles. The delay, confusion and disruption that the current social and health interfaces cause are being designed out of the system. The following services are currently planned (Table 3) to be transferred/developed at the Centre. However this is the start of a system wide review as part of the polycluster work and the PCT acknowledges the service requirements are not fixed.

The following table sets out the services which will be delivered in the Health and Care Centre, how they are currently provided and the consequences if the new Health and Care Centre is not built.
## Table 3: White City Health and Care Centre services

<table>
<thead>
<tr>
<th>Service</th>
<th>Current Provision</th>
<th>Consequences if the White City H&amp;C Centre is not provided</th>
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<tbody>
<tr>
<td><strong>Integrated diabetes services:</strong> a multi professional One Stop Shop service with Nurse Consultants, Doctors, Podiatrist, Retinal Screeners, Dieticians, Psychologists and Pharmacists</td>
<td>Charing Cross Hospital hosts the Integrated Diabetes service 8am-8pm one day a week. The nurses and doctor deliver care at the temporary site in White City, but patients need to travel south to see the rest of the team.</td>
<td>No space in north for retinal screening camera or for the whole team to deliver services at the same time. Patients will need to make up to seven separate appointments for their annual health check alone.</td>
</tr>
<tr>
<td>NICE guidance supports the model and improved outcomes are KPIs in the service specification. The integrated service provides improved value for money and reduces unplanned admissions.</td>
<td></td>
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</tr>
<tr>
<td><strong>Integrated respiratory service:</strong> a multi professional One Stop Shop service with Nurse Consultants, Doctors, physiotherapists, technicians and pharmacists</td>
<td>New service in Charing Cross from August. No service in North of borough at present despite highest incidence of disease and of unplanned admission due to respiratory disease in the North. Respiratory Consultant will provide some appointments in the temporary Health Centre from Autumn.</td>
<td>Diagnostic support could not be accommodated in any existing buildings except the acute hospitals. Uni-professional service requiring multiple appointments. Service fails to meet patient and clinical expectations. Current patients have requested services in the north, where more residents have respiratory disease. GPs have contributed to the redesign and actively requested provision in White City.</td>
</tr>
<tr>
<td>Evidence supports community care of respiratory disease in avoiding hospital admission. This service is better vfm than on tariff and reduces spend on unplanned admissions.</td>
<td></td>
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<tr>
<td><strong>Breathlessness clinic:</strong> A new service at the request of GPs for patients whose symptoms are not clearly heart or lungs. These people are often seen by many services repeatedly before a diagnosis and treatment. Joint cardiac and respiratory assessment service with diagnostics to reduce consultant-to-consultant referrals, streamline assessment and accelerate required treatment avoiding unplanned admissions.</td>
<td>Sufficient space for the team and the diagnostics support can only be found in the south - in the new Charing Cross space.</td>
<td>Residents in the north miss out or face added inconvenience as service is only available in the south of the borough.</td>
</tr>
<tr>
<td>Service</td>
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| **Musculoskeletal and pain service** (started April 2010): This combines the multi professional team and introduces new assessment and pain treatment services, takes physiotherapy out of the hospital where is has been delivered | Limited appointments are offered at the temporary site with long waits.                                                                                                                                          | Insufficient clinical space to deliver the required appointments in any area.
 |                                                                                       |                                                                                      | Waits would remain very high without more space.                                                                           |
|                                                                                       |                                                                                      | Residents in pain with limited mobility would need to travel to alternative sites to receive care.                                                                 | |
|                                                                                       | Deliveres to DH guidance and is reducing referral to surgery as part of the demand management programme.                                                                                                            |                                                                                                                                 |
| **Breast screening**                                                                 | New compliant service in the South, which is not big enough for the whole PCTs requirements.                                                                                                                        | No space to locate services in the north, despite evidence that residents in the north are those not attending.  |
|                                                                                       |                                                                                      | PCT is already behind target and below trajectory with only one site at Charing Cross. Position could not be improved without better access to services in area of greatest need. |
|                                                                                       |                                                                                      | Service fails to meet patient and clinical expectations: Patients and GPs in the North have requested a local service.                                                                                       |
| **Improving access to psychological therapies (CBT)**                                 | The PCT has supported this initiative to increase practitioners and numbers of appointments, but cannot find the space to deliver the service.                                                                 | No space to provide service despite good evidence for CBT and highest incidence of mental health issues in the North. |
| **Cardiology services**                                                              | Payment by Results services at acute trusts. GPs have little input and patients have a number of exacerbations and unplanned admissions                                                                                     | Community service could not be provided without additional pace.                                                            |
|                                                                                       | Subject to a current review by the PBC Consortia to explore community provision of services.                                                                                                                        |                                                                                                                                 |

White City Health and Care Centre – Business Case - October 2010 - Revised 4 November 2010
<table>
<thead>
<tr>
<th>Service</th>
<th>Current Provision</th>
<th>Consequences if the White City H&amp;C Centre is not provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health (whole services)</td>
<td>Current service provided in separate community mental health team premises</td>
<td>Missed opportunity to collocate services within mainstream primary care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Miss out on potential opportunity costs in terms of physical well-being of people with mental health illness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to meet patient and clinician expectations as previous consultations indicate desire for integrated services in the north of the borough.</td>
</tr>
<tr>
<td>Other services as part of the efficiency programme</td>
<td>Services are provided in a number of sites by different service. The PCT and the LA are working to provide services together to avoid hand offs, replication and reduce management costs. Ultimately the PCT seeks to identify vulnerable residents and provide care to keep them healthy. Moving spend from acute and unplanned services to community panned services.</td>
<td>Co-location is a start to integration and reduction in overlap and wasted management costs. Provision from smaller, south centred sites will delay new service development and increase travel costs and wasted time.</td>
</tr>
</tbody>
</table>
The clinical space requirement at White City has been reviewed from two perspectives:

- detailed consultation with current service providers to explore space needs over the extended day in this new facility.
- working from minimum room specifications (e.g. is air change required? Does service need interview, consultation treatment room space etc) and disease prevalence in Hammersmith & Fulham, average consultation length, length of treatment/number of interventions, efficiency (% compliance) and a number of other local factors to identify the number of rooms of each type required to deliver care to the population.

These two approaches led to similar outcomes, validating the original planning, but also challenging some services to better use the space they claim to require. This challenge, redesign and adaptation to work patterns and service delivery is now underway to ensure the required services do fit in to the space being built. Hammersmith and Fulham PCT has also worked with other local PCTs to apply this modelling to their facility plans.

Appendix 1 contains a summary of the space requirements calculations.

2.8 Benefits criteria

This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs.

Satisfying the potential scope for this investment will deliver the following high level strategic and operational benefits. By investment objectives these are as follows:

Table 4: investment objectives and benefits

<table>
<thead>
<tr>
<th>Investment Objectives</th>
<th>Main benefits</th>
</tr>
</thead>
</table>
| Objective 1: Improve integration between health services and health and social care services | • Co-location will allow the Local Authority to fulfil its White Paper requirement to “promote the joining up of local NHS services, social care and health improvement”  
• Redesigned pathways and co-location of health and social services will allow the traditional barriers to be removed and patient requirements to be delivered with less hand offs and no duplication  
• Providing the clinical space for mental health services with social and other health care provision will allow commissioners to procure integrated teams and service access and approaches currently not offered by the incumbent provide  
• One stop services need to locate the health care professional team together to maximise service delivery, team working, training and make the most efficient use of patients and staff time. Real time access to diagnostics is also required.  
• Physical or learning disabled service users can have multiple health and social care needs  |

---

4 Assumes the practices: White City HC, Canberra centre for Health, Kokar, Badat and Cordelia.

Disease prevalence from CSL data pack, except: MSK - estimated by service provider bases on new service, smoking white city h&f ph =18%, but 1/4 used as uptake poor, SALT paed: all children 23%= 57500 assume 2%, SALT: from stroke, Comm. Paeds :assume 5% of kids, 1 appointment, sexual health :assume 2 % of 16-64 age group, FP:5% of pop 16-64
<table>
<thead>
<tr>
<th>Investment Objectives</th>
<th>Main benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>social needs. Navigating services and coordinating inputs is a challenge. Fully integrated teams can focus on users’ needs rather than scope and coverage of separate teams, hand offs and handovers</td>
</tr>
<tr>
<td>Objective 2: Improve primary care access</td>
<td>• Clustering GPs together allows patients to retain trusted GPs while benefiting from extended hours access from the cluster. • GPs in the cluster can offer the range of enhanced services and specialist staff that single or small group GPs could not</td>
</tr>
<tr>
<td>Objective 3: Improve service quality</td>
<td>• Primary care and outpatients will be able to make immediate referrals to these onsite services to streamline the patients’ journey and ensure the appropriate choices are offered. • Opportunity for clinician to redesign services to provide holistic clinical pathways that minimise the necessity for hospital attendance and configure services around the patient. • Integration of care between different aspects of health and social care will allow better focus on personalised care for patients which reflects individuals’ health and care needs</td>
</tr>
<tr>
<td>Objective 4: Improve service productivity</td>
<td>• Shared services will reduce the administrative burden on GPs and practice staff allowing more time to be patient-facing. • Community Services back office functions, booking, scheduling and performance management can all be enhanced by co-location and integration. • Peer review and competition will support practice efficiencies. • The centre will allow the space to move services and support the potential to redesign pathways to replace consultant outpatient attendances with other Health Care professionals and telemonitoring.</td>
</tr>
</tbody>
</table>

2.9 Main risks

Risks are valued in the economic case in Section 3 below, and the management case contains a risk management strategy and detailed risk management plan.

The main risks for the White City development are shown in the table below.

Table 5: main risks and counter measures

<table>
<thead>
<tr>
<th>Main Risk</th>
<th>Counter Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in viability for the overall scheme due to changes in market conditions</td>
<td>• BBH has obtained sign-up from a Housing Trust for the residential aspect. • An agent has been retained to pre-market the retail space.</td>
</tr>
<tr>
<td>Changes in structure and policies of NHS mean the scheme is no longer relevant</td>
<td>• Objectives of scheme have been reconciled to White Paper aims. • GP Commissioner support obtained.</td>
</tr>
<tr>
<td>Competition to appoint contractor delays start of scheme</td>
<td>Competition being run now with the aim of having the contractor in place well before financial close.</td>
</tr>
<tr>
<td>SHA does not approve this business case</td>
<td>Guidance sought during the development of the document.</td>
</tr>
</tbody>
</table>
3 The Economic Case

3.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury’s Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the FBC documents the procurement process and provides evidence to show that the PCT has selected the most economically advantageous offer, which best meets service needs and optimises value for money.

3.2 Description of the appraisal process

This project commenced as a standard Lift scheme and was the subject of a formal Stage 1 submission. That submission set out the option appraisal process that led to the proposal to develop an integrated health and social care centre as part of the redevelopment of the site fronting Blomfontein Road, a site acquired on long lease by Building Better Health from Hammersmith and Fulham Borough Council. The appraisal process and outcome is detailed in 3.3. and 3.4 below.

The site was sold to BBH by the London Borough of Hammersmith & Fulham in 2006. (Note that under the LIFT process the transfer of the site only takes place at financial close). The site was sold as a regeneration scheme under the powers set out in the Local Government Acts.

The sales agreement committed BBH to trying to achieve a planning consent for a scheme which included:

- the opening up of Wormholt Park to the residents of the White City estate
- the inclusion of a collaborative care centre
- housing
- retail
- offices for Social Services (the Borough later decided this was not needed)
- S106 contribution to works on Wormholt Park

All the above has been complied with.

The proposals were worked out with a residents’ steering group, specifically convened to work on these proposals; a small architectural competition was held, and Rogers Stirk Harbour appointed.

BBH wrote to all the shareholders in BBH (West London) the LIFT company, inviting them to participate in the scheme. Both the public sector partners, the PCTs and Community Health Partnership declined, on the grounds that there was too much property risk; but supported the private sector going forward.

This is a regeneration scheme, and there is a considerable amount of cross-subsidy in the scheme. In addition the deprived estate of White City will receive a Rogers-designed regeneration scheme.

There is no land value attributed to the Health and Care Centre; and the housing is making a financial contribution to the Centre. In addition the park is being redesigned through the S106 arrangements, and will be an integral part of the facility.
3.3 The long-listed options

The long list evaluated within the Stage 1 case was as follows:

1. Do Nothing

This option would require the PCT to redesign services within the limitations of the existing estate. Service developments have already exceeded the estate’s capacity to support them in the North of the PCT with diabetes, respiratory, cardiac, musculoskeletal, breast screening and psychological therapies not being accommodated in the North.

The option would not allow for the upgrade of GP premises or provide any of the other benefits of a larger health centre and co-location of services with Social Services.

2. White City Health and Care Centre

This option would see the opportunity to deliver the borough’s primary and community services to 75,000 residents in the area of greatest need and deprivation. The non-compliant GP premises (i.e. those not able to be upgraded to be DDA compliant) can be removed from use and all the residents will be able to access enhanced care, facilities and opening times. For the first time breast screening services would be at the centre of the worst area of uptake.

3. Redevelopment of existing White City Health Centre

The existing White City Health Centre is a purpose built health facility constructed in 1979. The site boundary does not allow for an increase to the footprint of the building but there may be potential to increase the number of floors over which the accommodation is offered. The demolition of the existing building and provision of a new, larger facility is a possibility.

It would also be possible to sell the existing building and use the proceeds to subsidise an alternative development. However, the value of the capital receipt would be expected to be lower under this option than if the land could be sold for residential development. The resulting scheme would therefore be more expensive per square metre than using the new site.

In addition, to deliver this option temporary accommodation for existing services would need to be found. There is no spare capacity in the PCT’s estate, so all GP and PCT services would be relocated out of the area for the build period. The new space would not be large enough to accommodate social or voluntary services and the benefits of integrated working could not be realised. The site is inside the estate and has proved very difficult to access. Non-residents choose not to have appointments at this site.

4. Extension to existing White City Health Centre

It is possible to create an additional 1,500 m² of accommodation by extending the existing Health Centre upwards. Extending rather than replacing would require less service decant, but some services would still be removed during the build and social and voluntary care could not be accommodated within the resulting building.
5. Investment in Existing GP premises

None of the other existing local GP premises are capable of being improved from an estates perspective as they are chiefly converted residential buildings. There is an ageing GP population in the North of the Borough and a predominance of single handed and two partner practices. Primary care provision in this way does not allow patients the range of services and access they require or the PCT wished to commission.

6. Development of Hammersmith Hospital Site as a health and care centre

The PCT has done this successfully at Charing Cross Hospital and proposes to continue to lease space there to meet its service development needs. The Hammersmith site could be developed in a similar way. However, Imperial College Hospitals cannot release any space on this site. It is less well connected by public transport and less well positioned in the borough to compliment surrounding PCT Polyclinic developments. It has also demonstrated less appeal to residents than the White City based Canberra Centre for Health.

3.4 Preferred Option

The table below summarises the impact each of the six options would have on the four objectives of the development.

<table>
<thead>
<tr>
<th>Option</th>
<th>Objective 1 Integration</th>
<th>Objective 2 Access</th>
<th>Objective 3 Quality</th>
<th>Objective 4 Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Do nothing</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>2: New site at White City with integrated care centre</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>3: Redevelop existing site</td>
<td>None</td>
<td>None</td>
<td>Some improvement</td>
<td>None</td>
</tr>
<tr>
<td>4: Extend existing site</td>
<td>None</td>
<td>None</td>
<td>Some improvement</td>
<td>Some improvement</td>
</tr>
<tr>
<td>5: Upgrade substandard GP premises</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>6: Care centre at Hammersmith Hospitals</td>
<td>Some improvement</td>
<td>Worse than currently</td>
<td>Some improvement</td>
<td>Good</td>
</tr>
</tbody>
</table>

The White City Health and Care Centre best meets the objectives of the investment and was therefore chosen at Stage 1 as the preferred option.

3.5 Description of the preferred option

The White City Health and Care Centre is proposed to deliver:

- enhanced Primary Care to 50,000 patients
- unscheduled care to the North of the borough
- diagnostics to include X-ray, ultrasound, ECHO, respiratory, cardiac and diabetic labs
- child friendly, community, specialist and general NHS dentistry
- enhanced community pharmacy
- generic clinical space to provide the full range of redesigned clinical pathways and outpatient services to the 75,000 residents in the North
- mental health and psychological therapies
• learning disability and physical disability services
• working villages to new integrated health and social teams
• children’s space
• third sector shared and dedicated space
• employment and training space to third sector users in the community café
• breast screening services
• theatre and procedure space for local anaesthetic minor procedures

The site is located towards the northern edge of the London Borough of Hammersmith and Fulham, in the Wormholt and White City ward. The site is bounded to the east by the Bloemfontein Road which is a busy road connecting Uxbridge Road to the south with the A40(M) to the north.

To the west of the site is Wormholt Park, one of the few public open green spaces in the area. The area is predominantly residential with the exception of Loftus Road stadium and BBC White City which are both located within easy walking distance of the site.

Strategically located between two large but distinct residential neighbourhoods, the White City Estate and the Wormholt Estate, this redevelopment site offers the opportunity to create a new civic space, Collaborative Care Centre and retail provision which can help to link the two communities. The map below shows the Strategic Urban Context.

The Health and Care Centre is accommodated within a two storey element on the northern part of the site. It has an entrance which addresses the new space created on Bloemfontein Road, and a westerly facade that allows views in to the park. The Health and Care Centre is planned to frame views into the park.

Ground Floor

The Health and Care Centre is organised with a clear single point entrance on the new Bloemfontein Road public space, which gives immediate access to a reception point and vertical circulation. The building is then organised into a sequence of open ended fingers of cellular accommodation in between which are softer flexible toplit spaces. These double height spaces accommodate waiting areas, secondary reception points, play areas and primary circulation. The spaces are visually connected to the park by large glazed areas on the western facade allowing outward views enhanced by additional tree planting.

First Floor

Accommodation at the first floor level is organised in the same way as the ground with cellular accommodation overlooking the double height spaces accessed from generous galleries. Primary vertical circulation is organised within the conservatory type spaces. The core in the northern corner of the building will also connect to the basement for car parking and servicing access.
3.6 The procurement process

As the development progressed the PCT indicated that its financial position was such that it would be interested in purchasing the Health Centre outright as this seemed to offer a better VfM option than continuing with traditional Lift procurement. Following further discussions with all parties, including Hammersmith and Fulham Council who is to lease/sub lease 33% of the space in the centre and who is able to receive PFI Credits for this purpose, it was determined that a middle way of part capital contribution by the PCT was most appropriate. This capital contribution would pay for 25 years occupation of 66% of the space in the centre by the PCT and at the end of 25 years secure the transfer to the PCT of the long leasehold interest (249 years) in the whole of the centre held by FundCo for nil consideration. The space to be occupied by the Council was to be the subject of a LPA from FundCo for 25 years.

Although the capital payment to be made by the PCT can be shown to be better value for money than the traditional Lift route (see below in section 3.7) the resultant legal structure to facilitate this approach could no longer fit within the Lift framework. Months of discussion and development of appropriate legal structures that would not only secure the VfM benefits for the PCT but also conform with procurement guidelines have led to a final legal structure as outlined in section 4 below.

3.7 Economic appraisal

3.7.1 Introduction

This section compares the economic costs of the two procurement options. It is assumed that both options will provide the same service benefits, as set out above, and therefore this aspect is not considered further in the economic analysis.

The section also contains a costed risk analysis, calculation of optimism bias and consideration of the economic impact of the differences in tax receipts between the two options.

This section compares two options:
- the standard Lift approach
- a lease structure with the PCT contributing £9 million capital to the project (internal repairing and insuring lease – IRI)

3.7.2 Estimating costs

The estimate of costs for the development of the Centre and the provision of hard FM, lifecycle costs and building management has been provided by BBH, based on the design of the building and expected building and servicing costs per square metre. The costing of the Lift option assumes standard Lift financing with the residual value of the property being with LiftCo at the end of 25 years. The Lift option also takes account of the impact of the PCT being an investor in LiftCo – with the PCT providing an upfront equity investment and receiving a 15% IRR over the 25 years of the project.

The IRI option assumes:
- the PCT retains the value of the building at the end of 25 years
- a £9 million capital payment by the PCT at the start of the project

Both options assume that construction of the Centre will be completed by end March 2013, and have been discounted using HM Treasury’s standard inflation-free discount rate of 3.5% Appendix 2 contains the detailed economic costing of the two options.
3.7.3 Costed risk analysis

The risk profile of the IRI option is different to the LIFT option, as the PCT bears some additional risks under this option. These risks have been valued on the basis set out below.

**Construction or fit out cost overruns**
Both the LIFT option and the IRI option construction costs are capped by BBH. Once the procurement competition for the construction contractor and fit out contractor(s) has been carried out, the construction cost cap will be revised – but only in a downwards direction. There is therefore no risk to the PCT under either option, and the opportunity of a lower construction cost has not been included in the costing of the options.

**Construction or fit out time overruns**
The PCT expects that the cost of delivering services in the new health centre will be similar to the current cost of services - the new development leads to quality gains. If the construction or fit out period overruns against plan, this delays the benefits expected from the new health centre. There is no reason to believe that the risk of delays is different in the two options. This risk has therefore not been valued.

**Maintenance costs increase above plan**
This is a risk borne by the PCT in the IRI option for the interior of the PCT’s space. The following probabilities have been used to calculate the annual expected cost of this risk:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance and building management costs 5% lower than expected</td>
<td>10%</td>
</tr>
<tr>
<td>Insurance and building management costs as expected</td>
<td>60%</td>
</tr>
<tr>
<td>Insurance and building management costs 5% higher than expected</td>
<td>15%</td>
</tr>
<tr>
<td>Insurance and building management costs 10% higher than expected</td>
<td>10%</td>
</tr>
<tr>
<td>Insurance and building management costs 20% higher than expected</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Unavailability**
One advantage of the LIFT approach is that the PCT is entitled to deductions from the LPA payment if areas are unavailable for use. Availability is determined by whether the area is reasonably accessible, free from risk to any person’s health, safety or welfare and whether it can be used without undue inconvenience or discomfort for the purpose for which it was intended. While it is possible that the IRI lease could have similar provisions built into it, there is a much smaller annual charge to take availability deductions from.

In order to proxy the additional unavailability risk of the IRI option, it is assumed that unavailability will result in the PCT having to pay for alternative accommodation during the period of unavailability. The cost per square metre of alternative accommodation in this calculation is based on the LIFT LPA. The following probabilities have been used to calculate the annual expected cost of this risk:
Table 8: Unavailability risk scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>No unavailability</td>
<td>40%</td>
</tr>
<tr>
<td>0.1% of floor space unavailable throughout the contract</td>
<td>30%</td>
</tr>
<tr>
<td>1% of floor space unavailable throughout the contract</td>
<td>20%</td>
</tr>
<tr>
<td>5% of floor space unavailable throughout the contract</td>
<td>10%</td>
</tr>
</tbody>
</table>

Lifecycle costs
In the IRI option, lifecycle costs may not be as budgeted. This risk has been costed based on the lifecycle costs in the LIFT model, with the following scenarios applied:

Table 9: Lifecycle cost risk scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifecycle costs 10% lower than expected</td>
<td>10%</td>
</tr>
<tr>
<td>Lifecycle costs as expected</td>
<td>50%</td>
</tr>
<tr>
<td>Lifecycle costs 10% higher than expected</td>
<td>20%</td>
</tr>
<tr>
<td>Lifecycle costs 20% higher than expected</td>
<td>10%</td>
</tr>
<tr>
<td>Lifecycle costs 30% higher than expected</td>
<td>5%</td>
</tr>
</tbody>
</table>

The risk cost has been applied to the actual lifecycle costs included in the BBH model. This ensures that the quality of the building at the end of 25 years is the same in both options.

Residual cost risk
If the PCT does not spend the budgeted lifecycle costs on the building, the quality of the accommodation transferred at year 25 will not be as high as planned. However, as a lifecycle charge equivalent to that in the LIFT model has been included in the IRI option, no value is required for this risk.

Procurement route challenge
The PCT has obtained legal advice from their advisers, Bevan Brittan, on the likelihood and impact of procurement route challenge. A confidential Appendix to this business case sets out that advice. In summary Bevan Brittan believes the probability of a successful challenge to the process is low, and a small adjustment has been made to the risk analysis to reflect this low risk.

Residual value risk
In the LIFT option, BBH bears the residual value risk as it owns the building at the end of the 25 year contract. Under the IRI option, the PCT owns the building, and the financial analysis assumes a value of £9 million at year 24. The residual value of buildings can be very volatile, it is considered equally likely that the value of the building will be above or below the assumed value. Therefore this risk has an expected value of £0. However, as the health centre is required at year 24 for nil consideration this is not a realisable risk.
Termination risk

Construction Phase

The legal documents will not involve any financial outlay by the PCT in respect of works to construct the shell. The PCT will only buy the premises at the point of grant of the lease once the works are completed. The PCT will have a remedy to terminate any agreement if the works to construct the shell are not completed by a long stop date – normally twice the build programme. Consideration has been given to granting the PCT a right to buy back the facility during the construction phase in the event of FundCo abandoning the works or failing to build out by a long stop date. This is the remedy contained in the Lease Plus Agreement. As explained above, the health facility is just a part of the larger building being constructed by FundCo and therefore in order to be practically effective it would be necessary for the PCT to buy back the whole building and land. This would be a significant financial outlay for the PCT and it is highly questionable if the PCT should become a landlord of retail and residential units (assuming no new planning permission is sought). Therefore this right is unlikely to be incorporated in the agreement.

In the event of a failure by FundCo to deliver the building, the PCT would not suffer any financial loss. However, delivery of the expected benefits would be delayed, and a new project would be required to house the services. This risk has therefore been valued by reference to the expected development cost of a new project.

Operational Phase

The PCT will be taking a 25 year tenant internal repairing lease from FundCo with no landlord break right. As with any commercial lease the PCT will need to ensure compliance with tenant covenants to ensure they do not cause a breach of the lease that could allow the landlord to exercise its common law remedy of forfeiture.

If the PCT does forfeit its lease, it will lose the part of the £9m which has not been used at that stage of the contract. The probability of this occurring is very small.

At the end of the 25 years the PCT will be able to exercise its right to buy (for a nominal sum) FundCo’s long leasehold interest (which includes the area to be occupied by the Council). Discussions between the PCT and Council will need to take place in year 25 to determine if the Council will wish to continue the occupation of the facility.
3.7.4 Optimism bias

Optimism bias has been calculated for both options using the Department of Health guidance. The results of this are contained in Appendix 3 but in summary optimism bias adds 5.27% to the cost of the LIFT option and 6.2% to the cost of the IRI option.

3.7.5 Tax adjustment

HM Treasury’s Green Book recommends that the adjustment of market prices is appropriate where it may make a material difference to the appraisal decision. In practice, it is relatively rare that adjustments for taxation to be required, because similar tax regimes usually apply to different options. It can also be difficult in practice to estimate costs net of tax. However, in this case the tax regimes applying to the two options varies substantially. HM Treasury has provided supplementary guidance on tax adjustments for PFI projects. This section applies that guidance using the assumption that LIFT is sufficiently similar to PFI to use the same model.

The table below summarises the tax adjustment model as applied to this project:

<table>
<thead>
<tr>
<th>Table 10: Tax adjustment factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
</tr>
<tr>
<td>Starting factor</td>
</tr>
<tr>
<td>Ratio of nominal cost for facilities management services to capital value of project</td>
</tr>
<tr>
<td>Percentage of value of lifecycle maintenance spent on new build and improvements</td>
</tr>
<tr>
<td>Is the project on the capital account?</td>
</tr>
<tr>
<td>Is the project sector risky?</td>
</tr>
<tr>
<td>Total adjustment</td>
</tr>
</tbody>
</table>

3.7.6 Net present cost findings

The detailed economic appraisals for each option are attached at Appendix 2.

The following tables summarise the key results of the economic appraisals for each option (before and after applying discounting).

<table>
<thead>
<tr>
<th>Table 11: key results of the economic appraisal - undiscounted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
</tr>
<tr>
<td>Capital</td>
</tr>
<tr>
<td>PCT equity contribution</td>
</tr>
<tr>
<td>Revenue costs</td>
</tr>
<tr>
<td>PCT equity return</td>
</tr>
<tr>
<td>Residual value</td>
</tr>
<tr>
<td>Risk</td>
</tr>
<tr>
<td>Optimism bias</td>
</tr>
<tr>
<td>Tax adjustment</td>
</tr>
<tr>
<td>Total cost</td>
</tr>
</tbody>
</table>
3.7.7 Option appraisal conclusion

The analysis shows that the NPV of the IRI option is lower than the LIFT option.

3.8 Sensitivity analysis

The method used was ‘switching values’. Table 12 shows the values (in %s) at which the preferred option would change in the overall ranking of options.

<table>
<thead>
<tr>
<th>Changes required</th>
<th>LIFT</th>
<th>IRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>N/A</td>
<td>44%</td>
</tr>
<tr>
<td>LPA</td>
<td>33%</td>
<td>N/A</td>
</tr>
<tr>
<td>IRI Lease</td>
<td>N/A</td>
<td>203%</td>
</tr>
<tr>
<td>Lifecycle cost</td>
<td>N/A</td>
<td>454%</td>
</tr>
<tr>
<td>Maintenance cost</td>
<td>N/A</td>
<td>418%</td>
</tr>
<tr>
<td>Residual value</td>
<td>N/A</td>
<td>-90%</td>
</tr>
<tr>
<td>Risk</td>
<td>N/A</td>
<td>2015%</td>
</tr>
<tr>
<td>Optimism bias</td>
<td>585%</td>
<td>752%</td>
</tr>
<tr>
<td>Tax adjustment</td>
<td>N/A</td>
<td>731%</td>
</tr>
<tr>
<td>NPC</td>
<td>29%</td>
<td>41%</td>
</tr>
</tbody>
</table>

The sensitivity analysis shows that it would require very large changes in the underlying costs before the LIFT option would move into the preferred option position. This is considered to be unlikely.

3.9 Option appraisal conclusion

The preferred option is for the PCT to enter into an IRI lease for an integrated health centre at White City.
4 The Commercial Case

4.1 Introduction

HM Treasury guidance “Value for Money Assessment Guidance” (November 2006) states that single tender procurement may be suitable where there is only one supplier in the market able to fulfil the requirements of the tender. Given BBH’s ownership of the site, as set out above, this requirement applies to this procurement. The guidance sets out various ways that the procurer can seek to obtain value for money within a single tender arrangement:

- requiring the bidder to undertake transparent market testing of those parts of the supply chain where competition can be generated
- where market-testing is not possible, gathering data on comparable procurements so the prices, terms and conditions can be compared and benchmarked
- ensuring that specialist technical advice relevant to the particular service is available either in-house or through appointing external advisors
- examining the case for increasing flexibility in the contract term by limiting the initial term of the contract and/or incorporating break points in the contract such that the procuring authority can re-tender the contract should new suppliers enter the market

The PCT has borne this guidance in mind when designing the contractual route for the White City Health and Social Care Centre.

4.2 Contractual structure

The legal structure proposed is shown in the diagram overleaf:
The Contractor for the project will be selected via a pre qualification process which will include the PCT and the Council. The Contractor(s) will be selected using a suitable scoring matrix and the following criteria:

Section 2 - Administrative Information 5%
Section 3 - Technical Evaluation/Experience 20%
Section 4 - Organisation & Financial Information 15%
Section 5 - Project Specific Items-
  Quality 50%
  Risk Management/Cost Certainty

BBH/Dev Co - long lease
250 years

FundCo 249 year lease of
Health & Council space
£11 million

Shell & Core Internal
Repairing & Insuring Lease to PCT for 249 years
(less 1 day) of 66% of Health centre space
£4 million (?)

LPA to Council
25 years of 33% of Health centre space
£4 million

FundCo as partnering services agent manage
Third Party Contractors
Providing Fit Out at
£5 million (?)

FM agreement following separate
tendering exercise
(but based upon LIFT approach)
Funding
Programme
Innovative Design & Proposals
Engagement With the Wider Stakeholder Community

Presentation/Format: 10%

Competitive pricing will then be sought for the project with the pricing documentation formatted so that the following can be clearly identified:

1. The construction of the overall development to shell and core
2. Individual prices for the fitting out of the various elements of the development i.e. residential, health centre, retail and offices

All parties, including the PCT and the Council, have agreed on a tender list for the whole development. The firms invited to tender are:

- Ardmore Construction
- Bennetts (Construction) Ltd
- Bouygues UK
- Durkan
- Galliford Try Partnerships Ltd
- Higgins Homes
- ISG Interior/Exterior Ltd
- McLaren Construction Ltd
- Osborne
- Skanska UK
- Vinci

These firms will submit tenders as follows:

1. For the construction of the overall development to shell & core.
2. Individual prices for the fitting out of the various elements of the development i.e. residential, health centre, retail and offices.

This will ensure that both elements of the development (main construction and fit out) have been the subject of separate competitive procurements. The PCT will split its capped £9m capital contribution between the purchase of the long leasehold interest of the health centre shell and the fit out of that shell.

BBH holds the long leasehold interest (250 years) in the whole development site from Hammersmith and Fulham Council. It will grant to FundCo a slightly lesser interest (249 years) in the shell of the centre and undertake to manage the fit out process and hand over a fitted out centre in accordance with the tender process set out above. It requires £11m minimum from FundCo for this interest and this work as part of its overall development appraisal.

FundCo will grant a 25 year LPA to the Council of 33% of the space in the centre. It will grant an internal repairing lease for 249 years less 1 day to the PCT of the centre to shell finish, subject to 33% of the space being occupied by the Council for the first 25 years. It will also undertake to manage the fit out process for the PCT in accordance with the process set out above. The total costs to FundCo are around £13m as, in addition to
the £11m purchase price for the centre, there are the financing costs, legal and financial advisers costs, and management costs in establishing and managing the LPA on the Council part of the Centre. The PCT’s capital contribution to the purchase of this legal interest and for the fitting out of the centre and for the process of LPA grant on the Council’s part of the centre will be limited to a maximum of £9m.

The PCT will have a separate contract for FM and lifecycle management for the first 25 years. This will be with the FM provider under the Council LPA as it is not workable to have two providers for one premises. The commercial terms for this contract will have been subject to market testing by FundCo in co-operation with the PCT.

In the economic case the PCT has shown that this method of procurement is better value for money than the standard LIFT LPA approach (even allowing for the incidence of VAT as mentioned below).

In the Stage 1 submission options appraisal the only alternative location for the centre if it was not to be built on its existing site was the site identified by BBH. This was determined after a site search and remains the only known site opportunity to date.

The challenge to the proposed approach by the PCT to procurement of the centre would be if an owner/developer of a suitable alternative site in the area could claim its site was readily available for development. A hypothetical alternative development would require a site acquisition and design and build process through a third party. Premises of a minimum of 2,500m² GIA would be required to compare with the PCT element of the White City scheme. With car parking provision a site of around 0.5 acres would be required and this would cost a minimum of £2m. Total build costs and fees of £3,000/m² (a comparable figure with LIFT scheme costs at other sites) would constitute a build cost of £7.5m, totalling £9.5m, to which would be added interest on funding of sale and build costs plus a developers profit for management and risk. This approach would not produce a facility at a cost lower than £9m, would require identification of and acquisition of a site, and would involve a long timeframe from now to obtain planning consent and develop out. In addition for its £9m under the proposed scheme the PCT after 25 years has a building of 3,500m² rather than 2,500m², and therefore the ability to raise income from the extra space.

The PCT has to be satisfied however that the £9m it is being asked to pay is an acceptable figure i.e. that of itself it is value for money. This assessment can be made in one of two ways:

1. **Valuation of the benefits it is receiving**

   Is the NPV of 25 years of space in the centre at low rental and the transfer of the long leasehold interest after 25 years in the whole building equivalent to £9m payment today? The economic analysis in Section 3.7 above demonstrates that this is the case.

2. **Costs involved in being part of this development approach**

   | Construction cost (including fees and fit out) | £8.2m |
   | Share of common costs: S106, covenants etc | £3.2m |
   | Interest @ 6% for 2 years | £0.78m |
   | Developers Risk, management & profit @ 20% | £1.7m |
   | | £14.0m |

   To this figure must be added part of the £2m costs incurred by FundCo in setting up and managing the IRI arrangement for the Council without which
the PCT would not be able to procure its interest. These would be shared 50/50 with the Council so increasing above cost figure to around £15m.

The developer, BBH, agreed to transfer the health centre at £11m and has cross funded the health centre at around £4m resulting from the enabling commercial and residential development.

One further approach is to look at the structure as providing the PCT at completion with a 2/3rds interest in an £11m premises (District Valuer will support a current valuation of £11m) and the other third coming to the PCT at the 25th year. The initial interest is worth £7.33m and the extra interest NPV over 25 years (using the conservative £11m today’s valuation) of £0.89m gives a figure of £8.22m. This is close to the £9m required (and would be closer still if a higher residual value in 25 years time was used) and making allowances for some of the other costs mentioned above that have to be incurred for this approach to be workable, the figure can again be seen to be reasonable.

4.3 Heads of Terms

The Heads of Terms for this agreement are set out in this section.

4.3.1 Parties to the Agreement

a) Sub Lessor - Building Better Health White City Limited (BBH) or such company within Fulcrum Infrastructure Group

b) Sub Lessees

• Hammersmith and Fulham PCT (PCT)
• Hammersmith and Fulham Council (Council)

Property: Bloemfontein Road (former Janet Adegoke Leisure Centre), White City, London W12

The property was acquired by BBH on a 250 year lease from Hammersmith & Fulham Council in 2006 and the lease completed on 27th February 2007.

4.3.2 Preamble

The purpose of the Heads of Terms is to provide comfort to BBH as lead developer and its investors (both banks and equity) prior to financial close that subject to satisfaction of evidence of funding conditions for the remainder of the scheme (residential and retail) the Council and the PCT will enter into the following agreements.

Once SHA approval is given the PCT and the Council require BBH to achieve financial close for the whole scheme within a reasonable timeframe. The heads of terms are also to assist BBH as far as is reasonable, in finalising the overall scheme funding agreements and legal agreements with the residential investors and retail tenants in parallel with the SHA approval procedures.

BBH is a health led Regeneration Company and has planning permission for the consented scheme below. This scheme is an exemplar integrated health scheme with associated retail, office and residential elements. BBH has also entered into heads of terms with Notting Hill Housing Trust (NHHO) as their residential development partner.
The conditions precedent to the development agreement between BBH and NHHO are:

- resolution of the required residential mix and planning revisions by NHHO ("The amended scheme")
- pre-lets of the Health and Care Centre to Fulcrum Infrastructure Limited together with pre-let agreements with the PCT and the Council for the under letting of the Health and Care Centre by Fulcrum
- formal release of the Church Commissioners covenants
- completion of the Land Swap by Hammersmith & Fulham Council to BBH for nil consideration on Financial Close.

4.3.3 The Scheme

A mixed use scheme comprising:

**Non-Residential Elements**

- Health and Care Centre comprising 2,972 sq m (NIA) arranged over ground and first floors as per plans and specification – finished to shell and core only
- retail comprising 1,066 sq m (NIA) on the ground floor and as per plans and specification – finished to shell and core only plus 3 basement parking spaces
- office comprising 1,212 sq m (NIA) arranged over ground floor and first floors as per plans and specification – finished to shell and core only

**Residential Element**

- 8,830 sq m (NIA) arranged over 2nd-6th floors and comprising the mix and dwelling numbers as per plans and specification
- 113 basement parking spaces

NHHO propose to amend the mix in order to create more studio and one bed units in place of all the micro units. The total sq m and the split between affordable and private are to remain in line with the consented scheme. The Council’s Director of Environment is to provide, prior to exchange of contracts, a letter of comfort confirming his in principle agreement to the revised mix.

4.3.4 Programme

The key milestones are:

- signed Heads of Terms with the PCT and the Council - July 10
- grant of Satisfactory Planning Permission for amended Scheme - July 10
- SHA scheme initial approval - November 10
- Financial Close - February 2011
- start on site - early 2011
- practical completion of non-residential elements - end 2012
- practical completion of scheme - mid 2013

4.3.5 The PCT and Council pre-let Health and Care Centre agreement

The PCT will enter into a 25 year IRI lease with FundCo for the ground and first storey of the northern pod (2,972 sqm) Health and Care Centre together with a basement area and car parking (956 sqm) for a one off payment of £9m, payable on practical completion to FundCo. The initial 25 year lease will be an internal repairing and insuring lease on occupational terms similar to those set out in the LPA but with
amendments to cover the specifics of this scheme, principally the one-off lease payment. At the end of the lease the long leasehold interest held by FundCo for the Health and Care Centre will transfer to the PCT for a peppercorn.

The Council will enter into a 25 year standard version 5 LPA lease for the Council’s share of the ground and first storey of the northern pod Health and Care Centre for consideration of £4m of PFI credits with FundCo.

BBH will simultaneously enter into a 249 year lease of the Health and Care Centre with FundCo for a capital contribution of £11m payable by FundCo on practical completion to BBH.

These agreements are conditional upon documentary evidence of funding, building contract and the residential development agreement between NHHO and BBH. The agreements are also conditional upon evidence of funding in principle of £11m from FundCo to BBH.

4.3.6 Costs to Financial Close

The PCT and the Council will jointly underwrite the professional fees incurred by FundCo from the date of these heads of terms through to financial close capped at £250,000.

For the avoidance of doubt fees incurred by BBH which relate to the overall scheme will not be recoverable from the PCT or the Council in the event that the Health and Care Centre does not go ahead.
4.4 Personnel implications (including TUPE)

TUPE - the Transfer of Undertakings (Protection of Employment) Regulations 1981 - will not apply to this investment because it is not a PPP structure and no staff are transferring out of the NHS.

4.5 Accountancy treatment

The assets underpinning delivery of the service will be on the balance sheet of the PCT. Audit Commission, the PCT’s external auditors, has reviewed and confirmed that the assets will fall under IFRIC 12 – Service Concession Arrangement and as such will be capitalised and depreciated using the PCT’s normal depreciation policy.

4.6 Tax implications

4.6.1 VAT implications

The London Borough of Hammersmith and Fulham opted to tax the original land sale at White City. This cannot be revoked and therefore the PCT will need to pay VAT on the lease. Per HM Treasury guidance this is not reflected in the economic analysis but it is included in the affordability analysis at section 5.

4.6.2 Other tax implications

Advice has been taken by BBH to allow it to obtain the best possible tax position. The implications of this advice have been incorporated into the costs shown in this Business Case. Additional information on tax including the advice provided by Grant Thornton is available on request.
5 The Financial Case

5.1 Introduction

The purpose of this section is to set out the financial implications of the IRI option. The detailed analysis is contained in Appendix 4.

The affordability of the Health and Care Centre is set in the context of a significant decline in the rate of growth in NHS funding for the foreseeable future, and therefore the need to make substantial improvements in quality, efficiency and productivity to ensure financial sustainability. A major contribution to improved efficiency and productivity will be delivered through a shift of patient activity away from acute settings to community based settings - and by reducing dependency on acute interventions through greater emphasis on prevention and chronic disease management. The Health and Care Centre is a critical enabler to this model by providing the physical capacity and quality of facility necessary to deliver enhanced models of community based care.

5.2 The PCT's financial position

The PCT has a strong financial base - evidenced by historical performance, and sustained through the medium term within its five year financial plan. The PCT has kept tight control of expenditure, and has been successful in implementing a range of out of hospital care models which are already making a significant contribution in terms of reduced cost and reduced impact of activity growth. This has provided the PCT with significant financial headroom. This headroom has been used to provide financial support to other NHS organisations within the NWL Sector - with circa £7m repayable within 2 years - and has also enabled the PCT to resource a revenue contribution to capital of £5m for this scheme in order to reduce ongoing revenue costs and strengthen medium term affordability.

The PCT's medium term financial plans are based on downside financial assumptions - and are based on maintaining a recurrent surplus / under commitment of 3% during the 5 year financial planning period. Financial plans therefore maintain financial headroom of circa £10m during each year of the five year period.

5.3 Capital affordability

The revenue affordability model assumes a total capital contribution to the scheme of £10.8m. As noted above, the PCT has identified £5m as a contribution from brought forward revenue surplus. The balance has been considered under two scenarios.

Under the preferred scenario, a capital contribution will be made by NHS London of £4m. The balance of £1.8m will be resourced from identified premises disposals.

A second scenario assumes no capital contribution from NHS London - and therefore the need for the PCT to identify the full additional amount of £5.8m. Whilst this will be sub-optimal in terms of the impact on other premises development plans and the delivery of the PCT's strategic plan, a total of £5.7m can be contributed from planned premises disposals / rationalisation - with the balance of £100k from making a further contribution from non-recurrent revenue resources.

Whilst there is some risk that the proceeds of planned premises may be lower than currently estimated - the general expectation is that the values used within the model represent the minimum under open market sale conditions. Any risk that does
materialise will require a further contribution from non-recurrent revenue – from the 2% per annum (£7m) included within the PCT’s financial plan.

5.4 Revenue affordability

The financial case for the Health Centre goes beyond affordability – to the facility being a critical enabler to delivering the strategic shift in services from acute to community – and therefore a net contributor to the PCT’s financial position.

The financial case assumes a downside in terms of the financial contribution from reduced hospital activity and the net savings available after reprioritization of services. It also assumes a downside in terms of the operational efficiency from both the building infrastructure and the integration model. Using these downside financial estimates the costs released exceed the new costs of the Health and Care Centre by an average of 13% over the 6 year period of the model – and therefore demonstrate a good return on investment even under a pessimistic scenario. It would be expected that by further reworking of the operational model, and by factoring in the full range of possibilities for out of hospital service provision that the real return on investment will be in excess of 20%.

Table 14 below sets out the revenue costs over the first 6 years of the new build. As can be seen from the table, the revenue costs associated with the new build are substantially covered by costs released from related premises disposals. The balance of costs are met from a contribution from the costs released from the provision of out of hospital services within the new facility and broad estimates of the operational efficiency gains that will be achieved from a modern single building with an integrated model of service provision.

Table 14 demonstrates that the new facility will make a net contribution to the PCT’s financial position – with the scope for that net contribution to increase as the new service models are established and the benefits from the integrated service model are realised.

<table>
<thead>
<tr>
<th>Table 14 – summary of financial appraisal – revenue costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Revenue costs of new build</strong></td>
</tr>
<tr>
<td>Funded by:</td>
</tr>
<tr>
<td>Revenue costs released from related disposals</td>
</tr>
<tr>
<td>Year 1: £246, Year 2: £363, Year 3: £373, Year 4: £384, Year 5: £390, Year 6: £396, Total: £2,152</td>
</tr>
<tr>
<td>Net savings from Out of Hospital re-provision</td>
</tr>
<tr>
<td>Year 1: £50, Year 2: £95, Year 3: £95, Year 4: £95, Year 5: £95, Year 6: £95, Total: £525</td>
</tr>
<tr>
<td>Operational Efficiency Savings</td>
</tr>
<tr>
<td>Year 1: £12, Year 2: £18, Year 3: £18, Year 4: £18, Year 5: £18, Year 6: £18, Total: £102</td>
</tr>
<tr>
<td><strong>TOTAL funding contribution</strong></td>
</tr>
<tr>
<td>Year 1: £298, Year 2: £428, Year 3: £428, Year 4: £428, Year 5: £428, Year 6: £428, Total: £2,438</td>
</tr>
<tr>
<td><strong>Net costs (savings)</strong></td>
</tr>
<tr>
<td>Year 1: (£52), Year 2: (£65), Year 3: (£55), Year 4: (£44), Year 5: (£36), Year 6: (£32), Total: (£286)</td>
</tr>
</tbody>
</table>

5.5 Conclusion

The PCT has carefully assessed the financial case – in the context of its overall financial plan – and the capital and revenue implications of this scheme. The PCT is confident that the financial case is robust in terms of both capital and revenue affordability – and that this scheme will enable a net contribution to the PCT’s financial position over the short and medium term.
6 The Management Case

6.1 Introduction

This section of the FBC addresses in detail how the scheme will be delivered successfully.

6.2 Project management arrangements

In order to ensure that the new facility is delivered successfully and on time it is recognised that commitment at the highest level within the PCT and Council is required. In response to this, the White City Steering Group has been formed along with several work streams which report to the Steering Group. The Steering Group is chaired by Geoff Easton, LIFT Project Director.

The three work streams are follows:

- Commercial & Approvals Group - chaired by Geoff Easton
- Design Group
- Operational Issues & Policies Group - led by Nav Allibhai

Terms of Reference for Steering Group

The Steering Group’s responsibility is to ensure that the commissioning of the new building is achieved through successful partnership working with Fulcrum and LIFTCo who are key stakeholders in the Steering Group. The Group will oversee the work of the Design, Operational and Commercial work streams, and ensure appropriate structures are in place to deliver key outcomes required by the target completion date.

The Objectives of the Steering Group are to:

- agree and approve the strategic vision for the new health facility and ensure this fits with the PCT’s and Council’s financial plans and local/national strategies
- agree and regularly review the project programme for the scheme to ensure key tasks and milestones are being met by the respective workstreams
- support an inclusive communication strategy ensuring that stakeholders and partner organisations are kept abreast of developments and that appropriate public consultation is undertaken with users, staff, local residents and councillors
- manage the impact of change on staff and patients and other stakeholders in developing the new TGHC as an asset for the local community

The membership of the Steering Group is set out below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geoff Easton</td>
<td>WLHE</td>
<td>Project Director</td>
</tr>
<tr>
<td>Miles Freeman</td>
<td>H&amp;F PCT Commissioning</td>
<td>Director of Commissioning</td>
</tr>
<tr>
<td>Golda Okpala</td>
<td>H&amp;F PCT Commissioning</td>
<td>Deputy Director of Finance</td>
</tr>
<tr>
<td>Mark Jones</td>
<td>LB H&amp;F</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>John Corlett</td>
<td>WLMHT</td>
<td>Director of Estates</td>
</tr>
<tr>
<td>Sylvie Pierce</td>
<td>Fulcrum</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Nav Allibhai</td>
<td>WLHE</td>
<td>LIFT Project Officer</td>
</tr>
</tbody>
</table>
Terms of Reference for Workstreams:

- **Work stream 1 Design**: To ensure floor layouts are produced and agreed and that input is sought from managers, clinical advisers, end users, voluntary sector, etc. To put in place timetable for development of room data sheets and room loaded plans and ensure that these are approved by respective organisations taking space in the building.
- **Work stream 2 Operational Policy and Processes**: To produce operational policy document for the new building covering all day-today activities, including inter alia reception, car parking, supplies, storage, meeting rooms, photocopying, health & safety, security, etc.
- **Work stream 3 Commercial & Approvals**: To ensure legal arrangements are in place and that all sponsors are in a position to sign leases, Lease Plus or Underlease Plus Agreement at Financial Close. To ensure all sponsors obtain necessary approvals in writing in line with programme to financial close. To ensure issues on main commercial deal are resolved and do not effect progress with Health Centre.

### 6.3 Delivery Steering Group

The purpose of the delivery steering group is to provide a forum for all the stakeholders in the new development on the Janet Adegoke site at White City. The aim is to ensure that all stakeholders know what progress is being made, can help resolve any problems, and can participate in decision making as deemed appropriate.

#### 6.3.1 Terms of Reference

The terms of reference for the delivery steering group are:

- a forum for all stakeholders to influence the overall scheme
- to provide a process for monitoring quality
- to advise on the appointment of the contractor, and ensure that there is an appropriate audit trail
- to resolve problems of competing priorities
- to contribute towards an understanding of the overall costings and participate in any value engineering process
- to provide a forum for sharing information on progress and problems, for the next stage of the scheme through to completion
- to generate a real understanding of how the whole impacts on the individual parts of the scheme
- to provide a forum for raising concerns and jointly resolving them, as far as possible, to everyone’s satisfaction
- to determine tactics for working with outside agencies where appropriate
- to provide a forum where changes to programme, design, and other relevant issues can be reported on and dealt with
- to consider communication issues and relationships with the broader community of the White City and Wormholt estates

#### 6.3.2 Meetings

The steering group should meet monthly, unless the membership decides to meet more or less frequently. It should focus on high level strategy, and therefore should be attended by the key decision makers, supported by others from their organisation.
6.3.3 Membership

The proposed membership is as follows:

- **BBH (White City)**
  - Stephen Clarke
  - Sylvie Pierce

- **Day & Johnson (BBH’s project managers)**
  - Gavin Johnson

- **LBHF**
  - James Reilly
  - Mark Jones
  - Miles Hooton

- **Contractor**
  - To be appointed

- **Notting Hill HG**
  - Steve Rawlings
  - Project managers

- **H&F PCT**
  - Miles Freeman
  - Golda Okpala

- **Lift Co (Fulcrum)**
  - Eugene Prinsloo

- **Residents Association**
  - Harry Audley (community agenda items only)

6.4 Consultation

The consultation programme has been designed to help local residents to:

- understand the nature and role of the White City Health and Care Centre in their community
- contribute their ideas and opinions to influence the design and development of the services
- communicate their views of the ways in which they would like to access and use these services
- propose ways in which they would like to be genuinely engaged on an ongoing basis in order to shape and influence the commissioning and delivery of local service provision

There has been extensive communication and consultation on the Collaborative Care Centre and the wider development. Significant consultation on the planning aspects of the overall scheme took place in the early part of 2006. These led to changes and some redesign which was be consulted upon again when the scheme was resubmitted for planning. Since mid-2006 the focus has been on agreeing the schedule of accommodation and on developing block plans so that PCT has something tangible to present for comments. The block plans were issued in April 2007 and were taken to a meeting of the Residents Group on May 31st. The initial feedback was positive.

The actions carried out so far are summarised in the table below.
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Services by Somali and Eritrean Communities</td>
<td>2004</td>
<td>This was an action research project into the health and social care needs of the above communities; approximately 1,500 residents participated in this research project. The project provides key recommendations for improved access to current services and provision of future services.</td>
</tr>
<tr>
<td>Janet Adegoke Site Residents Project Groups</td>
<td>Oct 2004 - 2006</td>
<td>The Residents’ Group Chaired by Kevin Veness-Hafftra met on a monthly basis to discuss the White City LIFT Programme and comment on proposals for the White City CCC. This group was reconvened in March 2010, and shown the latest designs for the centre.</td>
</tr>
<tr>
<td>A Collaborative Approach to Developing a Diabetes Service</td>
<td>Dec 2004 - May 2005</td>
<td>This project targeted Black and Minority patients and carers as well as patients with learning and physical disabilities to identify their experiences of having diabetes and other long term conditions. The recommendations helped inform provisions for people with long term conditions.</td>
</tr>
<tr>
<td>Urban Studies Centre - White City CCC Consultation with Children and Young People</td>
<td>Autumn 2004 - Summer 2006</td>
<td>Consultations were linked to National Curriculum areas and targeted all primary and secondary schools, and community and children's centres in White City and surrounding areas.</td>
</tr>
<tr>
<td>White City CCC Consultation Event</td>
<td>July 2005</td>
<td>The consultation was carried out by the Council, the PCT, Threshold Housing Association, Richard Rogers Partnership, Groundwork, and was organised by Charlotte Pomery. This identified key health and social care themes for future consultations.</td>
</tr>
<tr>
<td>White City Open Day</td>
<td>Oct 2008</td>
<td>This successful event reported back to the community what had been identified by the community at the July 2005 event, and how plans had been changed as a direct result of that consultation. Information was given on how plans had been updated since that date. Attendees were encouraged to discuss their views, wants and desires for the health element of the facility, and these were all captured, and have been used in the specification for the interim Canberra Centre for Health.</td>
</tr>
<tr>
<td>Community Relations Group Workshop Event</td>
<td>Mar 2010</td>
<td>The workshop was targeted at Black and Minority Ethnic and Faith Communities and Community Organisations to help identify their experiences of accessing primary care services and put forward recommendations for future health and social care - including primary care services. Although the event was Borough wide, there was strong representation from voluntary and community organisations and communities in the White City.</td>
</tr>
<tr>
<td>White City Celebration Event</td>
<td>Apr 2010</td>
<td>This event was to celebrate the achievements of local people in becoming Health Champions, and the joint working with local people to promote Health and Wellbeing in White City. The event also reinforced that, in spite of the delays, the findings from the October 2008 event have been fed back to planning for the new centre.</td>
</tr>
<tr>
<td>Event</td>
<td>Date</td>
<td>Action</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hammersmith and Fulham Connected Care Action Research Project</td>
<td>Sept 2010</td>
<td>Turning Point was commissioned to undertake the project by London Borough of Hammersmith and Fulham, NHS Hammersmith and Fulham, and the Department of Health. The project has involved speaking to local people for their views on how services can be improved. The interviews were carried out by community researchers - people who live locally and are trained by Turning Point. 18 people were recruited to this position in total. Between December 2009 and June 2010, 831 people in the study area gave their views on local services through questionnaires, interviews, focus groups and community events. The intention of the research is to engage with local people on providing solutions for a cost effective and sustainable integrated approach to commissioning services. The community will - through this process - become more informed and better able to make choices about the kind of services that best fit locally.</td>
</tr>
</tbody>
</table>

The recommendations from the above consultations strongly mirror the Government’s White Paper principle of ‘nothing about me without me’. As a result during September 2010 the PCT facilitated a process of bringing together local steering groups under the umbrella of a White City Health and Well-being Steering Group whose aim is to:

- promote health and wellbeing locally through coordinated working
- facilitate links across primary care and other services
- inform the design of new or reconfigured statutory services, in particular White City Health Centre proposals
- ensure local services and activities are shaped by local people
- seek to ensure funding from statutory and voluntary sources for the area are best utilised and coordinated
- promote networking across the area
- promote information sharing across services to benefit residents

Multi-agency stakeholders include, local GPs, Well London Health Champions and Community Researchers - local volunteers trained in providing signposting to local health and social care services, providing outreach and local intelligence - Local Authority representatives, Tenant and Resident Group representatives.

This structure will ensure that stakeholders are kept abreast of and influence developments, aware of any changes to the development of the site, and briefed on the involvement opportunities there are as the scheme develops.

We also want to ensure that this will not be the only way for local people to be involved in the developments and have therefore identified other stakeholder and communication and engagement channels which include:

- Residents - via HAFFTRA
- Richard Rogers
- BBH
- Catalyst
- Hammersmith Hospital
- Voluntary Sector/HAFAD/Nubian Life/MENCAP/MIND
- PCT
- West London Mental Health Trust
- LB Hammersmith and Fulham Staff Teams and practitioners - health, housing, social care, Children’s Trust

43

White City Health and Care Centre - Business Case - October 2010 - Revised 4 November 2010
• GPs
• Hammersmith & Fulham Buildings Group, Hammersmith Society and other neighbouring Amenity Groups
• Marlene Pope, Project Officer - Environment
• Regeneration (Marc Billington/Kim Dero)
• Bryony Centre/Adult education
• Members
• Local MP
• Business economy - Camber of Commerce

6.5 Project plan

This is as set out in the following table.

Table 16: project plan

<table>
<thead>
<tr>
<th>Milestone Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenderers prequalified</td>
<td>1 October 2010</td>
</tr>
<tr>
<td>Professional appointments complete</td>
<td>30 November 2010</td>
</tr>
<tr>
<td>Site investigations complete</td>
<td>30 November 2010</td>
</tr>
<tr>
<td>Scheme design to RIBA Stage C</td>
<td>30 November 2010</td>
</tr>
<tr>
<td>SHA approval of approach</td>
<td>30 November 2010</td>
</tr>
<tr>
<td>Document freeze</td>
<td>31 December 2010</td>
</tr>
<tr>
<td>Residential planning approval</td>
<td>31 January 2011</td>
</tr>
<tr>
<td>Scheme design to RIBA Stage D</td>
<td>31 January 2011</td>
</tr>
<tr>
<td>Planning pre-commencement conditions resolved</td>
<td>28 February 2011</td>
</tr>
<tr>
<td>Scheme design to RIBA Stage D+</td>
<td>28 February 2011</td>
</tr>
<tr>
<td>Financial close</td>
<td>28 February 2011</td>
</tr>
<tr>
<td>Construction partner appointed and mobilisation</td>
<td>29 April 2011</td>
</tr>
<tr>
<td>Construction complete</td>
<td>31 March 2013</td>
</tr>
</tbody>
</table>

It should be noted that the only outstanding planning issue relates to the housing units. Notting Hill Housing Association has requested a minor change which reduces the number of housing units from 179 to around 155. At the moment this is expected to require a revised planning submission which is due to be made in early November 2010, and is expected to be agreed by the end of January 2011. This does mean that the judicial review period will commence on 1 February 2011. However, BBH believes that the nature of the change means the likelihood of challenge is very low. The enabling works will be started while the judicial review period is still open, as it is BBH’s belief that the risk of judicial review is minimal due to the nature of the changes. The original planning consultant Urban Practitioners are being used to handle the changed application.

6.6 Use of special advisers

Special advisers were used as follows:

Table 17: special advisers

<table>
<thead>
<tr>
<th>Specialist Area</th>
<th>Adviser</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Grant Thornton</td>
</tr>
<tr>
<td>Technical</td>
<td>Cyril Sweete</td>
</tr>
<tr>
<td>Procurement and legal</td>
<td>Bevan Brittan</td>
</tr>
</tbody>
</table>
6.7 Benefits realisation

The Benefits Realisation Plan is set out in the table below.

**Table 18: Benefits realisation plan**

<table>
<thead>
<tr>
<th>Project Objective</th>
<th>Benefit description</th>
<th>How realised</th>
<th>How measured</th>
<th>Benefit baseline</th>
<th>Key date for realisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Service Integration</td>
<td></td>
<td></td>
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<tr>
<td>GPs working together in a network approach to delivering care</td>
<td>Space in new premises for 7 practices comprising up to 14 GPs and associated practices nurses / nurse practitioners</td>
<td>Number of registered patients receiving care from the new centre</td>
<td>Registered population of current Health Centre</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Services working in an co-ordinated way across organisational boundaries</td>
<td>Space for multi-disciplinary teams to support joined up approach to delivering agreed care pathways</td>
<td>Number of patients at high risk of hospital admission (based on combined predictive modelling) who are managed by multi disciplinary team (MDT) working</td>
<td>Number of patients at high risk of hospital admission (using combined predictive modelling) who are managed by MDT working</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Improved medicines management</td>
<td>On-site pharmacy support medicines management particularly for patients on a high number of repeat medications</td>
<td>Reduction in admissions related to medication adverse events</td>
<td>Number of admissions linked to medication adverse events 2010/11</td>
<td>March 2014</td>
<td></td>
</tr>
<tr>
<td>Improved Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of an unscheduled care pathway for White City</td>
<td>Unscheduled care pathway included in White City service: Minimum 12/7 walk-in access, rapid response team, cross organisational access to care plans for patients at high risk of hospital admission and enhanced paediatric care</td>
<td>100% of patients have access to same day walk-in slots 100% of patients are able to book a GP appointment within 48 hours.</td>
<td>Access survey 2009/10</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Project Objective</td>
<td>Benefit description</td>
<td>How realised</td>
<td>How measured</td>
<td>Benefit baseline</td>
<td>Key date for realisation</td>
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</tr>
<tr>
<td>Improved access for planned care for patients with long term conditions</td>
<td>Commission planned care pathway, including: Continuity of care, advanced appointments with a named clinician, complex case management.</td>
<td>100% of patients able to book up to 3 months in advance with a named clinician Reduction in unscheduled care attendance for management of long term conditions Reduction in emergency admissions for diabetes, COPD and Asthma</td>
<td>% of patients able to book up to three months in advance with a named clinician Number of UCC attendances for long term condition management</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Improved access for patients outside core general practice hours</td>
<td>Extended hours provision as standard within the new contract</td>
<td>Number of hours of access to clinical services per week. (GP/ Nurse) Reduction in A&amp;E attendances Reduced usage of Out of Hours provision</td>
<td>Number of hours of access 2009/10. A&amp;E attendances for 7 practices 2009/10 Out of Hours usage 2009/10</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Improved access to primary care services particularly for those who face barriers to accessing traditional primary care</td>
<td>Commission enhanced ethnicity recording and use of translation and interpretation services</td>
<td>% of repeat unregistered attenders at Hammersmith UCC Improved ethnic coding Take up rates for translation services</td>
<td>% of repeat unregistered attenders 09/10 % of patients with ethnicity recorded Audit rates to produce baseline figure 2007</td>
<td>March 2014 April 2013 March 2014</td>
<td></td>
</tr>
<tr>
<td>Improved Primary Care Quality</td>
<td>Provide high quality primary care premises</td>
<td>Replace 4 practice premises that are unsuitable for primary care</td>
<td>Number of practices operating from premises below minimum standards Practice premises survey 2007</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Project Objective</td>
<td>Benefit description</td>
<td>How realised</td>
<td>How measured</td>
<td>Benefit baseline</td>
<td>Key date for realisation</td>
</tr>
<tr>
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</tr>
<tr>
<td>Increase the skills and capacity of general practice</td>
<td>Commission leadership for key primary care pathways relevant to the White City population including diabetes, CHD, COPD, frail elderly, mental health and paediatrics Health and Care Centre to be a training practice Requirement to meet RCGP practice accreditation</td>
<td>Reduction in secondary care referrals Leadership in service re-design work Number of GP trainers Practice accreditation status</td>
<td>Secondary Care referrals 2010/11 Leadership of service re-design by White City GPs in 2010</td>
<td>March 2014 April 2013</td>
<td></td>
</tr>
<tr>
<td>Improve the quality of primary care services with earlier diagnosis of disease and higher quality Chronic Disease Management</td>
<td>Better access for target groups (especially unregistered) Better co-ordination of care services including social services. Specialist consultant / specialist nurse oversight of CDM. Engagement of Secondary care and GPs as Commissioners to design appropriate evidence based clinical pathways</td>
<td>Increase in rates of elective cases to PCT average. Decrease in emergency admissions Decrease in Length of Stay Increase in prevalence to PCT average</td>
<td>Elective rates for North Hammersmith 06/07. Emergency admissions rates for North Hammersmith</td>
<td>April 2013</td>
<td></td>
</tr>
<tr>
<td>Productivity</td>
<td>Improve the range of primary care services to ensure that need to attend hospital is reduced and discharge is swiftly managed</td>
<td>Full range of Enhanced GMS services commissioned for all patients Better co-ordination of care services including social services Develop community matron model for the North Hammersmith Community</td>
<td>% of patients able to access all Enhanced Primary care services Decrease in emergency admissions Decrease in Length of Stay</td>
<td>% patients able to access all Enhanced Primary Care Services 2010 Emergency admissions rates for North Hammersmith 2010 Decrease in Length of Stay rates to national average</td>
<td>April 2013 March 2014</td>
</tr>
</tbody>
</table>
### Project Objective | Benefit description | How realised | How measured | Benefit baseline | Key date for realisation
--- | --- | --- | --- | --- | ---
Better use of resources through shared management and administrative functions. Development of admin/healthcare assistant roles to create a flexible workforce | Commission for integrated reception and management functions | Reduced per patient management costs | Current spend on management and admin across existing sites | April 2014

#### 6.8 Risk management

The strategy, framework and plan for dealing with the management of risk are as follows:

- identification of main risks agreed by Steering Group
- regular review during Steering Group meetings
- allocation of responsibility for management of risk to particular individuals
- joint responsibility of Steering Group members to ensure risks managed to achieve overall project objectives and avoid time and cost increases.

A copy of the project risk register is attached at Appendix 5.

This sets out who is responsible for the management of risks and the required counter measures.

#### 6.9 Contract management

The overall development project is being managed by BBH along commercial lines with designated contract management arrangements. The health centre is being delivered through FundCo (part direct leasing to PCT, part LPA to Council) and is following the process normally adopted for LIFT development. Management of the fit out process is being undertaken by BBH/FundCo as agent for the PCT and as LIFT provider for the Council.

As far as the PCT is concerned the contractual arrangements needed to secure its objectives from this development are overseen by the Project Director with support from the technical, financial and legal advisers.

#### 6.10 Post project evaluation

Post Project Evaluation will be based on the guidance issued by NHS Executive and the Department of Health.

The Project Director will be responsible for the development of the full Evaluation Plan. This forms the basis for the evaluation of all projects undertaken by LIFTCo throughout its lifetime. Although this is not strictly now a LIFT scheme the evaluation process adopted for such schemes will still be appropriate. The following will assist this process:

- the Tenants’ Representative - the representative of the scheme will be responsible for ensuring that data is correctly collected and collated for use in the evaluation
• LIFTCo – the private partner will be involved in the evaluation of projects as this will considerably add to the learning curve of all parties
• Partnerships for Health – as one of the key shareholders, and the central body responsible for LIFT, they will add significantly to the understanding of how the overall process has affected the individual schemes

The Evaluation Plan will include details of:

• the objectives and scope of the evaluation
• the success criteria for assessing the project
• the indicators/data used for measurement including collection methodology
• the persons responsible for data collection, analysis and evaluation
• identified resources and budget for evaluation
• communications plan for the dissemination of the results of the evaluation
• precise timetable

6.10.1 Evaluation during construction of the project

During the construction phase the Tenants’ Representative and LIFTCo will monitor issues including:

• adherence to timetable and cost
• performance against service standards
• procurement process
• fit to design solution

A detailed report will be written at the end of the Construction Phase to include:

• performance throughout the construction phase
• reasons for any variance against timetable or budget
• action suggested to prevent re-occurrence of above
• functional suitability of the building
• issues arising from design

6.10.2 Evaluation post-commissioning

After the handover, and given a reasonable ‘bedding in’ period, the project will be re-evaluated around 6 to 12 months after opening. The evaluation will cover:

• a re-assessment of the previous evaluation stage in the light of any arising issues
• a more detailed review of functional suitability
• building quality
• FM services
• the ‘snag list’ of the new facility
• initial performance against project objectives
6.10.3 Longer-term outcomes

The final stage of evaluation will take place once the full effects of the project are deemed to have materialised. This is expected to be within 18 months to three years of opening.

In addition to a more detailed review of all of the items noted above, the evaluation will also review:

- changes in operating costs
- changes in FM costs
- changes in risk allocation and transfer
- changes in clinical activity
- changes in clinical performance measures
- consultation with staff and users

Signed:
Date:
Senior Responsible Owner
Project Team

7 List of Appendices

01 - Space modelling
02 - Architectural drawings and plans
03 - Economic models & optimism bias
04 - Financial Analysis, detailed costings
05 - Project Plan and Procurement
06 - Risk Register
07 - Specifications and schedules - information to be submitted separately