White City Collaborative Care Centre

Stage 1/Stage 2 and Full Business Case

FOREWORD BY THE LEAD CABINET MEMBER FOR COMMUNITY SERVICES, THE LONDON BOROUGH OF HAMMERSMITH & FULHAM

On behalf of the London Borough of Hammersmith and Fulham, I am pleased to submit to you the Council's Final Business Case for social care PFI Credits to support the delivery of a new model of health and social care in a state-of-the-art building in the heart of White City.

This scheme supports the Council's strategic objectives to deliver high quality value for money services and to create a healthier borough for local residents as part of our Borough of Opportunity for all.

The Wormholt and White City ward is one of the most deprived areas in the country with high levels of unemployment, poor housing options, higher standardised mortality rates, higher levels of referral to adult social services and significantly poorer health outcomes.

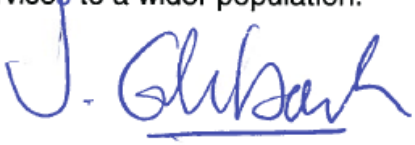
As a Council we are wholly committed to working with our partners to make a sustainable difference to people's life chances in this area.

The integration of Social Care with NHS services is a critical part of the Council's strategy to address these problems and the White City Collaborative Care Centre is fundamental to realising this ambition.

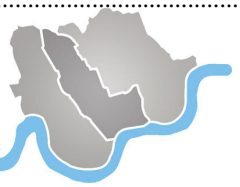
The health and social care centre is set in a development that will also include retail space and mixed tenure housing, including 67 affordable units. It will bring about substantial regeneration of the area, forming the western anchor of much larger scale physical, social and economic regeneration of the White City Opportunity Area.

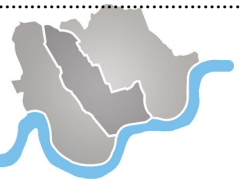
The Collaborative Care Centre is a partnership project between the Council, Hammersmith and Fulham Primary Care Trust (H&F PCT), the Building Better Health (BBH) LIFTCo, local voluntary agencies and the local community. There is a high level of commitment to the scheme right across this partnership and a considerable amount has been invested in advancing the development to this final stage and as far as possible removing barriers to delivery.

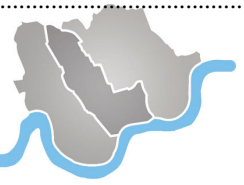
This scheme is very strongly supported by the Council. It will be delivered through a mixed-use building of high architectural quality that will provide general medical services to a population of at least 25,000 patients, serving as a hub to provide extended primary and community health and social care services to a wider population.



Councillor Joe Carlebach
CABINET MEMBER FOR COMMUNITY SERVICES, THE LONDON BOROUGH OF HAMMERSMITH & FULHAM







Appendices

Appendix 18: Funding Package Letter
Appendix 19: Site Valuation Report
Appendix 20: Benchmarking Report
Appendix 21: District Valuer's Reports
Appendix 22: Project Initiation Document
Appendix 23: Risk Register
Appendix 24: Benefits Realisation Plan
Appendix 25: Optimism Bias
Appendix 26: PFI Credit Annuity Calculation
Appendix 27: Cash Flows
Appendix 28: LIFTCo Financial Model
Appendix 29: Financial Advisors' Report

1. Executive Summary

1.1. Introduction

The development of the White City Collaborative Care Centre remains the cornerstone of the joint Council and NHS Inner North West London vision for the local implementation of the Continuity of Care Programme, facilitating the introduction of fundamental changes in clinical and social care that are required to improve the health and social wellbeing of people living in the north of Hammersmith & Fulham.

This Business Case has been prepared to set out the case for this development and describes the approach to services delivery that has been adopted and which is being driven by the local Clinical Commissioning Group.

This Business Case follows national guidance in the form required for a combined Stage 1 & 2 LIFT Business Case submission and seeks approval for the development to be undertaken through Building Better Health Limited, the local NHS LIFT Company.

1.2. Background

NHS Inner North West London: An interim Full Business Case was submitted to NHS London in November 2010. Feedback from the review led to reconfiguration of the project management arrangements, development of the project consistent with guidance produced by the Department of Health and the Treasury, and enhanced communication with NHS London and the Department of Health in order to ensure that both approving bodies are conversant with the project and its objectives.

London Borough of Hammersmith & Fulham: The Outline Business Case for social care PFI credits was submitted in November 2009. This was approved by the Treasury's Project Review Group and was reaffirmed following an updated submission in August 2010. Final agreement to the provision of PFI credits is subject to the approval of this Final Business Case submission, which, together with the NHS INWL's submission, sets out final intentions, costs, value for money and more detailed design proposals.

1.3. Service Vision and Strategic Context

Both organisations can confirm that this, final Full Business Case contains no change from earlier submissions in relation to vision and strategic planning and no change in interfaces with the wider health and social care economy.

In fact, the submission is stronger in that the principal driver for the facility is the delivery of the Continuity of Care Programme (the programme to integrate Social Care and NHS services); this programme has made progress since the last submissions, now driven by the Clinical Commissioning Group.

1.4. Services Delivery

In terms of content of the facility there have only been minor changes to the content of the facility that have arisen through more detailed analysis of epidemiology, demography, activity and capacity, together with greater progress on delivering the Continuity of Care Programme.

1.5. Communications and Engagement

A wide range of stakeholders has been involved in the development of the WCCCC proposals from its initial conception. The local communities which the centre will serve, the providers who will be based there and those potentially impacted by the related care pathway redesign have all been actively engaged.

Engagement work ensures that stakeholders are kept abreast of and able to influence decisions about the development, aware of any changes to the proposals, and briefed on the involvement opportunities there are as the scheme develops.

1.6. Briefing and Design Proposals

A new team of Project Advisors was established in March 2011. They have worked with key individuals in each of the client organisations and a range of stakeholders to develop the Design Brief, as well as with the LIFTCo design team on the design solution, with 1:200 layouts being agreed by the Joint Project Board on 15th September 2011.

The Project team has reviewed and validated the previous work undertaken on the project over a number of years. It has focused on understanding the history and how service intentions for the Centre have developed in light of the service shift already underway.

Once services robustness was confirmed, a strong joint brief (Tenants' Requirements) was developed in order to provide the Key Performance Indicators (KPIs) that would allow the design to be developed and tested and to ensure the delivery of the benefits associated with the development.

The designs have been developed at 1:200 & 1:50 scale to sufficiently demonstrate functionality and compliance with the Tenants Requirements. Work is now under way to finalise all aspects of the detailed design.

1.7. Commercial and Contractual Matters

The standard drafting for the Lease Plus Agreement (LPA) has been adopted, with a limited number of derogations that can be justified by reference to the relationship of the Centre to the wider development with Notting Hill Housing Association.

The section also describes the likely funding structure and cost structure for the funding, and demonstrates that this represents value for money for the PCT and the Council.

1.8. Financial Impact

Both the PCT and the Council can demonstrate that the WCCCC is affordable.

The PCT's share of the accommodation will cost £563,000 per annum more than the facilities which the services are currently using. However, this additional cost is covered by expected savings of up to £1,540,000 per annum which will be released through service changes facilitated by the delivery of the WCCCC.

After receipt of PFI credits, the Council's affordability gap amounts to £62,000 per annum, but the Council regards that as affordable.

1.9. Value for Money

The PCT and the Council have carried out extensive work to test the value for money of the WCCCC. On a quantitative and qualitative basis it has been that has demonstrated that:

- a new Collaborative Care Centre is the best way to deliver the strategic and service intentions for health and social care in the White City area
- LIFT provides the best route for delivery of the WCCCC
- the individual elements of the cost of the WCCCC can be shown to be value for money through benchmarking and reports of external parties such as the District Valuer

1.10. Risk, Project Management and Benefits Realisation

The PCT has approached the delivery of the WCCCC by establishing a project structure to ensure that both key organisations are kept up to date with developments and take part in decision-making, risks are appropriately identified and managed and communication between the PCT and the Council is maximised.

Management and delivery of the project has taken place in the context of changing organisational structures, developing policy and a challenging financial climate; the approach to mitigating the risks inherent in these issues is addressed under 'Key Risks' in this section of the Business Case.

As the project represents one element of a larger development, comprising residential and retail facilities, this has required close examination of the construction programme, risks associated with the operation of the WCCCC whilst the remainder of the development is still under construction and on-going service charges payable to the owner of the residential units.

The critical success factors that have driven the project in the period January to November 2011 include:

- Programme:

  - Delivery of a programme that recognises the challenges associated with the long gestation period of the project whilst ensuring that the key deliverables are appropriately managed and closed out
  - Early identification of the project risks and close management
- Design:
  - Underpinned by a strong, integrated brief (Tenants' Requirements)
  - Consistent demonstration of intimate links between the brief and the design
  - Close monitoring to ensure the delivery of Key Performance Indicators (KPIs)
- Contracts:
  - Interrogation of construction /fit-out risks
  - Interrogation of early operational risks
  - Delivery of signed-up occupiers
- Affordability:
  - Focus on value for money judgements
  - Focus on robustness of the financial model
  - Focus on robustness of affordability assessments

The key milestones for the remainder of the project are as follows:

Milestone	Current Planned Dates	Anticipated Dates
Planning meeting	11/10/11	11/10/11
SPB Stage 1 approval	20/09/11	20/09/11
NHS INWL Board Stage 1 approval	29/09/11	29/09/11
Business case submission	11/11/11	11/11/11
Judicial review ends	13/02/12	13/02/12
NHS London Business case approval	19/01/12	19/01/12
DH approval (PFI credits)	16/12/11	16/12/11
Treasury approval (PFI credits)	10/02/12	10/02/12
Financial close	Mid February 2012	Mid February 2012
Start on site	Early April 2012	Early April 2012
Handover	February 2014	Early December 2013
Operational date	April 2014	January 2014

2. Introduction, Background and Strategic Fit

2.1. Introduction

This document sets out the Business Case submitted by the NHS Inner North West London cluster, acting on behalf of NHS Hammersmith & Fulham, one of its constituent PCTs (hereafter referred to as the PCT) and the London Borough of Hammersmith and Fulham (the Council) for the development of the White City Collaborative Care Centre (WCCCC).

The development of the White City Collaborative Care Centre is a principal component of the Council's regeneration of White City and the PCT's plans to deliver redesigned health services for its local population.

The proposal is based on:

- a comprehensive understanding of the needs of the local population and the strategic context within which the PCT and the Council operate
- delivery of an integrated, client-focused model of care, linked to local and national service strategies, which will help deliver key performance and quality targets
- better local health and social care configuration that supports innovative practice, promotes high quality services and enables people to access services closer to home and outside hospital
- addressing other significant current pressures for change, such as poor estates conditions and cost pressures

The proposal has the support of the Hammersmith and Fulham Clinical Commissioning Group. The building of the WCCCC is a key enabler for the delivery of the CCG's commissioning intentions for 2012-15 and beyond. In particular it is a critical part of delivering its Continuity of Care programme, which will improve primary and community healthcare support to prevent hospital admissions and shift activity from acute hospital settings into community-based centres.

The proposal also has strong support from the local community and the GP practices, community care and social care teams who will move into the centre; this is included in Appendix 1.

The centre forms part of a mixed-use development, as required by the Council's strategic plan, comprising not only the centre but also affordable housing and retail space. It is a compact build being designed with the capacity and flexibility to adapt to changing healthcare needs. It offers good value for money both in terms of immediate improvements to the quality of healthcare estate in an area of high need, and being an essential enabler for pathway redesign to deliver more care through primary and community services.

The WCCCC is not simply a replacement for what exists at present. It is an essential tool within a larger integrated system of care that will allow the PCT and the Council to drive the transformational changes that are needed. Its design, operation and financial justification are based on its overall future role in the transformation and delivery of health care services to the people of White City and more widely across the north of the borough.

The approach adopted by the PCT is fully consistent with the Cluster's clinical strategy. Moreover, it is consistent with the integrated approach being developed in partnership with social services to promote people's independence and keep them out of hospital.

This case has been completed in accordance with the guidance set out in the Department of Health's '*Business case approval guidance for Primary Care Trusts with existing Local Improvement Finance Trusts*'. It is submitted to NHS London for approval to proceed to financial close and to the Department of Health for PFI credits.

Realising this investment will deliver the following high-level strategic and operational benefits (arranged by investment objectives):

Table 1: Investment objectives and benefits

Investment Objectives	Main benefits
Objective 1: Greater service integration	GPs working together in a network approach to deliver care
	Services working in a co-ordinated way across organisational boundaries, led by the Continuity of Care Programme and informed by the ICP project
Objective 2: Improved access	Improved access to GP appointments
	Improved access for planned care for patients with long term conditions
	Improved access for patients outside core general practice hours
	Improved access to primary care services particularly those who face barriers to accessing traditional primary care
Objective 3: Improved Primary Care Quality	Provide high quality primary care premises
	Increase the skills and capacity of general practice
	Improve the quality of primary care services with earlier diagnosis of disease and higher quality Chronic Disease Management
Objective 4: Productivity	Improve the range of primary care services to ensure that need to attend hospital is reduced and discharge is swiftly managed
	Better use of resources through shared management and administrative functions. Development of admin/healthcare assistant roles to create a flexible workforce.

Investment Objectives	Main benefits
	Community Health Services: improved modern health facilities to provide greater access and range of community health services designed with GP practices to target local patient populations
	Dental services: potential merger of GDS and specialist dental services will improve space utilisation and skill mix within the dental services provided

In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any changes to NHS services. These tests were to measure:

- the support for change by local GPs commissioners
- that plans were based on sound clinical evidence to improve outcomes for patients
- that there was strengthened public and clinical engagement on any proposals
- that patients' choices of where to be treated were considered when deciding how local NHS services should be arranged

The project has been assessed against the Secretary of State's four tests and the following table summarises the results of that assessment.

Table 2: Effect of the White City Collaborative Care Centre on the Secretary of State's four tests

Test	Effect of WCCCC
Patient, public and local authority engagement	• Section 3 of this strategic 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 WCCCC has been developed jointly by the PCT and the Local Authority and will house integrated care teams
GP support	• Hammersmith and Fulham has one Clinical Commissioning Group (CCG) which represents all practices within the borough • The CCG has given its support to the WCCCC
Clinical outcomes	• The integrated holistic service to be provided at White City will improve clinical outcomes as described in Section 2 below
Patient choice	• The WCCCC will provide additional services as set out in Section 6 below • Local residents have expressed a strong wish to be able to access health care in the White City locality

2.2. Format of the business case

Adoption of the Lease Plus Agreement (LPA) brings with it a need to refer to "FundCo" (who is the Landlord of the PCT under the terms of the LPA and a wholly owned subsidiary of LIFTCo). LIFTCo is a joint venture company between Building Better Health, Community Health Partnerships and Hammersmith & Fulham PCT, Ealing PCT and Harrow PCT. The brief and the design /construction responses are also titled as follows:

- the PCT's and the Council's joint brief is known as the Tenants' Requirements (TRs) and these are included in the LPA at Schedule 3
- the New Project Proposal has developed into a deliverable project, titled Landlord's Proposals. Those elements of the Landlord's Proposals that are pertinent to the submission are included within the LPA at Schedule 4

In order to demonstrate that all of the Department of Health's guidance requirements are fulfilled and that the Approval Criteria are clearly responded to, the Business Case is formatted to make identification of the detailed measures and relevant proposals easily recognisable.

The chapters of this Business Case are:

Foreword
Section One: Executive Summary
Section Two: Introduction and Background
Section Three: Strategic Context
Section Four: Services Delivery
Section Five: Brief and Design Proposal
Section Six: Commercial Case and Contract Structure
Section Seven: Financial Impact
Section Eight: Economic Case: Proving Value for Money
Section Nine: Project Management, Risk & Benefits Realisation

Each of Sections Three to Eight commence with a brief reflection of the means by which the approval criteria have been considered, followed by clear statements of the detailed measures that have been identified to objectively measure achievement of the Approval Criterion that is relevant to the section, as follows:

Table 3: Summary of Approval Criteria and Business Case Sections

Section	Approval Criterion	
Section Three: Strategic Context	2	The New Project can be delivered within the Affordability Cap
	4	The PCT and the Council are able to demonstrate that the New Project will provide value for money to the public sector
Section Four: Services	4	The PCT and the Council are able to

Section	Approval Criterion	
Delivery		demonstrate that the New Project will provide value for money to the public sector
Section Five: Brief and Design Proposal	1	The New Project meets each of the Tenants' Requirements, including standards contained in output specifications for facilities and services
	3	The New Project complies with the law and all applicable regulations
	4	LIFTCo is able to demonstrate that the New Project will provide value for money to the public sector
Section Six: Commercial Case and Contract Structure	3	The New Project complies with the law and all applicable regulations
	4	LIFTCo /the PCT /the Council are able to demonstrate that the New Project will provide value for money to the public sector
Section Seven: Financial Impact	2	The New Project can be delivered within the Affordability Cap
	4	LIFTCo /the PCT /the Council are able to demonstrate that the New Project will provide value for money to the public sector
Section Eight: Economic Case: Proving Value for Money	4	LIFTCo /the PCT /the Council are able to demonstrate that the New Project will provide value for money to the public sector

2.3. Project Background

In November 2010 NHS Hammersmith and Fulham submitted an Interim Stage 2 Business Case to NHS London for review. Feedback from the review led to:

- reconfiguration of the project management arrangements to ensure successful delivery of the project by forming an integrated project structure that better represents the collaborative nature of this project and the commonality inherent in the proposed content of the facility. This is illustrated in Section Ten.

  This approach has resulted in the minimisation of the risk of miscommunication of the project's objectives, better expresses the project's benefits to the local population and facilitates common ownership of the vision for local, integrated health and social care.

- enhanced common understanding of how the building will operate and better communication on issues such as ownership and contractual interfaces. This means that discussions on legal and commercial matters have been able to take place in an atmosphere of mutual cooperation that has reduced the length of time required to close out these requirements.

- the project development being consistent with guidance produced by the Department of Health and the Treasury, thereby minimising risk to the approvability of the project by NHS London, the Department of Health and the Treasury.

- enhanced communication with NHS London and the Department of Health in order to ensure that both approving bodies are conversant with the project and its objectives.

In terms of content of the facility, the vision remains the same and is referred to in more detail in Section 3. There have only been minor changes to the content of the facility that have arisen through more detailed analysis of epidemiology, demography, activity and capacity, together with greater progress on the elements of the Continuity of Care Programme which is the programme to integrate Social Care and NHS services (see Section Three).

Once services robustness was confirmed, a strong joint brief (Tenants' Requirements) was developed in order to provide the Key Performance Indicators (KPIs) that would allow the design to be developed and tested and to ensure the delivery of the benefits associated with the development.

More detailed interrogation of the structure of the overall development and associated costs, together with changes in policy at national level, have also resulted in a reassessment of the most appropriate procurement route. It has now been confirmed that the WCCCC is best delivered through the LIFT model, on Value for Money (VfM) grounds.

The table below summarises the activities that have taken place since the Interim Stage 2 Business Case was submitted.

Table 4: Activities

Dates	Activities
November 2010	Interim Stage 2 Business Case submission; focus on healthcare provision
February – March 2011	Review of proposals PID development and approval Appointment of joint advisory team, with the exception of legal advice Joint Project Team and Joint Project Board established
April – July 2011	Development of Approval Criteria Joint development of Tenants' Requirements Value for Money assessment of procurement routes Development of legal /contractual

	requirements Reviews of Financial Models and establishment of GMP Early design development Testing of proposals for ensuring VfM in construction, fit-out and Hard FM
August /September 2011	Appointment of Funder 1st stage construction contract tender Detailed design development Payment mechanism calibration Development of legal /contractual requirements Business Case development LIFTCo funding competition
October 2011	Detailed design development Agreement of Hard FM services Development of legal /contractual requirements Business Case development

The Joint Project Team has focused on:

- identifying clear rationales for clinical service provision and interfaces with social care needs
- developing strong relationships with LIFTCo and its design team
- developing robust Tenants' Requirements
- identifying key issues and putting in place the levels of support that it considers most appropriate to ensure the delivery of value for money solutions

More information on these approaches can be found in Section Ten of this document: 'Risk, Project Management and Benefits Realisation'.

3. Strategic Fit

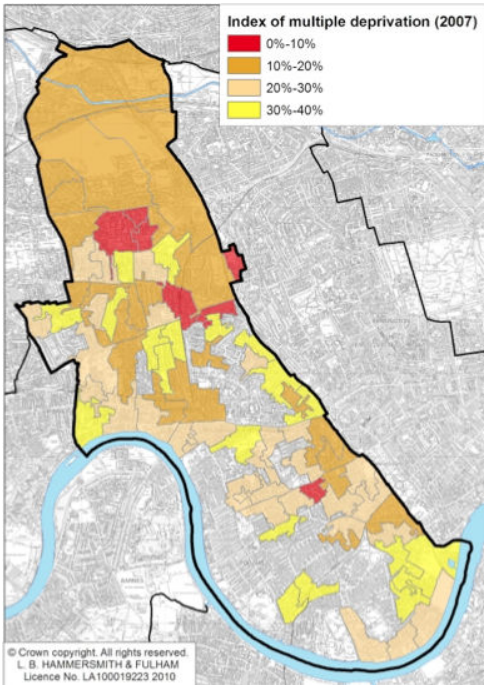
3.1 Introduction

The Joint Service Needs Assessment (JSNA) identified inequalities experienced by the residents in the north of the borough, and particularly White City, as:

- greater unemployment
- lower average incomes
- poorer education attainment
- poorer quality housing / overcrowding
- poorer access to health services

The Child and Well-being Index (2009) ranks Hammersmith & Fulham as the 23rd most deprived out of 354 local authorities in England

Figure 1: Map of deprivation in the London Borough of Hammersmith & Fulham



These inequalities manifest themselves in poorer health outcomes across a range of issues including higher levels of:

- heart disease
- respiratory disease
- teenage pregnancy
- diabetes
- depression

As an example the percentage of people diagnosed with coronary heart disease is significantly higher within the Wormholt & White City ward than in the rest of the borough.

This section sets out the broader context within which the development of the WCCCC is placed. It describes the overarching vision for the Council, and the strategy and programmes implemented to drive the delivery of the vision, in the context of local population health and social care needs.

The WCCCC forms part of a much larger programme of regeneration across the White City Opportunity Area. The housing element of the WCCCC proposal has been developed jointly with the Council's housing and planning services to ensure that it is specifically targeted to meet local need and the Council's physical regeneration plan. In line with the Council's targets, the WCCCC will feature a low-rise, mixed use development with an affordable housing element on the upper floors.

The development and submission of the Planning Application was completed in partnership between the Local Authority and the Developer, BBH.

3.2 The vision: Regeneration of White City

The Council and PCT share a vision for improving the health of White City residents. Public health information and consultation reveals a picture of poor health amongst White City residents that results in higher than average unplanned care admissions to hospitals, higher rates of chronic diseases and ultimately to a life span that is in parts 10% lower than the average for the borough. Further details of the epidemiology of the local population can be found in later on in this Section.

The Council's vision for White City is of a vibrant and creative place with a stimulating and high quality environment where people will want to live, work, shop and spend their leisure time. Regeneration will improve the physical environment, quality of housing and education in the area and create jobs that will be filled by local people.

The original strategy[1] contained a vision to create a borough of opportunity for all in an area with considerable deprivation. The key priorities in delivering this vision are:

- promoting home ownership
- regenerating the most deprived parts of the borough
- a top quality education for all
- setting the framework for a healthy borough
- tackling crime and anti-social behaviour
- creating a cleaner, greener borough
- delivering high quality, value for money public services

Further development of this vision has seen the announcement of a regeneration plan for the White City area.

[1] Community Strategy 2007

As an integral part of the development and ownership of this vision many local stakeholders contributed through various engagement fora. Core themes from public engagement that will be addressed by the White City Collaborative Care Centre development included the desire to see:

- modern fit-for-purpose buildings offering one-stop-shop support
- greater integration of health, social care and housing support
- improved quality of primary care (including access to out-of-hours and walk-in clinics)
- improved access to NHS dentistry
- improved access to mental health support
- better support for long-term conditions
- better information and sign-posting to relevant services
- services that promote health as well as treat illness
- better support for carers
- integration into the park

The approach adopted by the PCT and Council is fully consistent with the Sector's clinical strategy as well as the Council's Core Strategy (2010;Appendix 2) plus its 'Tri-Borough Service Plans and Proposals'. It will deliver the integrated approach to promoting people's independence and keeping them out of hospital.

3.3 Delivering the vision: Continuity of Care

Continuity of Care is an ambitious and complex programme covering all the main patient pathways. Its aim is to re-design existing pathways and where required design new pathways to create a seamless patient journey.

Development of these joint strategies has resulted in the inception of the Continuity of Care Programme.

There are a number of core strategic objectives for regeneration, many of which will be supported by the WCCCC development:

- Increase the supply and choice of high quality housing and ensure that the new housing meets local needs and aspirations, particularly the need for affordable home ownership and for homes for families.
- Ensure that both existing and future residents, and visitors to the borough, have access to a range of high quality facilities and services, including retail, leisure, recreation, arts, entertainment, health, education and training and other community infrastructure.
- Encourage and promote healthier lifestyles and reduce health inequalities.
- Protect and enhance the borough's open green spaces, promote biodiversity and protect private gardens.

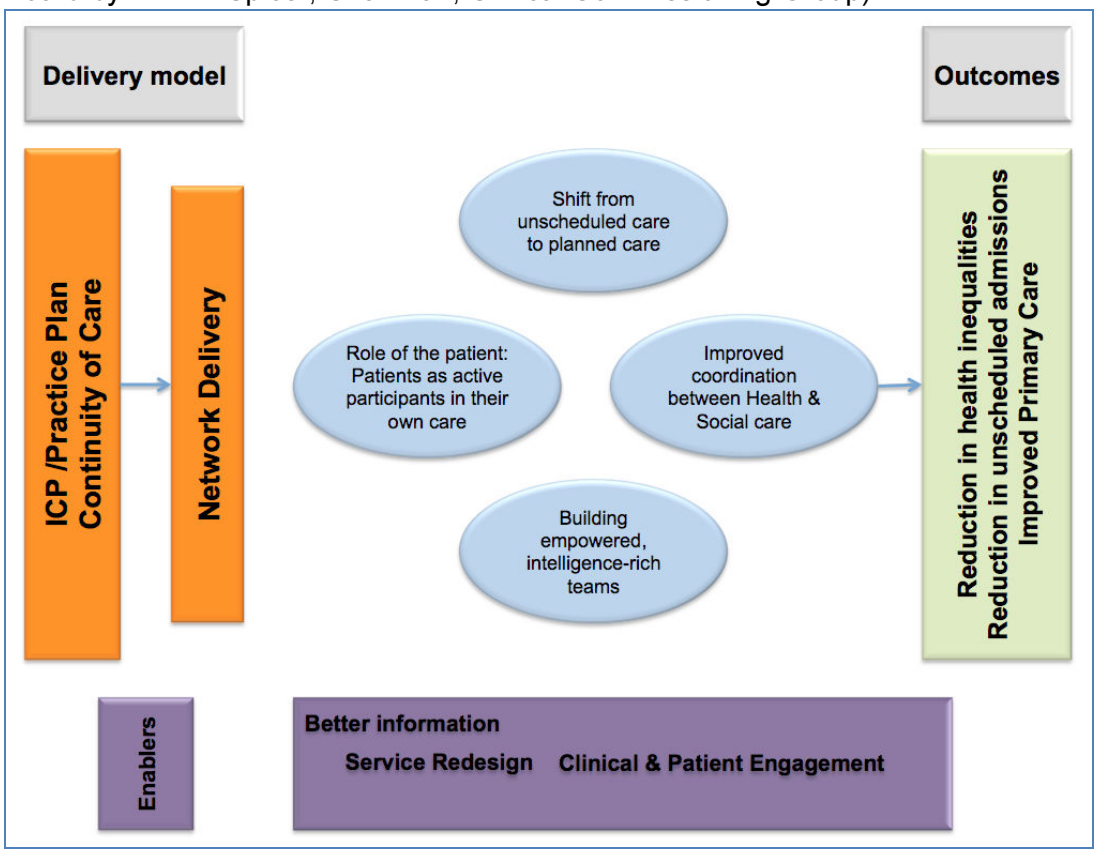
'Setting the framework for a healthy borough' is one of the priorities identified in Hammersmith and Fulham's Corporate Plan (2008-2011) and Community Strategy (2007-2014). These stress the need to reduce the use of more acute services by promoting healthier lifestyles and a healthier environment, and enabling independence for vulnerable residents through the provision of high quality, responsive health and social care services.

The Council's Community Services departmental plan (2008-2011) incorporates a vision for a neighbourhood approach to social care, as well as providing services that are integrated with the NHS to promote independence, responsibility and help residents reach their full potential.

The PCT's Commissioning Strategy Plan (2010-2014) sets out a programme to deliver the key goals of:

- enabling and supporting health, independence and well-being
- giving people more control of their own health and healthcare
- offering timely and convenient access to quality, cost-effective care
- proactively tackling health inequalities

Figure 2: Hammersmith and Fulham Aims for the delivery of Continuity of Care
(Source: 'Strategic Objectives – 2011 to 2015' presentation to the Health and Wellbeing Board by Dr Tim Spicer, Chairman, Clinical Commissioning Group)



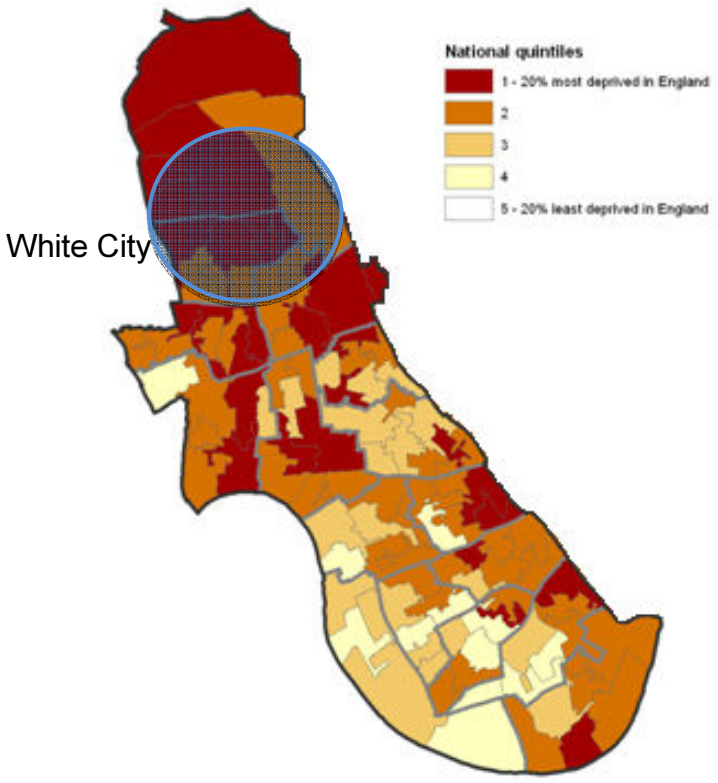
Since the establishment of the pathfinder Clinical Commissioning Group (CCG), Primary Care involvement and leadership in developing the Programme has grown. The commissioning intentions currently being drafted by the CCG include the following priority areas:

- developing integrated local delivery models
- shifting emphasis from unscheduled care to planned, personalised, pro-active care and support
- reduced reliance on acute services by moving care into the community and practice level

3.4 Service need

General assessment: The wards of College Park & Old Oak, Shepherd's Bush Green and Wormholt & White City are amongst the most deprived wards in Hammersmith & Fulham and nationally. The majority of areas within the wards sit within the most deprived quintile of areas nationally, and all areas within the wards fall into the most deprived 40% of areas nationally.

Figure 3: Index of Multiple Deprivation for Hammersmith & Fulham by National Quintiles (Dept. for Communities & Local Government, IMD2010)



The Northern wards of Hammersmith & Fulham generally have a high amount of Out Patient hospital attendances. In the financial year 2010/11, Wormholt & White City was the ward with the highest amount of Out Patient attendances.

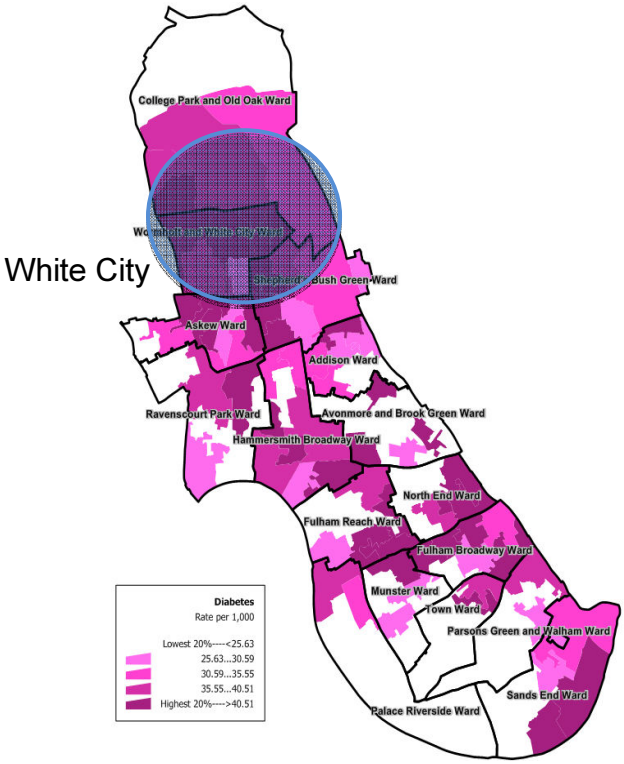
The Northern wards of Hammersmith & Fulham also have a high amount of hospital admissions. In the financial year 2010/11, Wormholt & White City was the ward with the highest amount of admissions, and Shepherd's Bush Green was the third highest.

In general, Hammersmith & Fulham has a low percentage of people living with a limiting long-term illness compared with London and England. However, all three Northern wards in the borough have higher than the average percentage of Hammersmith & Fulham residents with limiting long-term illnesses.

Also noteworthy is that, in the 2001 census, around 10% of those people living in the three Northern wards stated that their health was 'not good'. This was higher than the average for Hammersmith & Fulham, London and England.

Like many long-term conditions, the number of people diagnosed with diabetes is recorded by GPs. According to this information, some areas of Wormholt & White City and Shepherd's Bush Green have the highest prevalence of diabetes in Hammersmith and Fulham (Figure 4). Diabetes prevalence in north of the borough is higher than the average prevalence in Hammersmith and Fulham (33 per 1000), and London (32 per 1000).

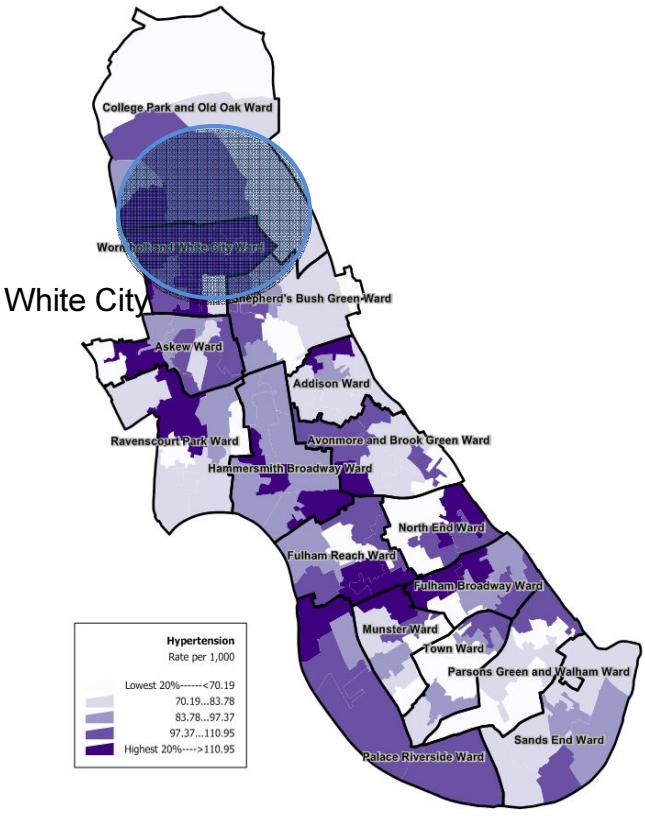
Figure 4: Map to show Diabetes prevalence in Hammersmith & Fulham (GP Data, 2011)



Persistent hypertension is one of the major risk factors for stroke, myocardial infarction, heart failure and arterial aneurysm. It is also a leading cause of chronic kidney failure. Moderate elevation of arterial blood pressure leads to shortened life expectancy. Dietary and lifestyle changes can improve blood pressure control and decrease the risk of associated health complications, although drug treatment may prove necessary in patients for whom lifestyle changes prove ineffective or insufficient.

In Hammersmith and Fulham, high prevalence of hypertension can be observed in Wormholt & White City (Figure 5). The prevalence in this area is higher than the average for Hammersmith and Fulham (95 per 1000) and London (109 per 1000).

Figure 5: Map to show Hypertension prevalence in Hammersmith & Fulham (GP Data, 2011)



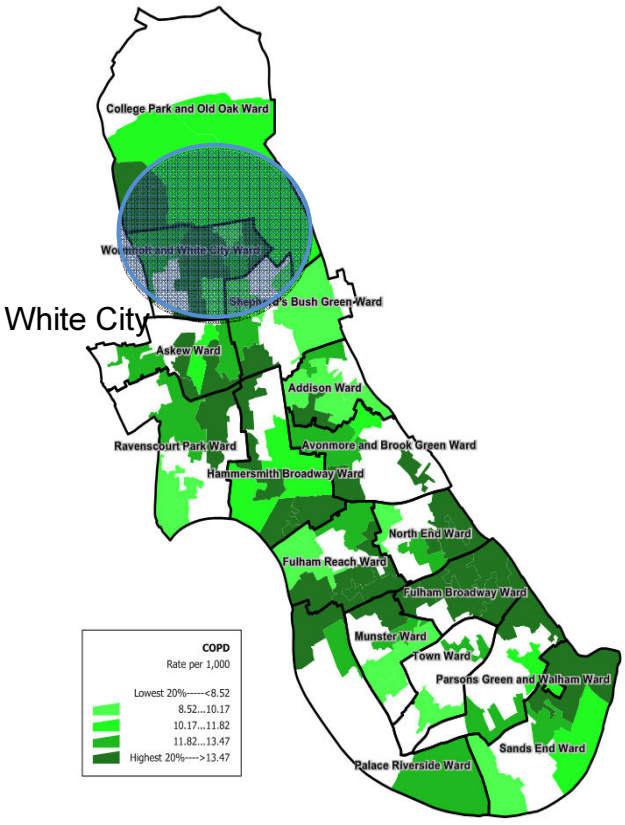
Chronic obstructive pulmonary disease (COPD) is a general term that includes conditions such as chronic bronchitis and emphysema. COPD can cause obstruction (narrowing) of the airways. In the UK, it is estimated that three million people have been diagnosed with COPD and another half million people have the condition but have not yet been diagnosed. COPD mainly affects people over the age of 40 and becomes more common with increasing age. It is more common in men than women.

The economic impact of COPD is significant. COPD accounts for more time off sick from work than any other illness; and it is one of the most common reasons for admission to hospital in UK (1 in 8 admissions are due to COPD).

Smoking is the cause of COPD in the vast majority of cases. About 15% of people, who smoke 20 cigarettes per day, and a quarter of 40 per day smokers, will develop COPD if they continue to smoke. Air pollution and polluted work conditions may also cause some cases of COPD, or make the disease worse.

COPD prevalence both in London, and in Hammersmith and Fulham is 10 per 1000. However, some parts of Wormholt & White City and College Park & Old Oak wards have the highest prevalence of COPD in the borough.

Figure 6: Map to show COPD prevalence in Hammersmith & Fulham (GP Data, 2011)



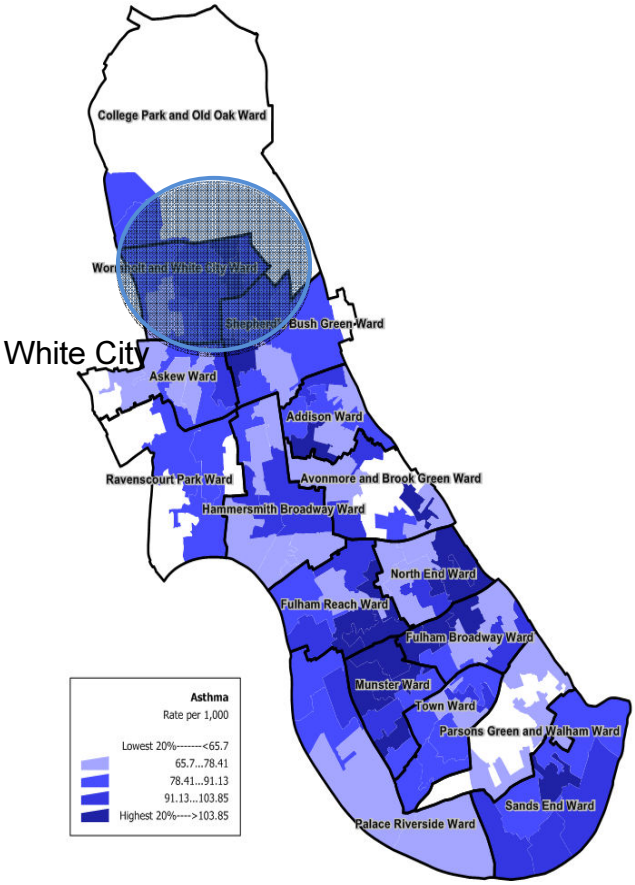
Like COPD, asthma is a condition that affects the airways. Asthma is caused by both genetics and environmental factors. There are often triggers in the environment that can result in a flare up of symptoms:

- respiratory infection - such as a cold or flu
- irritants - such as dust, cigarette smoke and fumes

- chemicals (and other substances) in the workplace - known as occupational asthma
- allergies to pollen, medicines, animals, house dust mites

Asthma prevalence in London is 48 per 1000 and 47 per 1000 in Hammersmith and Fulham. Some smaller areas of northern wards of Hammersmith and Fulham have significantly high asthma prevalence, nearly three times the rate of London as a whole.

Figure 7: Map to show Asthma prevalence in Hammersmith & Fulham (GP Data, 2011)



Further information: Appendix 3 to this Business Case contains a public health report providing more details on the demographics and clinical need of the population of the northern part of Hammersmith & Fulham.

Families and young people: The north of the borough experiences particular health inequalities for families and young people. The majority of families and young people living in the borough are resident in the north of the borough. In the ward of Wormholt and White City 25.5% of the population is aged 18 or under, much higher than other parts of the borough and England averages.

Hammersmith and Fulham's Children and Young People's JSNA 2010 identified that morbidities are distributed unequally in low-income families and BME children and that much ill health consists of clinical manifestations of social, economic and cultural determinants. The main morbidities are:

- chronic diseases in about a quarter of children, particularly high rates of eczema, asthma and respiratory illness
- high levels of obesity and malnutrition
- poor dental health, with dental caries the top cause of elective hospital admissions for children and young people
- physical & learning difficulties
- psychological and emotional morbidity
- STIs and other forms of sexual ill health

Accident and emergency use and emergency admission is higher amongst children living in the most deprived communities and a local priority is to reduce children's use of unscheduled care and hospital attendance.

Children in the area experience low levels of wellbeing (0-20% on the Child Well-being Index 2009) and higher rates of ill health.

A review of the local needs of disabled children was completed in February 2010. In summary:

- there are approximately 700 disabled children living in the borough
- of those, around 500 would meet thresholds for local services
- most families reside in the centre or north of the borough
- there are more male than female disabled children
- autistic spectrum disorder, learning difficulties and disabilities and speech, language and communication needs represent highest areas of needs
- many children have multiple needs (i.e. 2 or more disorders)

Approximately 180 Hammersmith & Fulham children were assessed as needing a joined up assessment or review from the local children development service in 2009/10. This included:

- 110 children who required a multi-disciplinary assessment (MDA)
- 150 disabled children were referred for speech and language therapy (SALT) as part of an MDA
- 486 children were referred for SALT under 5 with over 3,600 sessions delivered
- approximately 250 children were referred to the special school SALT team with around 1,750 sessions delivered
- the occupational therapy caseload is around 230 children, with over 1,000 face to face contacts
- 2,648 physiotherapy appointments were delivered

Referrals to all services have grown over recent years.

Planning for population growth: the Hammersmith and Fulham population is expected to grow in size by 6% by 2016, and by 12% in total by 2028, with implications for all agencies providing and commissioning services. The growth in the middle-age population (40-55) may cause an increase in demand for services to support with the treatment and management of chronic diseases, and the increase in numbers of older residents will cause an increase in demand for social care provision. With this population projection in mind, the design specification for the WCCCC includes a requirement for flexible, multi-use spaces within the building to allow for service expansion and development over time. This design requirement also meets DH criteria for ensuring a high degree of flexibility in capital investments to allow the PCT and the Council to respond to changing needs.

Prevention and early detection – Prevention is a long-term approach to reducing the prevalence of chronic health conditions and reducing pressure on acute front-line services. The combination of delivery of mainstream services with the provision of information, advice and guidance is intended to keep people well and help people to manage their long-term conditions better.

Taking a whole systems approach to the causes of ill health – The JSNA identifies priority areas for health and wellbeing outcomes in Hammersmith and Fulham as CVD, cancers, mental health, HIV, TB and excess winter deaths and outlines the key determinants (education and continuous learning, safety and social cohesion, environment, housing, employment, regeneration) and lifestyle factors (smoking, food and fitness, alcohol) influencing these. A review of the working practices of health, adult social care and voluntary sector service providers, followed by their co-location in a single building at the WCCCC, will ensure seamless integration of front-line provision from the Centre and reflects the importance of collaborative working between service providers.

Taking a neighbourhood approach to overlapping needs – The Mosaic segmentation tool identified many instances of overlapping need in the borough. Overall, deprived families in public sector housing and poorer minority families have the highest needs and worst health outcomes. Multi-disciplinary teams at the WCCCC will deliver a common assessment process leading to person-centred planning and self-directed care, whilst co-location of health, social care and voluntary sector services together on one site will enable people to move promptly through evidence-based 'pathways' of support. By managing complex/ overlapping cases in a co-ordinated way, more personalised care will be achieved, which will in turn reduce the use of acute services and reliance on long term care.

Plans for joint commissioning: The Prevention Strategy underpins the key objectives of the joint commissioning strategies. This strategy that ensures people are supported early in their care pathway to manage in the community and as independently as is practical with appropriate support. The strategies include a focus on the integration of health and social care teams to ensure that there is not duplication in provision and that transition, where necessary can be managed seamlessly.

The PCT has an excellent working partnership with the Council. The commissioning organisations have developed three key joint commissioning posts: mental health and learning disabilities, physical and sensory impairment and carers.

There is already an increased focus on realigning existing resources to facilitate improved outcomes through service redesign, rather than looking for new money to fund new initiatives.

The co-location of local primary care and mental health services will also provide opportunities to make further progress locally on the mental health National Service Framework. For people with depression or anxiety, primary care psychological therapy services will become much more accessible. Early intervention services, which work with individuals with the early symptoms of psychosis, will work closely alongside GPs to identify referrals and prevent deterioration in the condition.

Furthermore, with broader multi-disciplinary support available to GPs, it is anticipated there will be a reduction in formal referrals to secondary care. Discharges back to primary care will also be facilitated, thereby promoting a more recovery-based model of care.

These analyses reveal the need for a focus on delivering services to the population of White City that proactively support the prevention of ill health, and emphasise the expenditure of resources on identification and delivery of care to high-risk patients. The impact of this will be to empower people to manage their own health needs, reduce the risks of requiring hospital-based investigation and treatment and thereby reduce expenditure on acute-based care. This is the premise on which the Continuity of Care programme is based.

Without 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.

3.5 Facility need

Both organisations have programmes that link service development plans and estates /asset strategies (see Appendix 2 and Appendix 4).

The programmes respond to the following service drivers:

- that routine healthcare should be provided as close to people's homes as possible, while the most complex healthcare for major trauma, stroke and heart attack needs to be centralised to provide the best quality service
- that integrated services with greater responsiveness and a pro-active approach to Chronic Disease Management should reduce the number of unplanned hospital attendances and admissions

- that many of the current outpatient appointments taking place in hospital could be provided by GPs or nurses, and that where specialist outpatient care is needed should be provided as locally as possible, which will require clinicians to provide outpatient clinics in the community
- that centres should be developed that offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals

The core principles that underpin the estates strategies are:

- services should be designed for the convenience of patients and not for the convenience of the PCT or any particular staff or service group.
- services should be easily accessible
- services should be as close as possible to where people live. However, it should also be recognised that some complex services are best provided in larger units and therefore there may need to be a compromise on proximity in order to ensure clinical quality
- there should be a reduction in health inequalities; this is likely to entail an increase both in the quality and quantity of service provision in more deprived areas, and the corresponding need for a change in the nature and size of the estate from which current services are delivered
- services should be locally sensitive; this may mean different service provision and therefore different Estates requirements in different parts of the borough
- there should be an increased emphasis on ill-health prevention and self-help; this also is likely to extend requirements for community-based facilities
- the buildings used should also be good places for staff to work allowing the PCT to attract and retain the best staff

There are a number of factors that act as barriers to delivering the model of health and social care required by the White City population. The key barriers are:

1. Out-dated premises that fail to comply with current access requirements and act as a deterrent to service improvement
2. Wide variation in general practice quality
3. Lack of space to accommodate shifts of services from secondary to primary healthcare settings
4. Limited opportunity to co-locate services to support access and integrated working

The PCT's estates strategy envisages 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. There is no further space to expand at the Hammersmith site and the hospital is not as well served 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 via the extensive public consultation.

The PCT commissioned a study of potential locations for a centre that can deliver the services required to support the delivery of the Continuity of Care programme. A copy of this report can be found at Appendix 5. Site search criteria were provided and a combined desktop /physical site inspection approach were undertaken. Four potential sites were identified that were then explored in further detail. The result was that none of the sites were considered capable of delivering requirements during the timescale available due to a range of constraints.

The result of this exercise confirmed that the multi-use complex planned for the Blomfontein Road site was the only realistic option for location of the facility. Delays already experienced in developing the proposal have already meant that temporary locations have had to be found from which to deliver some primary /community care services to local people.

Temporary locations to be replaced by WCCCC

- the Canberra Centre for Health – a new practice which opened in January 2010 to boost general practice capacity in the area.
- the Canberra Dental Centre

Both of these facilities are located on a school site whose use will revert to playgrounds when the move takes place. There will therefore be no capital income available to inject into the WCCCC project once transfer takes place. There will however, be no double running costs for these contracts as contractors are aware of the potential for transfer to the new building and the building leases were set up with a break clause for when the new building becomes available.

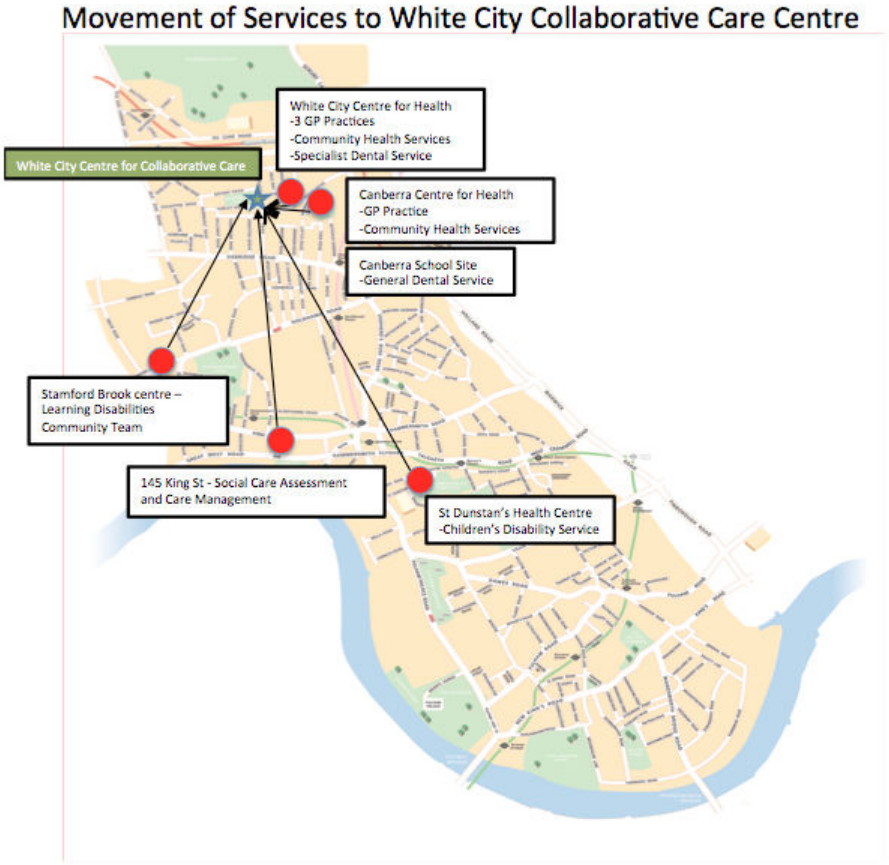
Unfit locations to be replaced by WCCCC:

- current White City Health Centre – housing three GP practices and a range of community care clinics and team office space. The sale of this site could release some capital, although such a sale could not take place until after the premises have been vacated
- the Milson Road Health Centre – which used to house a range of community care services. These services have transferred to temporary accommodation at Canberra School, White City Health Centre and White City Community Centre. Canberra can only be used for a further three years. Some residual services are still there but will move to a central hub at Charing Cross Hospital before transferring to White City. The PCT expects to sell Milson Road in April 2012
- St Dunstan's Health Centre – housing specialist community services for children with disabilities. Service requires more space and better facilities. This is a leasehold property that the landlord wishes to reclaim to develop for other

purposes. There will therefore be no capital income available to inject into the WCCCC project once transfer takes place

The map below identifies all of the services that will move into the WCCCC on its completion.

Figure 8:



The development of the WCCCC will support the Continuity of Care Programme by:

- providing the capacity to manage a greater number of patients and range of conditions within the community
- providing an environment that supports:
    - integrated working in multidisciplinary teams
    - supports secondary care clinicians working productively outside hospitals
    - for conditions that need both GP and hospital support designing the 'care pathway' so as much care as possible is available outside hospitals
- improving the quality of GP and community care health estate in the area
- enabling General Practice in the area to expand the range of services available to patients locally

Service and facility need across the period of the LPA: Section Four of this business case sets out in detail the services proposed for inclusion in the WCCCC. The proposed period of the LPA is 25 years. The PCT and the Council assume, on the basis of projections of increased demand associated with the specified client groups, that use of the proposed facility will continue at full capacity, with increasing provision of home-based care over time and as integrated care models and shifts of activity from acute to community settings develop.

Public sector land use and compliance with the PCT's estates strategy: The PCT can confirm that it will comply with the principles of 'Estatecode' and 'The Register of Surplus Public Sector Land – Inclusion of NHS Land' when disposing of any land.

3.6 Business Case assumptions and constraints

This sub-section summarise the basis on which the business case has been built and the impact on other services.

Over the last year, clinicians, managers and patient representatives in North West London have developed a 4-year Strategic Commissioning and QIPP (Quality, Innovation, Productivity and Prevention) Plan to 2014/15. This has involved the:

- development of a case for change
- using benchmarking and case studies to set priorities
- development of models of care aligned to the settings in which they could be delivered
- review of the impact of proposals on provider clinical and financial viability
- development of high level implementation plans
- development of detailed plans for 2011/12

The strategy is based on a robust case for change that was developed by over 100 senior leaders within North West London. The key constraint to addressing the case for change is financial. Under the local scenario, North West London will need to close a projected £1bn funding gap if there is no change in the demand for care and the way it is delivered. Through the case for change, opportunity analysis and engagement processes, key priorities have been identified, each with underpinning initiatives:

- areas with opportunity to improve quality and patient experience, and make significant QIPP savings:
    - urgent care
    - planned care
    - mental health
    - end of life care
    - acute contracting/procurement
    - prescribing
- key enablers to improving quality and patient experience and to making QIPP savings:
    - primary care

  - long term conditions
- areas that are a priority for quality improvement but not significant QIPP opportunities:
  - specialist services
  - staying healthy
  - maternity & newborn
  - child health

The strategy will impact on all providers:

- a reduction in income for acute providers from £1.5bn in 2010/11 to £1.23bn in 2014/15 due to de-commissioned services and service re-provision although some of this money is expected to be re-invested in hospitals
- acute providers also need to make a 4% year-on-year efficiency saving, becoming more efficient in providing the activity that remains with them
- a consolidation of some services and localisation into the community of others will mean the movement of income and services between providers
- non-acute providers will need to be more productive and efficient, such that they can either contain activity at current levels and cost or provide additional activity (excluding demographic growth) at current price levels

This means that:

- some services will need to be consolidated onto fewer sites
- hospitals will need to reduce capacity as less activity is provided on hospital sites
- staff may need to work differently in the future, especially working more closely with colleagues in different care settings, providing more outreach services and support in the community
- some trusts will struggle to respond to efficiency pressures impacting on financial or clinical viability and will need to look at options such as merging with other organisations and/or putting in place network support arrangements with other trusts
- providers of out-of-hospital services will need to work together to provide out-of-hospital care more efficiently and reduce demand for activity through joint working

Two additional initiatives, elements of which cross-cut the Continuity of Care programme, are the Integrated Care Pilot (ICP), which is being delivered across North West London, and the QIPP programme which the PCT is responsible to the Cluster to deliver. In principle the ICP shares the same vision as Continuity of Care, across a wider footprint but with a narrower focus of care limited to diabetes and the frail and elderly, who account for 10% of the population but absorb 28% of the spend on healthcare in North West London. The engagement of the majority of Hammersmith and Fulham Practices in the ICP (including all of the practices planned to move in to the White City Collaborative Care Centre) alongside Central London Community Healthcare, Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust means that there is a broad strategic coalition focused on improving services that prevent admission

to hospital. The pilot programme, based on US Integrated Care Organisations, sees the formation of multi-disciplinary groups typically covering 40,000 patients, proactively managing the care of the most vulnerable patients through integrated care planning processes and resource allocation.

The financial context of the current environment demands significant cost savings from organisations across the health economy. Integrated care provides a win-win solution – through working together providers can create savings of approximately 10% in the two pilot pathways which can be shared between commissioning and providing organisations, allowing commissioners to deliver healthcare within budget while providers are able to avoid price deflation by reducing unnecessary hospital care. These benefits can be realised in both the short and longer term. Initially the majority of savings will be seen in the high-need, high-cost patient segments. In the longer term, as efforts in primary prevention and overall well-being pay dividends, the number of people developing medical conditions later in life will be reduced. Modelling, based on the improvements made in other systems, shows that an IC pilot covering the whole borough population could reduce health and social care spend for people with diabetes by £1m after 1 year, and a further £2.4m after 5 years, and for the elderly by £3.5m after 1 year, and a further £2.7m over 5 years. Further modelling suggests this would mean a reduction in emergency admissions of around 650 admissions across the borough population.

The Continuity of Care programme aims to accelerate aspects of delivery that will enable Hammersmith & Fulham to meet the outcome targets of the ICP, whilst maintaining its overall objective to integrate health and social care. Integrated primary and community health and social care has been evidenced as a patient centred approach to delivering care within a system that improves the experience for patients, achieves better outcomes for service users and patients, and enables limited resources to go further.

The table below shows how the Continuity of Care approach responds to the White Paper themes.

Table 5: Continuity of Care and the White Paper themes

White Paper theme	Continuity of Care
Putting patients and public first	• Redesign of clinical services – 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, with 4 of the 9 local GP practices based at the Centre • Increase in capacity and capability in primary and community care 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

White Paper theme	Continuity of Care
	care available to patients without having to be referred to hospital
Improving healthcare outcomes	• Improvement of prevention and early detection for those most at risk – 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 • Creation of integrated teams offering patients a simple holistic service – integration will occur between secondary and community health services and across health and social care boundaries
Autonomy, accountability and democratic legitimacy	• Supports GPs as commissioners 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
Cutting bureaucracy and improving efficiency	• 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

The White City Collaborative Care Centre (WCCCC) will provide a single point of access for local people to get all their needs met for community health care, social care and housing support. The intention is to ensure that people achieve maximum independence, by combining health and social care teams to create a single assessment and care management process, ending duplication and multiple visits, and leading to a reduction in both expensive acute care costs, and in high cost social care.

The development of the WCCCC will support the Continuity of Care Programme and wider North West London Strategic QIPP Plan by:

- providing the capacity to manage a greater number of patients and range of conditions within the community
- providing an environment that support integrated working in multidisciplinary teams, and supports secondary care clinicians working productively outside hospitals

- improvements to GP surgeries and health centres, refurbishing or relocating services from the buildings not fit for purpose to modern sites
- ensuring consistently high quality services are available across all local GP surgeries
- expanding the range of services from GP Practices available to patients locally
- linking health and social care services so people who need help to know who is responsible for their care
- for conditions that need both GP and hospital support designing the 'care pathway' so as much care as possible is available outside hospitals

The pilot is being designed based on the assumption that whichever parties have more of the downside risk will receive more of the upside reward. These financial assumptions are shown in the table below:

Table 6: Continuity of Care Financial Assumptions

Item	Amount £m	Assumptions
Commissioners' desired savings for diabetes and elderly care of the pilot population	11	The difference between what the IC would need to be paid for diabetes and elderly activity at 3.9% growth (£194 million) and what the providers would be expected to be paid under integrated care improvements for a population of 380,000
Spend for additional out of hospital activity	-2.05	Financial modelling estimates an additional £2.05 million of out of hospital activity in 2011/12 in order to begin making reductions in acute activity
Management costs of the IC pilot 4	-1.6	In future this will be paid by the providers, but in the initial year they will need financial support to cover the transition costs (staff to run the pilot)
Incentive payment for integrated care pilot providers	-3	This incentive amount is set at 1.6% of the total amount of resource expected to be utilised in the pilot (£179), comparable to similar incentive percentages (CQUIN,LES)
Commissioner savings at the end of 2011/12	3.55	

The key strengths of the pilot include:

- early release of secondary care funding to support primary care transformation
- aligning financial incentives to support collaborative working
- creating MDT working to facilitate timely decision making and action
- speeding up information exchange between services and providers

The pilot objectives represent a subset of the wider 'continuity of care' transformation agenda in Hammersmith and Fulham, which is being developed with the active engagement of general practice.

The financial modelling for this business case can be found in Section Seven, Financial Impact.

Impact on other NHS bodies: Where services are the same as those that are delivered in an acute setting and are consultant led, the PCT will look to achieve productivity gains through more effective commissioning of the services and greater integration with other services to smooth the patient journey along care pathways and enhance the local integrated approach.

Outlined below are the key impacts that it is expected the development will have across the provider landscape:

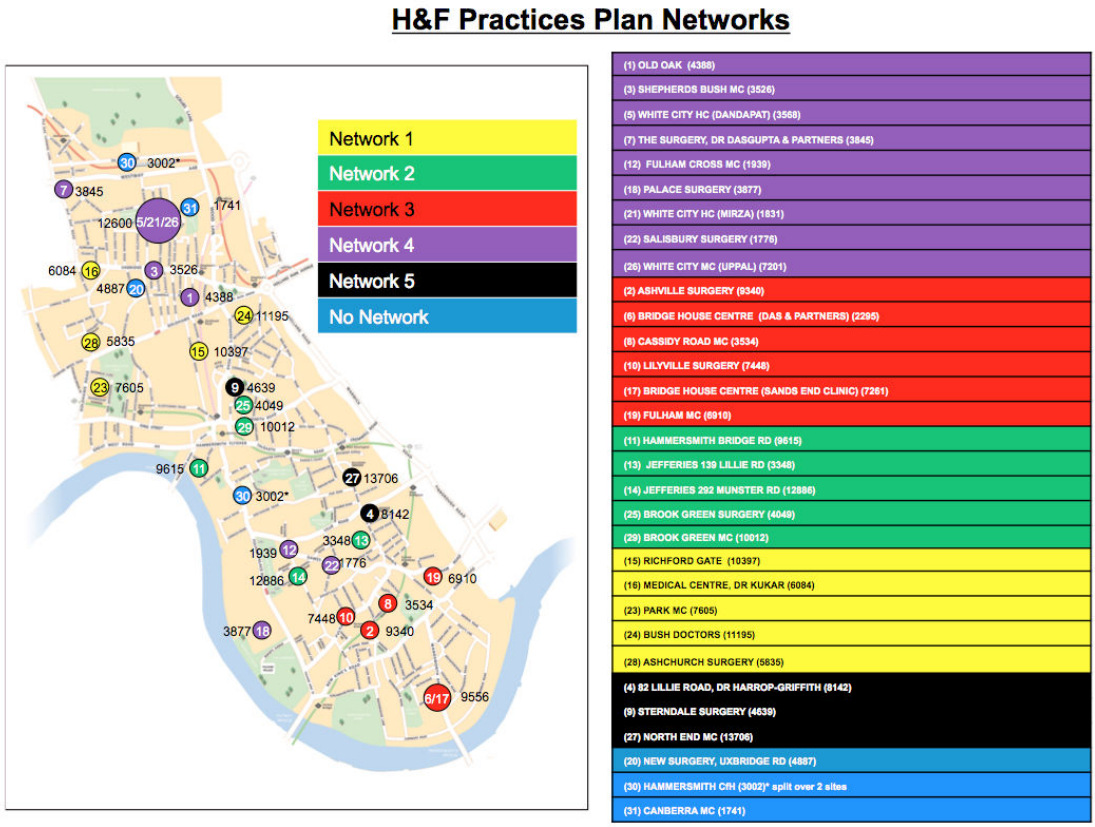
General Practice: The White City population requires a new model of care to support its needs. The model must provide proactive high quality integrated care services available in the community. Without this, health and social care spending on emergency and unscheduled interventions is likely to continue to rise without any positive impact on the health and well-being of the population.

The 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.

The four practices identified to move into the WCCCC support the proposals and have agreed to the relocation. The primary care services located at WCCCC will have capacity to serve a total population of around 25,000 people.

NHS Hammersmith and Fulham has worked closely with GPs across the borough to drive up the quality of primary care and address a range of infrastructure issues. Considerable improvements in quality have been delivered through programmes such as QOF+ (a local enhancement to the Quality and Outcomes Framework). Elsewhere in the borough numerous GP surgery refurbishments and relocations have addressed poor quality premises.

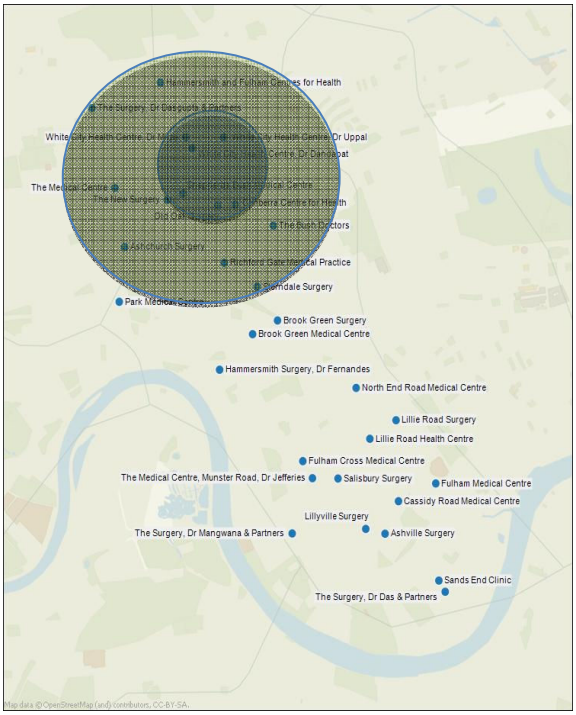
Figure 9:



Individual GP practices have chosen or are choosing to join to one of 5 neighbourhoods based on populations of 40,000 to 50,000 patients. The network that covers White City is Network 4, which currently provides services to a list size of 31,951 people. Delivery of the WCCCC will ensure that additional populations will have access to enhanced community based services so that the total population with access to these services rises to between 45,000 and 51,000 (see diagram below).

Strengthened clinical leadership and collaboration driven by the development of local service networks will raise overall standards of care.

Figure 10: Catchment area for the WCCCC



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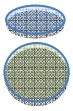


White City catchment area

Prospective catchment area for specialist community services

Multi-disciplinary health and social care teams at the WCCCC will deliver a common assessment process leading to person-centred planning and self-directed care, whilst co-location of health, social care and voluntary sector services together on one site will enable people to move promptly through evidence-based 'pathways' of support. By managing complex/ overlapping cases in a co-ordinated way, more personalised care will be achieved, which will in turn reduce the use of acute services and reliance on long term care.

Acute Hospitals: Imperial College Healthcare NHS Trust provides the bulk of acute hospital services to local residents. The WCCCC will support strategic plans to shift activity out of acute settings, and therefore has the potential to affect the trust's income streams. However, the Trust's wider strategy is to become focus on specialist acute services and has indicated a willingness to work with commissioners to shift suitable activity into new community settings, either through Trust teams working in the community or the re-provision of services from alternative providers.

Community Care: Central London Community Healthcare NHS Trust is the local provider of community services. The trust is keen to develop specialist community based nursing and therapy services, and needs better estate to provide such services from. The statements of support provided in Appendix 1 confirm that CLCH is confident the development will have a positive impact on their work.

Mental Health: West London Mental Health NHS Trust provides the majority of mental health service to local residents. The WCCCC development will support the Trust to deliver improved community based services and have a positive impact on their ability to support people in an area of high incidence of mental health problems. A statement of support is provided in Appendix 1.

NHS Dentistry: Increased capacity for NHS dentistry has been commissioned in the area through a new practice housed in temporary accommodation. The WCCCC will provide the opportunity for the provision of more comprehensive dentistry services.

Impact on the third-sector: These are voluntary or non-profit organisations for which the development of the WCCCC presents new opportunities. The facility will provide space and sessions for:

- expert patients' programmes
- interpreter and Advocacy Services
- welfare rights and citizens' advice
- self-help groups
- Alternative Health provision
- space for voluntary groups to meet (Community Seminar rooms)

Interactions with the independent sector: The commissioners of services will rely on a combination of the following priorities in determining any requirement for services provided by the independent sector, in line with the 'any qualified provider' concept:

- priorities for identification of need, arising from epidemiology and demographic data
- prioritisation in line with the Continuity of Care programme
- feedback from the local networks of local need
- quality assurance parameters applied to existing services providers

Third party income: The original proposal for the facility included provision of a pharmacy. Further investigation of local provision found a number of pharmacies in close proximity to the new facility so an integrated pharmacy has not been provided. However, there is the opportunity to locate a pharmacy in the adjacent new build retail area. Any decision on whether or not to provide an adjacent pharmacy will be dependent on the Council's more detailed plans for regeneration of the White City area. Should a pharmacy be provided in the future, it has been agreed between the PCT and Fulcrum that the PCT will be entitled to half of the premium received for the lease and the rent over and above the first £12,000 a year will be shared on a 50:50 basis with the PCT. The PCT's proportion will

be converted into a single payment by calculating the Net Present Value (NPV) of the PCT's share of the rent and this will be paid within 30 working days of the pharmacy lease being completed.

3.7 Stakeholder involvement

A wide range of stakeholders has been involved in the development of the WCCCC proposals from its initial conception. The local communities which the centre will serve, the providers who will be based there and those potentially impacted by the related care pathway redesign have all been actively engaged.

Our engagement work ensures that stakeholders are kept abreast of and able to influence decisions about the development, aware of any changes to the proposals, and briefed on the involvement opportunities there are as the scheme develops.

A programme of consultation and engagement has been maintained with residents in the White City and surrounding areas over a number of years. Engagement has covered both specifics of the centre itself and the wider health and development needs of local communities. A summary of the main engagement activities is given in Appendix 6.

The feedback has been influential in designing plans for how the centre will operate and which services will be available. Temporary services put into the area in the interim have specifically responded to the needs identified by local residents and joint strategic needs assessments for the area.

Core themes from public engagement that will be addressed by the WCCCC development include the desire to see:

- modern fit for purpose buildings offering one-stop-shop support
- greater integration of health, social care and housing support
- improved quality of primary care
- improved access to NHS dentistry
- improved access to mental health support
- better support for long-term conditions
- better information and sign-posting to relevant services
- services that promote health as well as treat illness
- better support for carers

The PCT and the Council also want to ensure that residents and other key stakeholders continue to be involved in the WCCCC development and a forward looking communications and engagement plan is being developed for the next phases work through to completion and service launch.

3.8 Equality Impact Assessment

An equality impact assessment form has been completed, and is included in Appendix 7. This concludes that a full equality impact assessment would go over ground that has

already been covered through needs assessments and numerous engagement exercises, and is not recommended at this point.

However an engagement plan should be established that presents the latest WCCCC plans to the local community and explains why some of the original features of the Centre are no longer viable. This will ensure that the PCT and the Council are meeting their duties to consult, engage and feedback under the Health and Social Care Act. The dialogue can then move on to how to make the final services as effective as possible for local residents. This recommendation is supported by the PCT and an engagement plan for the next phase of work is being developed (see section 3.7).

4. Service Delivery

4.1. Introduction

This section sets out the range of policy and strategic objectives for the NHS and Local Authority that will be supported by the building the White City Collaborative Care Centre. The development will help deliver on a broad range of priority issues ranging from reducing health inequalities and improving health, to designing integrated care pathways, through to improvements in social care services and the regeneration of the borough's most deprived areas.

The project was subject to a stringent audit at the beginning of this year, which resulted in adjustments to the services to be provided at the facility. The review resulted in a revision of spatial requirements driven by the developments in Continuity of Care and a focus on client facing services in order to maximise the impact on the health and well-being of local people. Office accommodation is now only included where it is essential to the delivery of integrated care pathways. The table below summarises the changes and associated rationales.

Table 7: Services delivery developments

Original services requirement	Revised services requirement	Change	Rationale for change
Primary Care			
Urgent Care		Included in Primary Care	Extended opening hours of Primary Care
Minor surgery		None	
District nursing and specialist nursing services		None	
Podiatry		None	
Leg ulcer clinic		None	
Psychological therapies		None	
Family planning		None	
Maternity services		None	
Dental Services		None	
Diagnostic services			
X-ray		Excluded	Insufficient demand
Mammography		Excluded	Provision now established elsewhere
Ultrasound		None	
ECG		None	
Phlebotomy		Not to be provided as a separate service but by the GPs as is currently the case	
Pharmacy		Excluded	Four pharmacies within walking distance of the facility
Integrated Adult and Children's Social Care		None	
Housing services	Internet access points to broader range of social care services including housing		Housing service will continue to be provided from King Street consistent with the Council strategy
Learning Disabilities Community team (joint with health)	Children with Disabilities Services	None	
Learning Disability Day Services	Children with Disabilities Services	LD day services will be provided elsewhere	CWD is an Integrated health & social care team; Client-facing sessions to be held at WCCCC. LD day services are

			not a core local authority function and are being outsourced.
Independent Living Service for younger disabled people	Children with Disabilities Services	Office accommodation to be based elsewhere	Integrated health & social care team; Client-facing sessions to be held at WCCCC.
Physical Disabilities Teams		Office accommodation to be based elsewhere	Integrated health & social care team; Client-facing sessions to be held at WCCCC
Community Mental Health Team that serves the north of the borough		Office accommodation to be based elsewhere	Client-facing sessions to be held at WCCCC
HAFAD, the combined Welfare Rights and Disability Benefits project, and other voluntary sector partners, for example MIND and MENCAP		Office accommodation to be based elsewhere	Client-facing sessions to be held at WCCCC
Drugs and Alcohol service		Excluded	Provided elsewhere

4.2. Mapping Continuity of Care to the provision of services at the White City Collaborative Care Centre

The council's Mosaic segmentation tool identified many instances of overlapping need in the borough. Overall, deprived families in public sector housing and poorer minority families, the two groups concentrated in the north of the borough, have the highest needs and worst health outcomes.

In order to address this overlapping need, NHS Hammersmith and Fulham and the London Borough of Hammersmith & Fulham have made significant progress in integrating commissioning teams in order to support the delivery of the Continuity of Care programme. Initial work led to the creation of a joint children's commissioning team sitting within the PCT. Since PCT clustering and Tri-Borough agreements between H&F, K&C and Westminster councils this has developed to include integrated adults commissioning teams.

Integrated care: The Continuity of Care Programme represents the vision of the Borough Executive of Hammersmith and Fulham for the delivery of integrated services across Health and Social Care. The Borough Executive comprises the Clinical Commissioning Group for Hammersmith and Fulham (which represents all 31 GP practices in the area), the London Borough of Hammersmith & Fulham and the PCT Borough Director.

Work on reducing avoidable acute care contacts commenced with the Integrated Care Pilot; a partnership between acute hospitals, community trusts, GPs, and Local Authorities. The objectives of the pilot are to provide integrated pro-active delivery of planned care to patients with diabetes and frail elderly patients in order to reduce unscheduled secondary care, reduce lengths of stay where hospitalisation is required and improve the quality of care to patients. This initiative has been running for some time and continues as part of the broader Continuity of Care programme. More detailed information on the Integrated Care Pilot is available at Appendix 8.

The WCCCC will support the delivery of integrated care by providing capacity for community based multi-disciplinary assessments and acting as a one-stop-shop location for the bulk of appointments patients require across the range of acute, primary, community and social care services. For diabetes in particular this model of working relies on the enhanced community based services that have been implemented and will move into the WCCCC from existing temporary accommodation.

The Continuity of Care programme is predicated on the assumption that many hospital and nursing home admissions could be prevented and better patient outcomes achieved through more timely and targeted intervention with at-risk individuals.

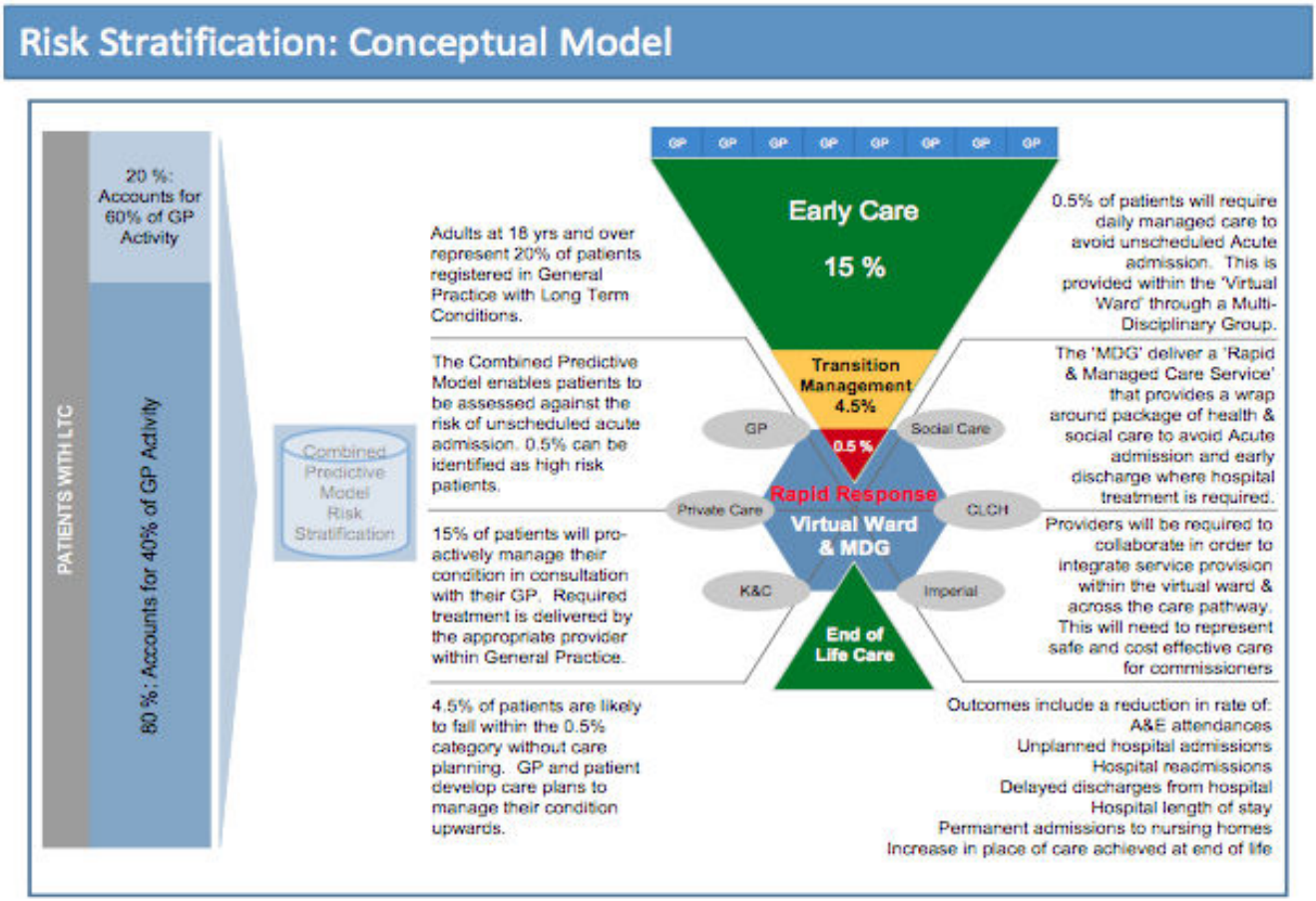
The programme aims to re-shape the health and care system so that it is designed to effectively manage long-term conditions in community settings. Specifically, the objectives are to:

- improve the service user experience through integration of services which are delivered at the right time, in the right place, by the right provider
- improve the overall health and wellbeing of Hammersmith & Fulham residents, and to reduce disparities in health outcomes between groups, through prevention and early intervention
- reduce the rate of unplanned hospital admissions and readmissions, and optimise length of stay, and thereby realise associated savings on acute hospital cost
- reduce the rate of permanent admission to nursing homes
- increase the productivity of the primary, community, and social care workforce

This will be delivered through five inter-linked programmes:

- Risk Stratification & Care Planning
- Early Care
- Transition Management
- Rapid Response
- End of Life

Figure 11: How risk stratification works



Early Care is an approach based on pro-active monitoring and primary care support of patients at higher risk of hospital or care home admission. Primary care teams will work with patients to help them identify the information, advice, support, and resources they need to self-manage. This process will include discussion about the patient's health condition(s) and medication, their goals, the resources and programmes they will attend/access to help them self-manage, and what to do and who to contact if there is a problem.

Where appropriate, this process will include advance care planning to facilitate choice of place of death. Some Early Care clients may also require additional support and follow up such as telecare /health monitoring, hybrid (health + care) home support workers, and health or care professionals who are able to visit at home. By combining these interventions there will be the ability to maintain clients at home safely and cost effectively through:

- remote vital signs monitoring
- remote or on-site medication adherence prompting and monitoring
- telephone support
- advice, education, and training on self-care
- prompts and bio-feedback on physical exercise and rehabilitation regimes

- remote monitoring of client movements and events (e.g., fridge, fall sensors)
- early intervention where a problem is indicated
- enhanced medication management

People with very complex needs that cross health, housing, and social care, consistently feedback that accessing the right services at the right time is not always straightforward; this is a message also received from GPs.

In particular, as each service has its own referral points, eligibility criteria, funding streams, assessment processes, and IT systems, people are sometimes unclear where to go for help and may have to repeat their stories several times as they negotiate 'the system'.

A more integrated system of care that is directed by general practice would be both easier to access and better able to respond to people's needs before a crisis develops which may result in hospital or care home admission. Transition Management will bring together access to community health, supported housing, and social care so that:

- there is one point of referral, screening, coordination, & budget/resource management for home and community care services including community nursing, therapies, continuing care, social care, supported housing, and adaptations
- all major funding streams (social care, continuing care, community health, housing support) are combined for the service user at the point of entry

Rapid Response is an integrated service delivering home based nursing, rehabilitation and re-ablement to support individuals for a period of up to eight weeks. The service targets the following groups of people:

- individuals who have experienced an acute exacerbation, or a health and/or social care 'crisis', but who can be safely managed in the community with a package of care, as an alternative to unnecessary admission to hospital, or into residential or nursing care
- individuals who require access to swift, intensive care in order to enable them to remain in their own home at the end of life
- patients who are suitable for early supported discharge from hospital and who can be safely transferred into the community with an appropriate care package in place

Rapid Response will provide holistic assessment to individuals using a single assessment process, and will deliver combined packages of social and nursing care and therapies. GPs will provide medical oversight, and there will be access to specialist advice and resource. There will be a single point of access to the Rapid Response Service, with a guaranteed response time of 2 hours.

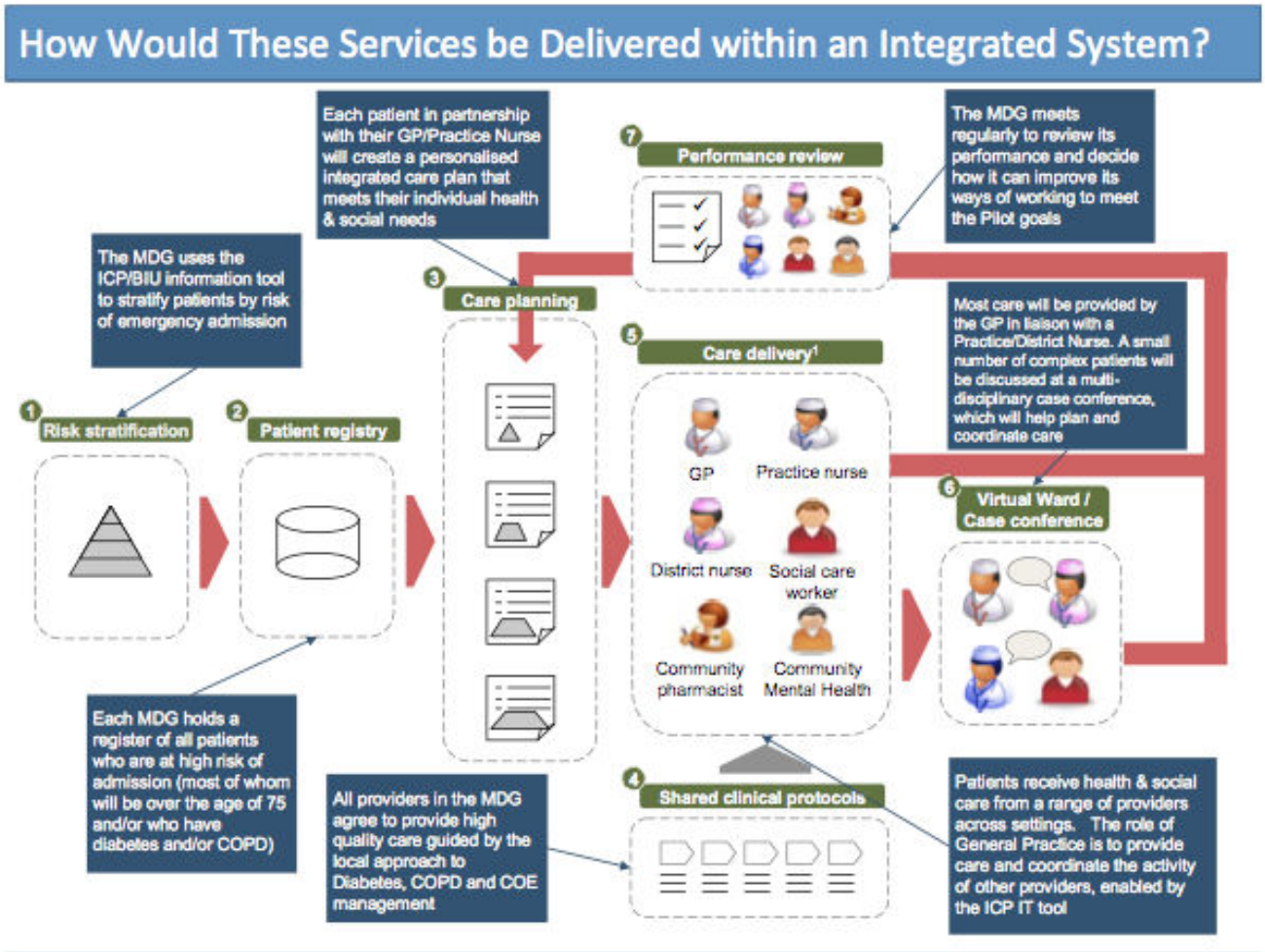
Research demonstrates that there is real potential for end of life care services to reduce expenditure associated with hospitalisation while at the same time accommodating the

expressed preferences of patients. The aim of this programme is the full implementation of the Gold Standards Framework across all providers and to manage those with a terminal prognosis within community settings, and prevent admission, generally through A&E by means of an integrated care record.

Integrated care and service redesign: The WCCCC development will support the further development of a number of care pathway redesigns that have been identified as priorities for White City.

Integration of services across NHS provider boundaries and between the NHS and social care are critical to delivering the benefits of this redesign work. For this to be achievable there must be high quality modern health centres suitable for delivering enhanced primary and community care and supporting multi-disciplinary working. The diagram below illustrates the approach to multi-disciplinary assessment of need that aims to deliver the improvements in service delivery as set out in Section Three:

Figure 12: Integrated Assessment: a new model of care delivery for adults



4.3. Care settings and services in the WCCCC

The WCCCC will offer a flexible range of facilities from which services will be delivered in a local primary care setting. The Centre will provide a single point of access for the community to a range of health and social care services with patients and users being able to access a wide range of quality services within a primary care environment, with interventions requiring multiple professionals provided from larger, flexibly designed spaces.

The following clinical and social services will be provided at the WCCCC:

- General Practice services
- Specialist Community Health Services: including services such as:
  - Diabetic care
  - Podiatry
  - Tissue viability
  - Dermatology
  - ENT
  - Musculo-skeletal
  - Respiratory (including COPD and Asthma)
  - Maternity
  - Paediatrics
- Sexual & reproductive health
- Primary and Community Care Dental Services
- Children with Disabilities Service
- community nursing and occupational therapy
- H&F Advice - Adult Social Care:
  - Assessment teams
  - Social Workers
  - Information point
- Mental Health Services:
  - Improving Access to Psychological Therapies
  - Community team consultations
- Learning Disability Community team sessions
- Training programmes, including:
  - Expert patients' programmes
  - Health trainers
  - Health Promotion & Illness prevention (e.g. smoking cessation)
- Health Promotion
- Sessional bookings from other services such as:
  - Interpreter and Advocacy Services
  - Welfare rights and citizens' advice
  - Self-help groups
  - Alternative Health provision
  - Space for voluntary groups to meet (Community Seminar rooms)

The generic clinical space planned into the WCCCC 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 NHS and Borough can share staff and resources, and out-of-hospital support is currently being redesigned to integrate health and social teams and professional roles.

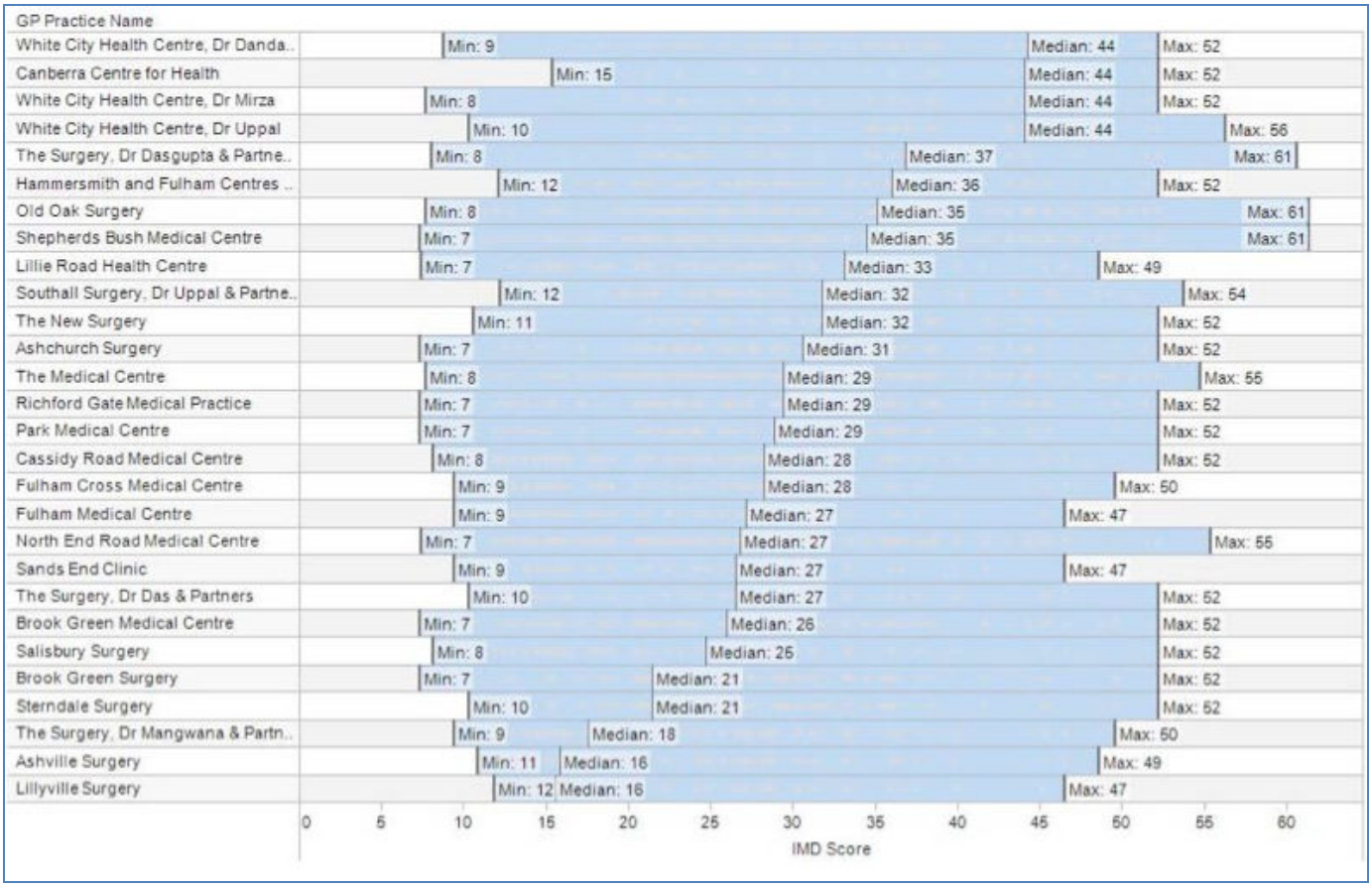
4.3.1. General Practice Services

There are 31 general practices in the borough, ranging in size from single-handed doctors to teams of 20+. One practice is based in temporary accommodation in White City. The quality and range of services varies considerably across practices and the current geographical spread means the more deprived areas in the north are under-served.

The WCCCC will form a hub for the 9 practices in the White City area. Four practices will relocate to the Centre. The other practices will become spokes in the delivery model. Existing lists will transfer to the Centre - there will be no new lists. 50,000 local residents will have access to enhanced services, which will include an out of hours centre.

The Index of Multiple Deprivation scores for the populations serviced by the Hammersmith and Fulham practices are illustrated in the graphic below, from which it can be seen that the four practices moving into the WCCCC rank highest in the borough. It is therefore vital to ensure that the Continuity of Care programme is established for these local people as soon as possible in order to start making real progress in improving the quality of care and reducing the drivers of need for unplanned health and social care.

Figure 13: Distribution of IMD Score by Hammersmith & Fulham Practice (Source: Index of Multiple Deprivation 2007)



The four GP practices already provide a mix of direct and locally enhanced services, as demonstrated in the practice profiles contained within the 'Demographics and Clinical Need' Appendix 3.

There are many potential benefits for patients to having GPs co-located at the WCCCC. These will include being able to access many services and clinicians in the same place and often on the same day. This is particularly the case with diagnostic services such as ultrasound and echocardiography where currently patients often have to travel to other part of the borough. Speedy access to diagnostics allows GPs to diagnose more quickly and accurately and can reduce unnecessary trips to acute hospitals for patients. It will also support the provision of one-stop shops such as for people with diabetes who need to see a range of clinicians on a regular basis.

Co-location of services also allows services to be delivered more seamlessly. Patients should not notice when they move from one provider to another for different elements of their care. Communication between providers is supported not only by good IT systems, but also by the ability to communicate informally. This is facilitated through co-location.

Routine GP appointments will be available from 8am to 8pm. This will improve access to GP services for many people. It will also allow the workload to be spread more evenly

over the day. In many practices there are currently peaks of activity in the morning and then again in the early evening. This could have an impact on traffic in the surrounding area; however, spreading the work over a 12-hour period will partially mitigate this impact. A detailed transport assessment has been completed as part of the planning application.

4.3.2. Specialist Community Health Services

Central London Community Healthcare is the main provider of community nursing and therapy services. The new premises will provide a hub for the delivery of a range of specialist community services in the north of borough. These are likely to include:

- diabetic care
- podiatry
- tissue viability
- musculo-skeletal
- respiratory
- maternity
- paediatrics
- sexual and reproductive health

4.3.3. Maternity and Children's services

Consultation with local residents in the White City area identified that they wanted improved access to good quality antenatal and children's services and extended access to GP services.

The WCCCC will provide a valuable resource to deliver integrated and accessible maternity, children's and health promotion services to address the significant child and maternal health inequalities in the White City area and north of the borough, including:

- midwifery clinics, antenatal and preparation for parenting sessions
- outreach and community based paediatric services for management of long term conditions asthma and eczema management
- oral health promotion and dental services, including fluoride application for under fives
- immunisation catch up sessions, including for HPV
- child and family nutrition and obesity prevention services
- family support and parenting services for BME families
- CAMHS support for GPs

4.3.4. Primary Care Dental Services

A primary care dental service will be provided, which includes a range of special needs services provided historically as a community dentistry service. Special needs services will include oral surgery and specialist paediatric services. The service will contribute towards and develop health and social care programmes to improve the oral health of the

population and in particular the oral health of young children. This will support the PCT's commitment to improve access to high quality preventative orientated NHS dental services and reduce inequalities in oral health within the White City area.

4.3.5. Children with Disabilities service

The community paediatric service in Hammersmith and Fulham is currently delivered from two sites. Children from the centre and north of the borough go to St. Dunstan's, located in the grounds of the William Morris 6th Form College near Charing Cross Hospital, and children from the south go to Doughty House, next to Chelsea and Westminster Hospital. The accommodation at St Dunstan's is extremely cramped and the service has been asked to vacate the premises so a local college can use it. Current service configuration arrangements have been unsatisfactory for some time. Lack of space is contributing to unacceptably long waiting times for assessment and intervention at critical points in a child's development (especially in their very early years). Inadequate facilities mean that staff spend valuable time travelling to, and setting up in, external or alternative venues; time which could be better spent with patients. The service has a vision to create an integrated centre for disabled children and has been looking for suitable premises to provide it from for some time.

Disabled children are some of the most vulnerable children in our society, and their families often live complicated lives to fulfil all their needs. The vision for an integrated centre for disabled children is to radically improve access, co-ordination of services, assessments and treatment, and have a space which parents and their families' feel is welcoming. The vision would be to enable:

- a single child-centred service, which is easy to get to, welcoming and enables parents to meet one another including at the weekends. The space for the service would be designed with children and families in mind and be focused on being safe, secure and welcoming to children and families
- easy access to the space specially designed for disabled children. Appointments would all be at the same place and access to the building will be designed to meet the needs of disabled children. Children and their families will be involved in the design of the space.
- children to be seen more quickly, and the communication between the family and the professionals improved by strengthening the links between primary, secondary and specialist care. There are long waiting times for assessments, and this is partly because of accommodation and dislocation of services. Having one site where children can be seen by a team of health professionals will improve this and by sitting alongside primary care the links between primary and specialist care can be strengthened and developed
- more joined up support for families, with many of the professionals working with the families based at the same building, managed by the same person, and working to the same systems. This co-ordination of advice, information and support is vital for families with complex issues to deal with

- a shared information system, which supports professionals to work more closely together and reduces the need for parents to feel they have to orchestrate the communication

In other parts of the country, models of integration have been developed and the service aims to use their experience to develop the most effective and efficient model to respond to patient needs. This includes making services work for children and their families better, but also using professional time efficiently, and the accommodation in the most flexible and cost effective way.

The main children's services to move to White City will therefore be community paediatrics and associated therapies. These services work with some of the borough's most vulnerable children who may have severe and complex medical needs and disabilities including autism, cerebral palsy or global developmental delay, may present with severe child protection health concerns, or who may be looked after children. Community paediatrics therefore involves distinct but linked service areas, each with several elements.

These are summarised below:

- child development services:
- multi-disciplinary assessments & reviews
- neuro-disability services
- referral to specialist assessment and treatment
- clinical nurse specialists
- social work liaison
- Clinical Psychology service
- Social community paediatrics:
- Designated Doctors (looked after children and safeguarding)
- adoption and looked after children medicals and health assessments
- child protection assessments and advice
- Public health paediatrics:
- immunisations and vaccinations clinical lead
- special educational needs assessments & input to special schools
- Special Needs Register (data collection and coordination)
- paediatric audiology follow up and treatment identified by the New Born Hearing Screening Programme (NHSP)
- Therapies:
    - physiotherapy
    - occupational therapy
    - speech and language therapy (SALT)
    - music therapy

4.3.6. Hammersmith & Fulham Advice Service

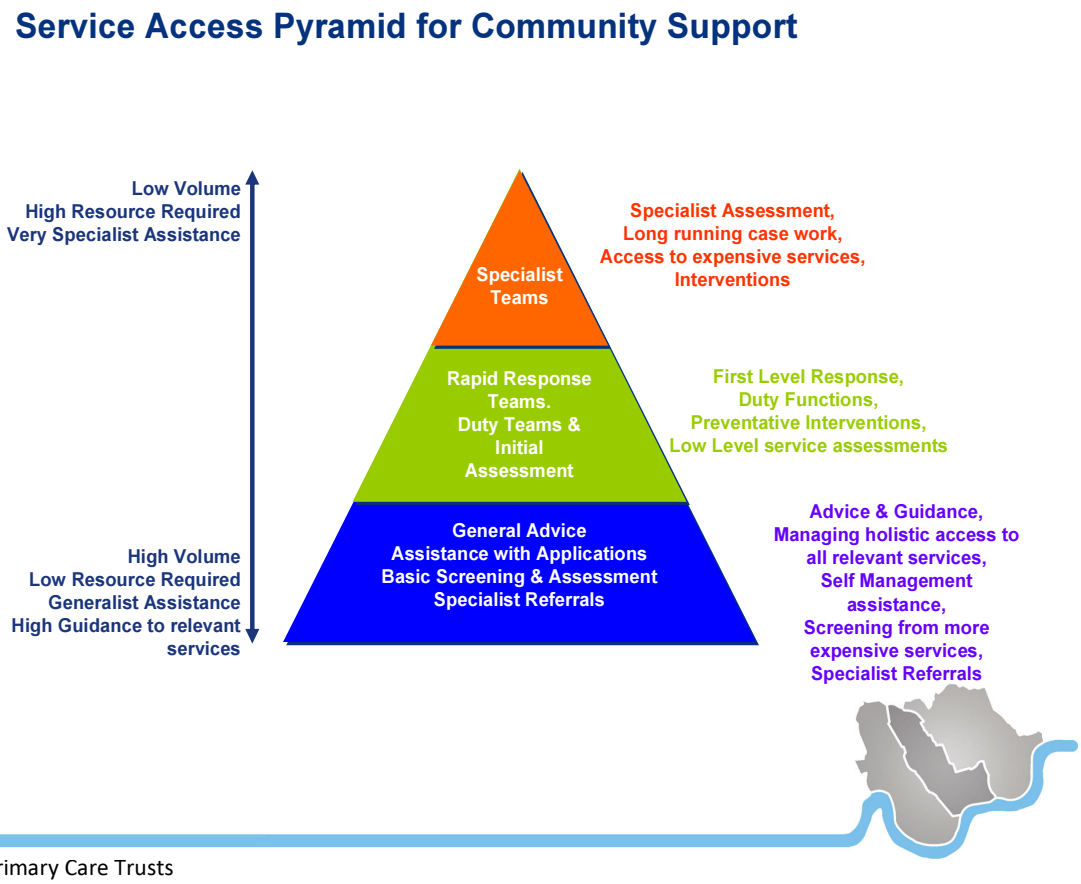
Hammersmith & Fulham Advice is an approach introduced in 2007 that will be re-created within the WCCCC to serve the north of the borough. It will aim to service the clients who are the dominant consumers of adult social services, those who have a preference for face-to-face contact. This preference is suited to the nature of the services in question, many of which require human contact to establish entitlement or to assess need. The Hammersmith & Fulham Advice approach improves access to services for these customers by providing:

- single point of access where a holistic assessment of a person or family circumstances or needs can be undertaken for adult social care
- high quality screening at the front line, and accurate signposting to alternative providers where appropriate - in order to reduce dependency
- improved customer service which provides safeguards for people at risk, to improve the service users' experience of service delivery by teams sharing information when appropriate
- multi-skilled, highly trained and customer focused staff
- processes that are efficient and integrated

The service is accessed through a single telephone number, or by enquiring in person. An integrated team of Community Support Advisors undertake the multi-faceted role of answering calls, greeting visitors and undertaking initial Screening Assessments.

The diagram below shows the service model for the advice service.

Figure 14: Service model for advice service



The entry point to the services is at the bottom of the pyramid. This is shown in blue in the diagram above. This provides basic advice and screening and is the highest volume of enquiries. The objective of this part of the pyramid of service is to provide broad guidance across the realm of community support services to ensure the customer is provided a holistic and joined up service and that the same information does not have to be captured several times later on. It also ensures that the customer does not have to find his or her own way within the organisation for different facets of need. However, it also attempts to screen the customer to prevent expensive resources being wasted further up the pyramid and in a high proportion of cases no further assistance from further up the pyramid will be needed.

The green teams in the pyramid have more specialist expertise within their own service area and attempt to provide a rapid first level response and a resolution in most cases. They need to be aware of potential join-up points with the other services but do not have the breadth of generalist capability of the blue teams.

The red teams are the specialist casework teams with longer running cases and dealing with specific needs. They tend to more expensive and access to these teams is limited. It is the function of the blue and green teams to ensure that only the necessary cases reach this part of the organisation and that when they do these teams are provided with all of the information from all parts of the organisation so that a more effective diagnosis of service needs can be ascertained.

The service principles of the advice team are to:

- Provide high quality customer service by:
    - ensuring front and back office process are improved
    - standardising tasks
    - improved access:
    - by providing many services in one place
    - reducing the number of visits to various locations
    - fewer phone numbers to access those services
    - less confusion on how to get through to the right service
    - more resolution of customer queries at first point of contact where possible
    - improved access to information
    - on the phone / face to face visits / home visits / office appointments / suggest alternative providers

- Maximise residents' independence and reduce reliance on professional services:
    - thorough screening /gate keeping role at the point of contact
    - increased availability of information about:
    - alternative providers
    - eligibility criteria
    - length of the process to receive a service, thus helping inform people of the choices they may have for their needs/wants

- to help people navigate through the system to the services they require sooner
- staff have a culture shift – ownership of query, knowledge & awareness, skills, new roles/functions/team structure

- Support staff in working more efficiently:
  - streamlining high volume and manual processes
  - reducing handoffs where possible
  - automating key processes and providing templates
  - reducing the demand for the back office to be involved with a client by improved resolution in the frontline setting where appropriate
  - reducing the need to handle an enquiry or activity more than once by improved screening.
  - redefining the processes where tensions exist e.g. reviews, duty, answering phone calls, home visits, planned vs unplanned work
  - using technology to view and update client records appropriately
  - easier to work with colleagues if using the same processes / systems / co-located
  - training in new skill areas and expanding knowledge base across services where needed

Hammersmith & Fulham Advice at White City will provide a single multi-skilled entry function to adult social services. This will include a team of Community Support Advisors who are well skilled and trained as 'super' receptionists. Each advisor will understand enough about all of the service areas to ensure that an effective screening is undertaken for all entrants to the service.

They will be able to manage the access to other assessment teams so that the customer gets the breadth of services required. The advisors will be able to screen customers and deal with their needs where they do not need access to more specialised services.

Behind the front of house Community Support Advisors will be the rapid response and duty assessment teams. These will be more service specialised than the Community Support Advisors but will also report to the Community Service Manager to ensure that the requisite join ups with the front of house teams and between the service silos are maintained. It is expected that the rapid response and duty teams will handle the majority of assessment load with only a minority of the work feeding through to the specialist teams.

4.3.7. Mental Health Services

The majority of mental health services are provided by West London Mental Health NHS Trust.

Wormholt and White City and the three surrounding wards have the highest referral rates to mental health services in the borough. The co-location of primary care and specialist

mental health services will provide opportunities to make further progress locally on the mental health NSF.

It is intended that the Improving Access to Psychological Therapies services (IAPS) that are currently provided from the general practices that are moving into the centre will also relocate. In addition, community team consultations (nurses and social workers) will take place here for patients from the north of the borough.

The specialist teams will handle the more specialised casework and longer running relationships with customers.

4.4. Confirming how services map with needs

The provision of the services identified above will match the analysis of needs as described in Section Three, as follows:

Figure 15: Mapping needs with services to be provided at the WCCCC

											Children								
	unemployment	low incomes	poor education	poor quality housing	access to health services	heart disease	respiratory disease	teenage pregnancy	diabetes	depression	Chronic diseases in about a quarter of children, particularly high rates of eczema, asthma and respiratory illness		High levels of obesity and malnutrition	Poor dental health	Physical & learning difficulties	Psychological and emotional morbidity	STIs and other forms of sexual ill health		
General Practice services					√	√	√	√	√	√	√		√		√	√	√		
Community Nursing & Occupational Therapy					√														
Specialist Community Health Services																			
Speech and language therapy					√														
diabetic care					√				√		√								
podiatry					√														
tissue viability					√														
musculo-skeletal					√										√				
respiratory					√		√				√								
maternity					√			√											
sexual & reproductive health					√			√									√		
heart disease					√	√													
dermatology					√						√								
ENT					√														
Gynaecology					√														
Dental services					√								√	√					
Children with Disabilities Service					√							√	√		√	√			
Audiology					√										√	√			
Speech and Language Thprapy					√								√		√	√			
OT					√										√	√			
Physiotherapy					√										√	√			
Music Therapy					√										√	√			
Paediatrics					√						√		√		√	√			
Adult Social Care										√									
Assessment teams		√		√	√										√	√			
Social Workers		√		√	√										√	√			
Mental Health Services																			
Improving Access to Psychological Therapies					√					√						√			
Community team consultations	√	√	√	√	√					√						√			
Learning Disability Community team sessions	√	√	√	√	√										√				
Training programmes, including	√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	√		
Expert patients' programmes			D		√	√	√	√	√	√									
Health trainers			D		√	√	√	√	√	√			√						
Community Champions	√	√	√		√								√	√			√		
Health Promotion & Illness prevention			√		√	√	√	√	√	√			√	√	√		√		
Health Promotion			√		√	√	√	√	√	√			√				√		
Sessional bookings from other services such as :																			
Interpreter and Advocacy Services.	√	√	√	√	√														
Welfare rights and citizens' advice.	√	√	√	√	√														
Self-help groups.	√	√	√	√	√	√	√		√	√									
Alternative Health provision.					√														

4.5. Relationship between services and space at the WCCCC

Integrated service delivery means that patients may not always access primary care services directly, but via referrals received from other services to be delivered at the centre. The intention of this approach is to aim to identify patients requiring health care assessment before they may otherwise have done so themselves. This provides the opportunity to offer advice and support that may prevent unplanned admissions to hospital or attendances at A&E /urgent care centres and to pre-empt the need for avoidable outpatient appointments.

GPs are in the process of stratifying their patient populations by risk category, so that high-risk patients can receive detailed care plans. Care /services will then be able to be provided either at home or close to home (WCCCC).

As care /services will be provided by multi-disciplinary teams, and these pathways are currently under development, the demand and justification for space cannot yet be demonstrated by using historical patterns of referral.

In future, the boundaries of who provides what services may change; what will remain consistent will be the clinical oversight of services by local GPs.

The planning for the facility has therefore taken the approach to capacity planning set out in Section Five and Appendix 9. The table below summarises the calculated requirement and the actual facilities included in the design proposals. The calculated requirement has been slightly uplifted to reflect the expected population increase in the area and to accommodate further shifts in activity from the acute sector (see Section Three) on top of the additional community activities.

Figure 16: Capacity Planning

Tenant		Rooms Calculated from Capacity Analysis						Allocated Rooms					
		C/E & Consulting & Interview rooms	Treatment room	Specialist rooms	Group room	Community Seminar	TOTAL	C/E & Consulting & Interview rooms	Treatment room	Specialist rooms	Group room	Community Seminar	TOTAL
PCT	General Practice	15					**15.00**	14.00	2.00	2.00			**18.00**
	Community Services	6	2				**8.00**	7.00	3.00				**10.00**
	CWD	5		5			**10.00**	6.00		6.00			**12.00**
	Dental		3	2			**5.00**	3.00		2.00			**5.00**
Council		3				0.60	**3.60**	5				2	**7.00**
Shared					0.22		**0.22**	2			1		**3.00**
TOTAL		**29**	**5**	**7**	**0.22**	**0.60**	**42**	**37**	**5**	**10**	**1**	**2**	**55**

The Council calculations do not include the requirements for the LD Community team and Mental Health team consultations

The table below summarises how the different services are likely to make use of the space within the Centre.

Figure 17: Summary Services Mapped to Space

	General Practice			Spec. Comm		CWD									H&F Advice		Dental		Shared	
	C/E room	Treatment room	Procedure room	C/E & Consulting rooms	Podiatry / TV treatment rooms	MDA room	Med Exam room	Sa LT room	Audiology	Music Therapy	Sensory	Nursing / SW / Psychology	Physiotherapy	Occupational Therapy	Interview rooms	Counselling rooms	Dental Consulting	Dental X-Ray	Group room	Community Seminar rooms
General Practice services	√	√	√																√	√
Specialist Community Health Services																				
Community Nursing & Health Visiting				√								√	√						√	√
Occupational Therapy				√	√									√						
diabetic care	√	√		√	√															
podiatry					√															
tissue viability					√															
musculo-skeletal	√	√		√									√							
respiratory	√	√		√																
maternity	√	√		√															√	
paediatrics	√	√		√									√	√					√	
sexual & reproductive health				√															√	√
heart disease	√	√		√																
dermatology	√	√		√																
ENT	√	√		√					√											
Gynaecology	√	√		√																
Dental services																	√	√		
Children with Disabilities Service						√	√	√	√	√	√	√	√	√						
Adult Social Care															√	√				
Assessment teams															√	√				
Social Workers															√	√				
Mental Health Services																				
Improving Access to Psychological Therapie	√																			
Community team consultations	√														√	√				
Learning Disability Community team sessions															√	√				
Training programmes, including																				
Expert patients' programmes																			√	√
Health trainers																			√	√
Community champions															√	√			√	√
Health Promotion & Illness prevention																			√	√
Sessional bookings from other services such as :																				
Interpreter and Advocacy Services.															√	√			√	√
Welfare rights and citizens' advice.															√	√			√	√
Self-help groups.															√	√			√	√
Alternative Health provision.	√	√		√	√					√	√								√	√

5. Brief and Design Proposal

5.1. Introduction

The White City Collaborative Care Centre will be constructed on the site of the former Janet Adegoke sports centre in White City. The site is located towards the northern edge of the London Borough of Hammersmith and Fulham, in the Wormholt and White City ward, 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 new centre sits in the vicinity of the current patient population and is proximate to the existing GP practices which will be relocating to the new centre. This coupled with its location in the area of need for the new service profile represents an ideal geographical fit.

This section of the FBC sets out the Tenants' Requirements for the Collaborative Care Centre and then describes BBH's response to those requirements, demonstrating that the PCT and Council's requirements will be met by the proposed development.

5.2. Development of Design Proposals

A new team of Project Advisors was established in March 2011. They have worked with key individuals in each of the client organisations and a range of stakeholders to develop the Design Brief, as well as with the LIFTCo design team on the design solution, with 1:200 layouts being agreed by the Joint Project Board on 15th September 2011.

5.2.1. Approach

The Project team has reviewed and validated the previous work undertaken on the project over a number of years. It has focused on understanding the history and how Service intentions for the Centre have changed in light of current strategy and the service shift already underway. For example, it had previously been intended to relocate 2 Community Mental Health teams to this building - but in the interim these services have already been reconfigured and will no longer require a base within the building. The service and facility profile has been challenged, resulting in a more generic set of facilities which will permit maximum flexibility for future changes in service delivery.

The earlier design solution was reviewed to consider how circulation, patient flows and overall functionality could be improved within the constraints of the building footprint. The previous capacity modelling has been revisited and supplemented.

5.2.2. Design Brief

Service Vision: The Centre will provide a single point of access for local people to get all their needs met for community health and social care. The intention is to ensure that people achieve maximum independence, by combining health and social care teams to create a single assessment and care management process, ending duplication and multiple visits, and leading to a reduction in both expensive acute care costs, and in high cost social care.

Design Objectives:

- To provide a purpose built modern healthcare facility that is fit for purpose and provides flexibility to meet the changing healthcare and social needs in the short, medium and long term, of the local population
- To resolve the current problem of substandard clinical space from which current GP practices and community services operate
- To embrace and promote sustainability during construction and operation through design
- To provide additional capacity in areas where current trends would indicate that demand will exceed capacity
- To introduce innovative service provision that embraces technology and new ways of working that facilitate the delivery of high quality accessible services
- To design a community facility which can be appreciated and valued by residents as a community asset even if they are not users of services
- To provide clinically and operationally appropriate services that can be safely and economically delivered in a primary / community setting
- To ensure that the configuration of services has a strategic, clinical and operational fit within the wider network of health and social care
- To optimise daylight and sunlight and realise a relationship with the green space that benefits visitors and staff

5.2.3. Tenants' Requirements

The detailed Tenants' Requirements are contained in Appendix 10 and comprise a comprehensive series of documents covering all design, operational and functional requirements of the new collaborative care centre covering the aspirations and requirements of both client groups. In summary, the White City Collaborative Care Centre will contain following clinical and social services:

- **General Practice Services** – initially four practices will be relocating to the centre with approximately 10,000 registered patients. The centre has been designed to provide full General Practice services to a population of 25,000 patients (reflecting

demographic growth and likely changes in current GP provision), and as a hub for 50,000 patients. It will serve as the hub for the Multi-Disciplinary Group delivering the "Continuity of Care" programme of risk-stratification and individual case management of people at medium and high risk of hospitalisation. This will be supported by the availability of diagnostics such as ultrasound and ECG and visiting specialist consultant support

- **Specialist Community Health Services**, on a sessional basis, including:
  - community nursing
  - diabetic care
  - podiatry
  - tissue viability
  - musculo-skeletal
  - respiratory
  - maternity
  - paediatrics
  - sexual and reproductive health
- **Primary Care Dental Service**, including a range of Special Needs services provided historically as a Community Dentistry service. Special Needs services will include Oral Surgery and Specialist Paediatric services
- **Children with Disabilities Service** (provided by Central London Community Health and Chelsea & Westminster NHS Foundation Trust)
- **Multi–disciplinary assessment of children** with complex health and development needs
- Specialist Physiotherapy
- Speech and Language Therapy
- Music Therapy
- **H&F Advice** - adult social care
  - assessment teams
  - social workers
  - occupational therapy
- **Mental Health Services**
  - Improving Access to Psychological Therapies
  - community team consultations
- **Learning Disability Community Team** sessions
- **Health Promotion**
- sessional bookings from other services such as :
  - interpreter and advocacy services.
  - welfare rights and citizens' advice.
  - self-help groups
  - alternative health provision

In support of these services, support services will include:

- office and administration space. The following will be accommodated:
  - general practice staff
  - integrated care teams

N.B. with the exception of GP practice administrative space, the desks within the new centre will not be dedicated but be available on a “hot-desk” / “smart-working” basis

- FM Services – including domestic services, goods /waste management and help desk support for building maintenance issues.

In addition, community services will include:

- information point.
- space for voluntary groups to meet (community seminar rooms)

5.2.4. Detailed Requirements

A set of Performance Indicators have been identified, against the proposals will be measured:

- fitness for purpose
- flexibility and adaptability
- sustainability
- capacity
- innovation
- Information & Communications Technology
- social well-being
- safety
- affordability

Schedule of Accommodation: The required accommodation for the Centre has been determined through detailed consultation within both of the Client organisations over an extended period. This is summarised in the tables below. The Briefing Schedule represents the Clients' requirements, based on HBN guidance on sizing & allowances for circulation & communication. Discussion with the architects indicated that the shape and deep-plan nature of the building resulted in a less efficient use of circulation & communication space and that it was therefore not possible to provide the nett area required by the HBN-based Briefing Schedule.

An adjusted briefing schedule was therefore prepared in an attempt to fit the required service accommodation into the available space by reconsidering room sizes (showing reductions in some cases while maintaining functionality), rather than by reducing the numbers of rooms. This is based on a modular grid of 4.25m x 0.75m, as proposed by the Architects.

Administration space has been included for the General Practices, but not for any of the other PCT services. Office accommodation for the Children with Disabilities service is not included and this will need to be provided close to this location in another building. For integrated teams (80 staff - council space), 7 desks have been provided per 10 staff. This equates to 56 desks which are intended to be used on a "hot-desk" / "smart-working" basis

No external space is scheduled, all of which falls within the ownership of the Landlord of the development

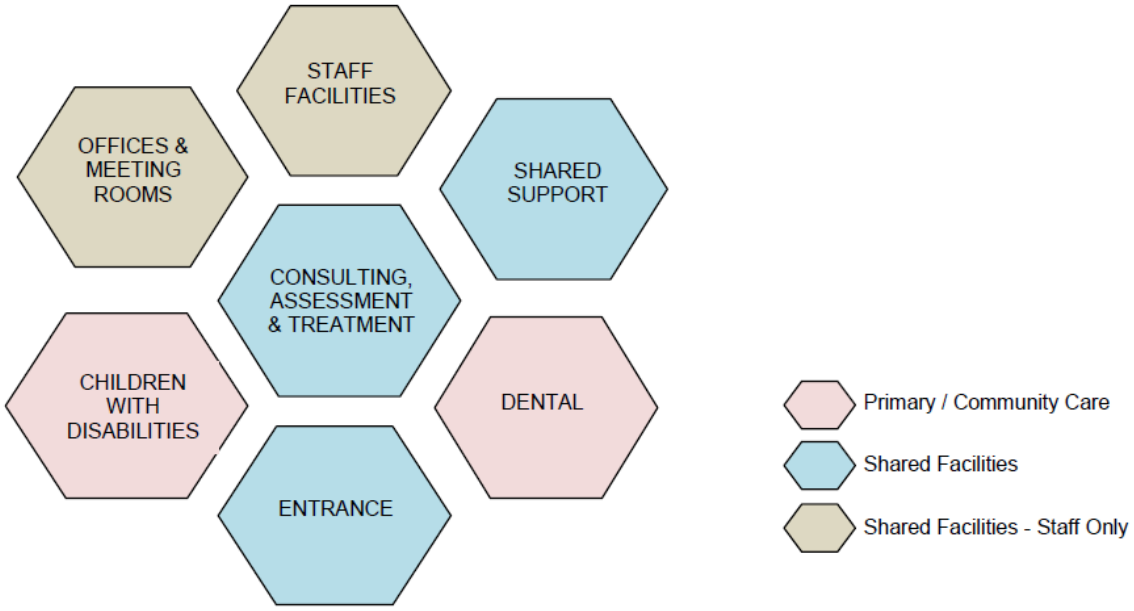
Table 8: Required Accommodation

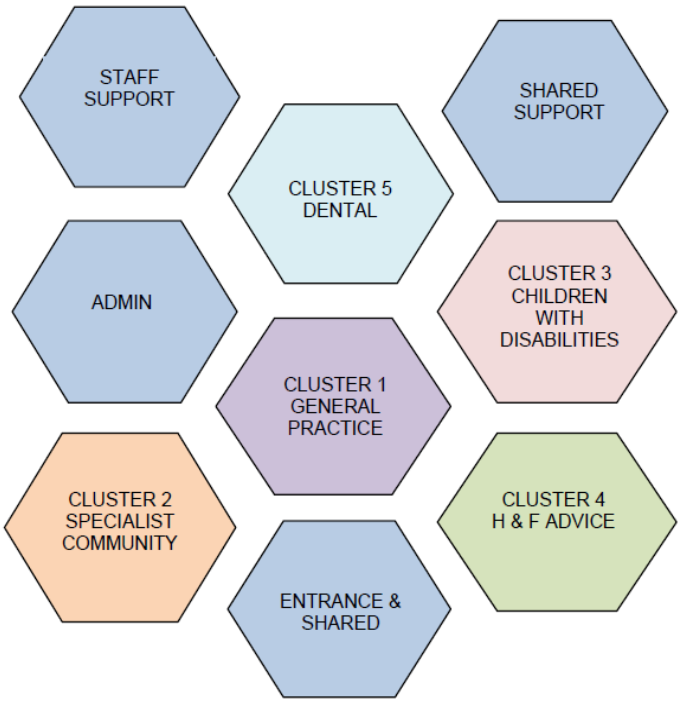
Department	Area (m2)		
	HBN-based Briefing Schedule	Adjusted Briefing Schedule	As-Drawn Schedule
Entrance & Shared Facilities	530.50	511.00	478.42
Cluster 1 (General Practice)	340.00	309.00	313.40
Cluster 2 (Specialist Community Care)	200.00	186.00	188.42
Cluster 3 (Children with Disabilities)	257.00	251.00	256.19
Cluster 4 (H&F Advice)	88.00	81.00	83.10
Cluster 5 (Dental)	136.00	123.00	124.00
Admin.	548.00	534.00	559.07
Staff Support	128.00	126.00	136.00
Support	125.00	115.00	100.16
Nett Centre Total	**2352.50**	**2236.00**	**2238.77**
Allowances	1020.51	1137.01	1134.00
Gross Centre Total	**3,373.01**	**3,373.01**	**3,372.77**
Basement - Plant & Circulation	187	187	187.00
Gross Building Total	**3,559.80**	**3,559.71**	**3,559.77**

Department	PCT								Council	TOTAL
	General Practice				Community	CWD	Dental	Total		
	Canberra	Dandapat	Mirza/ Kukar	Uppal						
Entrance & Shared Facilities	66.90	66.90	50.18	50.18	96.01	72.75	42.94	445.87	282.03	727.90
Cluster 1 (General Practice)	148.06	146.06	112.94	111.54	0.00	0.00	0.00	518.60	0.00	518.60
Cluster 2 (Specialist Community Care)	0.00	0.00	0.00	0.00	344.32	0.00	0.00	344.32	0.00	344.32
Cluster 3 (Children with Disabilities)	0.00	0.00	0.00	0.00	0.00	260.89	0.00	260.89	65.22	326.11
Cluster 4 (H&F Advice)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	119.00	119.00
Cluster 5 (Dental)	0.00	0.00	0.00	0.00	0.00	0.00	154.00	154.00	0.00	154.00
Admin.	36.36	36.36	29.27	29.27	9.08	6.88	4.06	151.26	429.11	580.37
Staff Support	12.21	12.21	9.16	9.16	21.73	16.47	9.72	90.67	45.33	136.00
Support	10.49	10.49	7.86	7.86	18.66	14.14	8.35	77.84	38.92	116.76
Nett Centre Total	**274.02**	**272.02**	**209.41**	**208.01**	**489.80**	**371.11**	**219.07**	**2043.45**	**979.62**	**3023.07**
Allowances	31.41	31.41	23.55	23.55	55.88	42.34	24.99	233.13	116.57	349.70
Gross Centre Total	**305.42**	**303.42**	**232.97**	**231.57**	**545.68**	**413.45**	**244.06**	**2,276.58**	**1,096.19**	**3,372.77**
Basement - Plant & Circulation	17	17	13	13	30	23	13	124.67	62	187.00
Gross Building Total	**322.22**	**320.22**	**245.56**	**244.16**	**575.57**	**436.09**	**257.42**	**2,401.25**	**1,158.52**	**3,559.77**
Breakdowns	9.1%	9.0%	6.9%	6.9%	16.2%	12.3%	7.2%	67.5%	32.5%	
								67.5%		

Adjacencies: Adjacency requirements for facilities within the building have been identified graphically to assist in discussions with the design team.

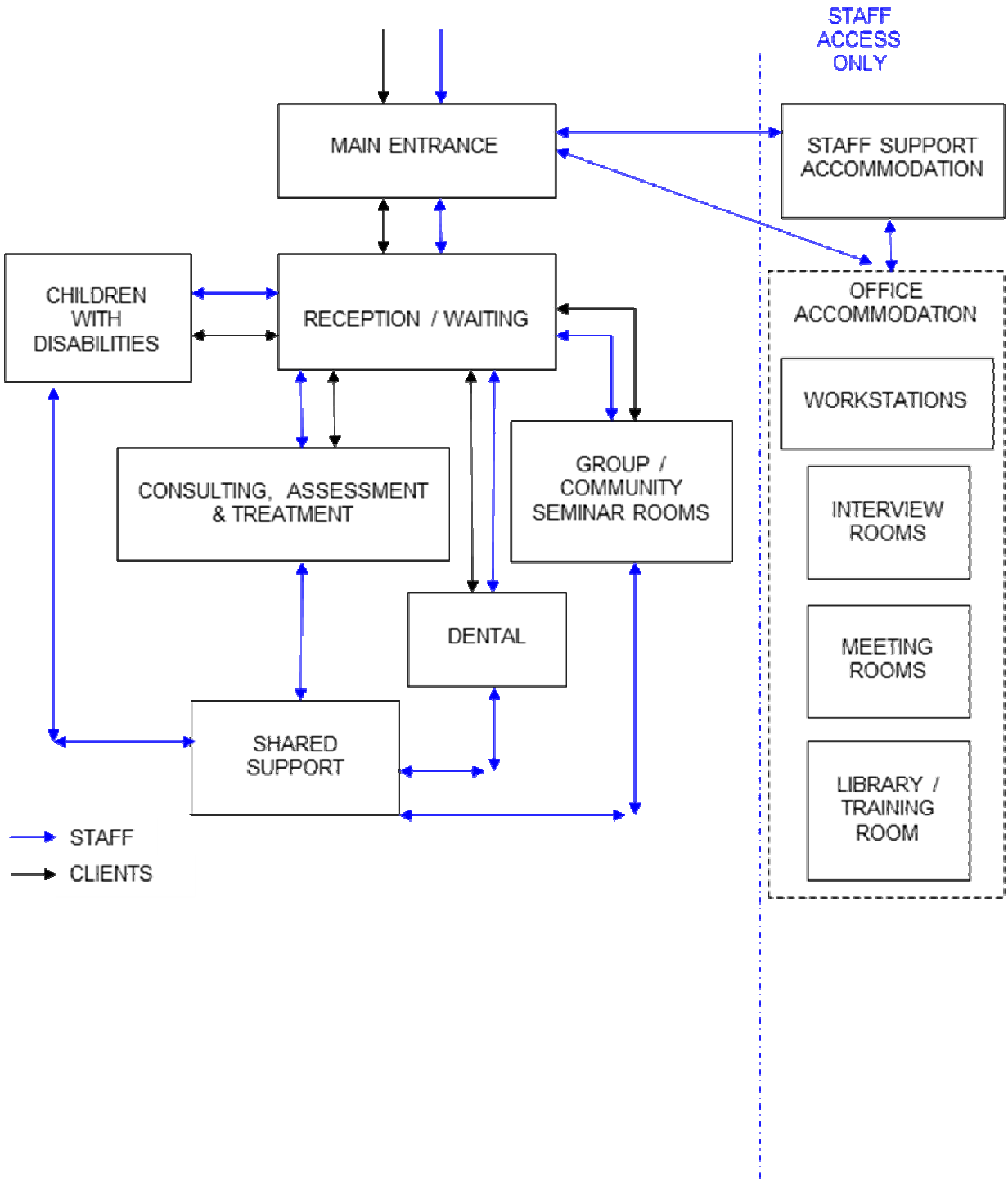
Figure 18: Adjacencies





Flows: Patient and staff flows through the facilities within the building have been identified graphically to assist in discussions with the design team. The Overview is shown below, with more detailed flows for each service being included in the Tenants' Requirements.

Figure 19: Overview of patient and staff flows



Design development: Room layouts are being developed and reviewed in consultation with clinical user representatives.

5.2.5. Capacity modelling

Appendix 9 contains a detailed description of the capacity modelling carried out to ensure the White City Collaborative Care Centre contains the optimum amount of accommodation.

The original space modelling for the Centre was based on activity projections for the area in 2008. This has been reviewed and updated analysis has been undertaken for each of the service areas. Some of the services included in the analysis at that time have since been accommodated in other locations - while the further development of Clinical Strategy in the intervening period has identified additional services that will be included.

The intention is for the Centre to provide sufficient capacity within the building to accommodate:

- current activity
- the expected population increase in the area
- further shifts of activity from the acute sector
- additional community activity

This will in part be achieved by extending service delivery hours and days in order to provide more flexible service delivery, while making most efficient use of the building. This shift in patterns of service delivery is being driven by the commissioning agenda as reviews and renewals of contracts permit - and will be implemented incrementally.

Across the service areas, the updated analysis has taken several approaches:

- analysis of available activity data with future planning principles to calculate space required – in some cases the data is not available in a suitable format to be analysed in this way
- analysis of current room utilisation at White City Health Centre, Canberra Centre for Health and Canberra Dental centre, with future planning principles to calculate future rooms requirements, where only limited activity data was available
- analysis of space available with future planning principles to calculate potential throughput

In terms of the Planning Assumptions, for most services 10 hours per day and 5.5 days per week operating at 85% utilisation have been used. The exception is Children with Disabilities where an 8 hour day is used to reflect the needs of the service users. It is intended that this will be achieved from date of the occupation of the Centre - with the potential for hours to extend to 14 for 6.5 days per week.

General Practice: Activity data was collected for a sample week in January 2010 for all practices across Hammersmith and Fulham PCT. Based on this, the number of appointments per head of practice population were determined - as an average for Hammersmith and Fulham; and for the highest level of contacts within Hammersmith and

Fulham. The national average amount of appointments per head of practice population was obtained from a report from the Primary Care Foundation for the Department of Health "*Urgent Care - a practical guide to transforming same day care in General Practice*" published in 2009. Using these 3 different rates, the potential number of appointments required for the intended practices' population of 25,000 were calculated - and the number of rooms required to deliver these appointments.

Analysis of the potential throughput for the General Practice rooms included in the building showed additional capacity available. This will allow for:

- minor surgery
- on-going delivery of the IAPS service by the West London Mental Health Trust
- on-going delivery of activity by other disciplines (e.g. physiotherapy)
- expansion of practice populations, reflecting the expected growth in the local population
- further shifts of activity from the acute sector

Specialist Community Health Services: The activity data for these services which is available in a suitable format for analysis is limited. Therefore the analysis of this data shows an incomplete picture of the facilities requirements to deliver the anticipated future services. Current utilisation has therefore been analysed and this shows a requirement for 6 CE / Consulting rooms and 2 Treatment rooms for Tissue Viability/Podiatry. The rooms provided in the centre allow room for expansion of the service in response to the growing population and shift of services into a community setting.

Primary Care Dental Service: The service in the new centre will combine the services currently provided under the Primary Care and Community Dental contracts. The current activity for both of those contracts has been reviewed - although it should be noted that for this period the Primary Care dental contract was underperforming by 37%. Therefore current room utilisation has also been considered which indicates a future requirement for the amount of rooms provided, with some scope for additional activity within that space.

Children with Disabilities Service: Activity data has been obtained from the Commissioning team and planning assumptions agreed with them. For Physiotherapy, Occupational Therapy and Music Therapy assumptions have been made about the breakdown of group and individual activity.

H&F Advice - Adult Social Care: In addition to the Assessment activity included in the analysis, it is intended that these rooms will also accommodate sessions of activity from the Community Learning Disability team and Community Mental Health teams.

5.2.6. Conclusion

The table below summarises the calculated requirement and the actual facilities included in the Brief. The calculated requirement has been slightly uplifted to reflect the expected population increase in the area and to accommodate further shifts in activity from the acute sector - as well as the additional community activities.

Table 9: Calculated Requirement and Actual Facilities in the Brief

Tenant		Rooms Calculated from Capacity Analysis						Allocated Rooms					
		C/E & Consulting & Interview rooms	Treatment room	Specialist rooms	Group room	Community Seminar	TOTAL	C/E & Consulting & Interview rooms	Treatment room	Specialist rooms	Group room	Community Seminar	TOTAL
PCT	General Practice	15					**15.00**	14.00	2.00	2.00			**18.00**
	Community	6	2				**8.00**	7.00	3.00				**10.00**
	CWD	5		5			**10.00**	6.00		6.00			**12.00**
	Dental		3	2			**5.00**	3.00		2.00			**5.00**
Council		3				0.60	**3.60**	5				2	**7.00**
Shared					0.22		**0.22**	2			1		**3.00**
TOTAL		**29**	**5**	**7**	**0.22**	**0.60**	**42**	**37**	**5**	**10**	**1**	**2**	**55**

The Council calculations do not include the requirements for the LD Community team and Mental Health team consultations

5.3. Approval Criteria

The key performance indicators arising from the high level objectives, which have formed the approval criteria for the BBH design, are:

Fitness for purpose: The design and construction must provide for good standards of space (area, height, form and scale) which are operationally and energy efficient and economical and which have the capacity to be flexible for future changes in service provision (see 'flexibility' below and in Appendix 10 to the Tenants' Requirements). The design must also consider the aesthetics, durability, cleanability and sustainability of all materials used in the construction, finishes and furnishing (see technical output specifications and 'sustainable design evaluation').

Flexibility and adaptability: The aim is to provide a flexible solution that will be sustainable over the lifetime of the building by enabling short, medium and long term change, both in healthcare services and other community activities and services, including extended hours of use. This flexibility and adaptability will have access, security, services, storage and management implications.

Flexible accommodation allows different activities to be accommodated in a given space without physical rearrangement of engineering services taking place. Adaptable accommodation is space that has certain basic parameters which, when built upon, will facilitate the use of the space by other activities by the physical rearrangement of building elements, services and furniture. Adaptability therefore requires the installation of removable partitions and furniture that can be added to, subtracted from or rearranged as required.

Further information on flexibility and adaptability can be found in Appendix 9 to the Tenants' Requirements.

Sustainability: Both clients are committed to "development that meets the needs of the present without compromising the ability of future generations to meet their own needs". The clients are looking to LIFTCo, to respond to the sustainability agenda in all three key aspects:

- social
- economic
- environmental

Further detail is provided in Appendix 7 to the Tenants' Requirements.

Capacity: The clients expect the design to demonstrate how it can respond to any changes in capacity requirements that may occur during the life of the new facility. This will be achieved, for example, through standardisation of room shape and layout to maximise future flexibility in use; and through ensuring that the fabric of the building is suitable to cope with maximum building throughput. Details of the capacity modelling for the facility can be found in Appendix 2 to the Tenants' Requirements, which are in Appendix 10 of this document.

Innovation: The PCT expects to see evidence of the incorporation of evidence-based design solutions in the provision and configuration of space, especially where they provide a response to the patient safety agenda.

Technology: Technology in this context refers to information and communications technology (ICT). ICT is not a discrete business function. It is a set of technologies and service that together play a part in most aspects of both:

- the health services to be delivered from the White City Collaborative Care Centre such as support for people with long term conditions
- the operation and management of the facility itself such as security and telephony

In recent years, the systems and technologies that support these services and operations, such as personal computers and CCTV cameras, have converged on a common infrastructure based on a standard communications protocol (IP). This means that they can share the infrastructure within the facility and also, most importantly, exploit

a common means to communicate across a Wide Area Network between sites and on to the wider NHS network and Internet.

The clients are looking for solutions that not only recognise and respond to these developments but also provide the flexibility to respond to future expectations.

Social well-being: It is essential that the building, both externally and internally, is designed to provide a positive healthcare experience that promotes the wellbeing of all building users, is not intimidating and does not cause anxiety. This involves consideration of the physical, psychological, emotional and therapeutic effects of the building environment. Natural light and the view of green spaces from the building will be significant issues in achieving this. Specifically relating to natural light, the PCT expects to see that the design demonstrates that natural light will be available into all rooms / spaces where staff work.

The massing and façade treatments should highlight the civic impact required by an important local building within the context of the surrounding buildings and environment, while providing a human scale that ensures that it is an accessible, approachable and welcoming community facility.

The design and layout of the waiting areas should provide a human, non-institutional scale with a secure, reassuring, calming environment. They should accommodate a variety of functions and facilities, including quiet area(s), private spaces/rooms, children's space, information point, community services, use for out-of-hours public activities. They should be visually pleasing (natural light, natural materials, reduction of glare, sensitive and appropriate texture and colour selection), acoustically comfortable (reduction of echo and unwanted sound intrusion) and should be visually linked to external open space. Finishes should be durable and easily cleaned so that they maintain their original appearance.

Clarity of way-finding is critical to reducing the anxiety of patients and visitors. The building layout should respond to this need by providing a design that enhances intuitive way-finding, shortens travel distances, and allows natural light to penetrate and be integrated into the internal spaces. This should be supported by high quality interior design that incorporates the use of colour, symbols and artwork as a means of guiding people through the building, as well as consistent and appropriate signage.

Specific facilities within the Centre, such as the Vending Lounge, should be located to enable open space to be directly visible.

ASPECT (A Staff and Patient Environment Calibration Tool) provides guidance and a method of assessment for social wellbeing, and will be used by the clients as an informal tool to inform their assessment of the design.

Safety: Considerations of safety are broad-ranging and unless they are sensitively handled they can result in solutions that are detrimental to ambience of the facility (see ‘social well-being’ above).

The clients have set out their expectations of safety in terms of accessibility, infection control, security and health & safety (see Appendices to the Tenants' Requirements). The concept of 'front of house' and 'back of house' contributes to the safety agenda by separating the flows of goods and waste from those of patients, staff and visitors. The clients are looking for a design solution that achieves such separations, both internally and externally.

Affordability: The local population will expect the delivery of a local community facility that is inclusive and inspirational. Delivery of these expectations will require careful management of the design process and the PCT's detailed service briefing sheets and planning principles aim not only to provide clarity to the design team but also reflect carefully balanced judgments regarding operational versus design requirements. Although these documents provide a baseline against which the design can be measured, they will not answer all of the questions that will arise during design development.

Key to delivering an affordable solution has been the introduction of robust change management controls into the design process so that any requests for changes to the brief have to respond clearly defined value for money criteria. The clients will expect LIFTCo to demonstrate how such controls can be implemented.

Quality: The clients are committed to achieving excellence in healthcare design, and LIFTCo's designs have been assessed against the following principles:

- **functionality**: the design should deliver the occupants functional requirements with sufficient flexibility to "future proof" the design
- **access**: good access to facilities both for everyday and emergency situations, using both private and public transport, should be available for all irrespective of physical ability. Way finding and signage will be clear and an integral part of the design solution. Proximity to areas of pedestrian activity with good lighting and being overlooked from public spaces help to minimise the risk of crime and provide a sense of comfort to all users. Access to the reception area is, for most people, the point where the first impression is made, however, the approach to the building and the ease of access will also play an important part in that process
- **space standards**: space standards shall be developed around ergonomically sound principles. Patient areas should be sized to enable an efficient yet comfortable and therapeutic environment
- **character and innovation**: facilities should be welcoming for patients and conducive for staff to give their best results
- **internal environment:** designs shall ensure that patients are treated with privacy and dignity in safe and comfortable surroundings. The building must also provide staff with the optimum working conditions
- **urban and social integration**: the buildings shall be designed to integrate into the fabric of their surroundings, rather than be insular, detached or self-contained.

Integration of landscape and external works into the overall design will be critical from the outset

- **performance:** standards of day lighting, artificial lighting, ventilation, acoustics and thermal comfort should be tailored to deliver the highest levels of patient comfort and staff efficiency in a safe and secure environment
- **engineering**: designs should incorporate the latest and emerging technology
- **construction**: construction should be of a high build quality with a strong regard for sustainability issues to minimise maintenance and life cycle costs. Standardisation and prefabrication of building elements could be considered if they are appropriate

Designs have been assessed using the '*Achieving Excellence Design Evaluation Toolkit (AEDET)*' and reflect the content of the CABE "*2002 Vision: Our Future Healthcare Environments*" report published in June 2002.

Commission for Architecture and the Built Environment (CABE): an important part of CABE's remit is to scrutinise the quality of buildings in the public sector. CABE has set out seven key design issues that Health Care Trusts must address if they are to achieve better quality, patient-focused health care environments:

- balancing clinical requirements with patient and staff needs - beware of the agglomeration of services to the detriment of the internal environment. Do not forget about high natural lighting levels, access to outside space, generous corridors and waiting areas close to the point of treatment
- urban design – draw up a strategic plan at an early stage to identify opportunities and constraints that the site offers and employ an urban designer early on
- landscape – a high quality landscape is not an optional extra, it offers real value to a health building and the surrounding community. Do not let clinical or car parking pressures get in the way of landscape benefits
- space standards – be clear about minimum standards. Trusts should defend the space required for public functions and apply quality thresholds
- legibility – new medical facilities must be easily accessible providing clear, legible and short routes both inside and outside the centre
- client management structure – client teams must be small and dedicated solely to the project with direct responsibility to the CEO
- supply side issues – successful projects need strong integrated bidding teams. To achieve this, clients must demand quality and bidders need to invest in quality design and understand how an architect adds value

Account has been taken of the guidance on design quality included in the DCMS publication "*Better Public Buildings*", the OGC guidance "*How to achieve Design Quality in PFI Projects*" and the 4Ps "*Achieving Quality in Local Authority PFI Building Projects*"

Design Life: within the Client's Project Brief, the building design life is required to be for the full duration of the Lease Plus Agreement, and materials are required to be suitable for purpose, appropriate to local context and have regard to sustainable sourcing. The

anticipated life expectancies for the following architectural and engineering systems included in the designs are as set out in the following table:

Table 10: Design lives

Element	Minimum Design Life to First Replacement
Building Structures	60 years
Drainage Systems	60 years
Internal Walls	25 years
Finishes	5 to 10 years
M&E Plant	15 to 25 years
M&E Systems	15 to 20 years
Lifts	25 years
Telephone and Data Systems	15 years

Materials have been chosen to meet the required Design Life proposals.

5.4. Clinical Functionality

Appendix 11 contains the schedule of accommodation and the Tenants' Requirements at Appendix 10 sets out the clinical functionality requirements for the White City Collaborative Care Centre.

5.5. Change Control

The development of the Tenant's Requirements and close collaboration with the design team during development of the Stage 2 proposals has successfully managed change control issues to this point, such that there have been no adverse impacts on cost.

5.6. Reviewable Design Data

The Guidance states that 'while Reviewable Design Data provides a useful mechanism for engaging the Participant in the completion of design work after Stage 2, this should be restricted mainly to particular finishes and other non- critical design areas, unless specialist elements are involved.'

At Stage 2 the PCT has taken an approach to design review that will ensure that all matters of functionality are either finalised, agreed and documented pre-contract, or the functionality requirements of any matters yet to be finalised are agreed and clearly expressed. The schedule of Reviewable Design Data post Financial Close will therefore be minimised and the current schedule itself is included in the LPA.

5.7. BBH's Design Proposals in response to the Tenants' Requirements

A full copy of LIFTCo's Proposals can be found in Appendix 12. These have been developed in direct response to the Trust's Tenants Requirements (TRs). The direct

outputs from LIFTCo, which represent and illustrate their interpretation of the healthcare planning proposals for the new development, are contained in the following information included in the LIFTCo proposals documentation:

- site plan at 1:500 scale
- floor plans at 1:200 scale
- selected loaded room plans at 1:50 scale

5.8. Compliance with Approval Criteria (Design & Specification)

5.8.1. Fitness for Purpose

The Trust's Construction Requirements stipulate that the design solution must demonstrate fitness for purpose in a number of ways:

Clinical functionality: the scheme has been developed throughout to ensure compliance with clinical functionality. The main focus in obtaining the final layouts has been a careful analysis of clinical adjacencies and patient and staff pathways through the building. A series of organisational and adjacency studies were prepared and discussed in detail in order to ascertain the optimum design solution for the brief.

Space standards: a process of reviews at key stages was established in order to check that space standards, including room areas, proportions and heights, were appropriate for the anticipated activities. This involved a series of 'due diligence' reviews with Health Planners to assess compliance of the scheme with the Tenants' Requirements. There has also been an on-going assessment of comparative schedules of accommodation that list current proposed room areas against those first included in the Indicative Schedules as part of the project brief. Where individual rooms depart from current guidance in terms of overall size, these have been individually tested to ensure that functionality is maintained.

The standardisation of room sizes around the structural grid also assists in maintaining future flexibility with the extensive use of non-loadbearing elements allowing the repackaging of room enclosures in the future which will work around established structural bays and openings thus allowing the modular scaling of rooms in equal units as originally envisaged by HBN 11-01.

Design vision: the design vision encompasses two main areas. Firstly, in considering the experience of the building user, whether as a patient, visitor or member of staff. The design solution addresses their needs by, amongst other things, incorporating as much natural light as possible into the internal spaces, allowing for views both internally and externally to assist with orientation and way-finding. Also, a wide variety of internal spaces ensures that patients and staff can find a suitable area to suit their needs. The second aspect of design vision relates to the image that the building conveys to the local community and environment in relation to modern healthcare service delivery.

Ease of use and legibility within the building are also key concepts of a successful design and the careful location and layout of circulation space in the new building proposals coupled with the logical clustering of clinical services and the various departmental spaces have all been developed with these aims in mind.

Parking: this has been highlighted in the brief documentation as a specific area for consideration due to its sensitive nature for building users, local residents and the Local Authority. A robust methodology has been implemented to analyse and predict traffic activity in conjunction with the Green Travel Plan, which was submitted as part of the Planning Application. Consultation with the local highways department and local councillors as well as project stakeholders has led to a deliverable solution now set out in the scheme proposals which have received the support of the local planning authority.

Planning: in 2009 the London Borough of Hammersmith & Fulham gave consent to a mixed use development with health, retail, office, community, residential uses and the creation of a new piazza. Following a review of the scheme undertaken by Building Better Health and is housing partner, Notting Hill Home Ownership, in late 2010 a decision was taken to make some minor material changes to the scheme in relation to a reduction in the number of units, alterations to the residential mix and associated minor design alterations. Following consultation with the local planning authority it was decided to conclude these changes by way of a formal full application.

This revised full application was considered at committee on the 11th October 2011 and was granted conditional full planning approval subject to a series of conditions / reserved matters that very much mirrored those applied to the earlier approval.

None of these conditions / reserved matters is considered exceptionally onerous or unreasonable and the LIFTCo is in the process of seeking to discharge these conditions ahead of the target financial close date, concentrating on those conditions which are subject to “pre-commencement” obligations.

A full copy of the planning approval notice together with a tracker for the planning conditions noting the party responsible for their discharge and the progress made to date, is contained in the Appendix 13 to this business case.

The planning approval granted is also subject to a section 106 agreement which places an obligation on the scheme developer to contribute towards the upgrade of the highway in the vicinity of the new centre (including traffic calming, access provision and new crossing points to serve the scheme etc) as well as for the provision of additional ‘Blue Badge’ disabled user parking bays located on the public highway to facilitate access to the new centre. In addition the planning obligations include for much needed improvements to the public realm about the site and moreover to Wormholt Park which the new centre backs onto and overlooks. The total planning obligation under the section 106 agreement has been equitably apportioned between the various elements to the overall White City development including the new health facility.

All costs associated with clearing reserved matters and the planning obligations under the section 106 agreement have been identified, quantified and factored into the financial model.

5.8.2. Flexibility & Adaptability

The design and layout of the building reflects the most recent guidance published by the Department of Health, regarding primary and community care facilities. One aspect of the guidance is to allow healthcare buildings to be more flexible, both on a day-to-day basis, increasing the utilisation of clinical rooms, and on a longer term basis, to ensure that buildings have a longer lifespan. This can be achieved by enabling the layout to flex in order to accommodate changes to the clinical services delivered from the building and also to accommodate changes in the models of care.

The need for a layout that incorporates elements of adaptability and flexibility has been carefully considered during the design process including:

Use of generic rooms with standardised infrastructure: this has been implemented, wherever possible, in order to allow a range of different activities to take place in a single space without physical rearrangement of engineering services or structure. Clinical rooms have been generally sized so that they can accommodate a wide range of activity. These also allow for the specialisation of room equipment if required, but ensure that rooms can revert back to generic room types in the future. This approach avoids bespoke solutions that cater to only a single clinical service.

Community facilities: these spaces, such as group rooms, have been located close to the main entrance so that they can be accessed easily without disturbing clinical areas. This also assists with phased shutdown out of hours as the rest of the ground floor can be locked off separately.

5.8.3. Sustainability

The new building layout has been designed to support new clinical models of care and will also act as a catalyst for operational and managerial change. This offers an opportunity to develop more sustainable operational policies and work patterns.

Issues are being addressed that promote sustainability both during the construction process as well as during the on-going lifespan of the building. The PCT and the Council fully support the environmental agenda. The project team has developed a series of overarching principles to set the sustainability agenda for the redevelopment project and the intention is to exceed current statutory guidance wherever possible.

It has been recognised that sustainability issues must be addressed as early as possible in the design process to maximise the environmental benefit. The scheme will meet the 2010 Building regulation requirements and incorporate a number of sustainability features including renewable energy generation via photovoltaic panels located on the roof of the new scheme.

5.8.4. BREEAM Rating

The latest BREEAM report, dated September 2011, indicated a target score of 71.39% (Excellent). The report highlighted the potential to achieve a score of 80.89% with additional work. The current design proposal reflects a scheme that can achieve an 'Excellent' rating within the current cost plan. A copy of the current BREEAM report is contained in Appendix 14.

5.8.5. AEDET Review

A full review of the building design has been undertaken using the AEDET Evolution toolkit and the results of this are contained in the Appendix 15 to this business case. The review was undertaken with representation from the Project Team and the Client representatives. The average total assessment for the scheme shows an average score of 4.57 out of 6 across the 10 assessment criteria

5.9. Safety

It is imperative that all users of the building are safe and secure and also that they feel safe whilst in the building or anywhere within the site. Areas where safety and security have been considered include:

- **Control of infection**: safety from infection and enable simple cleaning regimes wherever possible to minimise the spread of infection
- **Fire safety**: safety from fire and enabling safe evacuation from the building in the event of a fire
- **Staff observation**: visibility of all entrances and exits from the building, together with visibility of all public and waiting areas has been addressed through the positioning of staff bases and receptions
- **Technology**: staff call, CCTV, building management, systems, etc. are utilised to provide a safe environment. All rooms within which a client / patient may be alone are provided with a nurse call system that reports to each of the reception areas. The building has CCTV provision to enable the movement of people within corridors, external paths, entrances and car park that are monitored at the main reception desk
- **HTM/ HBN compliance**: ensuring that all rooms and spaces are designed in a way that they are fit for purpose in accommodating their intended activities
- **DDA / accessibility**: ensuring that all appropriate areas of the building are safe to access for all members of the community
- **Secured by Design**: the proposals are being developed in conjunction with Secured by Design. This is a Police initiative advising on the design of new developments to address issues that promote safety and security. The design of the CCTV and lighting installations are very much influenced by and compatible with the principals of Secured By Design

5.10. Cost Optimisation

The programme allows for regular affordability checks throughout the design process to ensure that the building will be delivered to budget.

This is based around a robust process of open book tendering which has allowed for a high level of cost certainty to be established prior to submission of the Stage 2 Business Case.

LIFTCo has embarked on a two stage tender process with the first stage based on an competitive competition to select a main contractor based on a submission of overheads and profit, preliminaries and an initial cost plan for the new development.

On selection of the main contractor offering the best value for money in relation to the stage 1 criteria, a process of open book market testing has been undertaken with production information for the various subcontractor packages having been issued for tender in order to market test the developing elemental cost plan.

At this time, at the submission of the Stage 2 Business case, sufficient progress has been made in the competitive open market testing of the main subcontractor packages for the main contractor to be able to confirm a guaranteed maximum price for the development to LIFTCo which has been assessed in value for money terms and reported on elsewhere in this business case. On-going work continues on refining the cost plan and undertaking further market testing with a view to improving the position at Financial Close with the safeguard to the Clients of the GMP underwritten by LIFTCo's main contractor

Specification and product selection continues to be made based on value for money considerations, both of the initial product and of the on-going maintenance required. Facilities management, Lifecycle and maintenance implications have therefore been carefully considered with specialist input provided throughout the design development, which has been key to ensuring best value.

Facilities management services have similarly been subject to open book competitive tender with an FM provider now selected by the Liftco

5.11. General Development Overview/Design and Access Statement

A summary of the principal design features of the building which have been developed during the Stage 2 process as part of the production of the LIFTCo Proposals for the Collaborative Care Centre follows below.

The proposals for the comprehensive redevelopment of the former Janet Adegoke Centre site respond to both the immediate site context and also the wider context of the White City area. The provision of housing situated above a new community health and social services facilities in addition to new retail on the site has created the opportunity to integrate the development into the surrounding network of facilities.

The accommodation of these new facilities in two distinct ground level buildings on the site creates a natural gateway to the park from Bloemfontein Road, and allows the continuation of the Australia Road axis in to the park, linking the scheme directly through the White City estate, to the BBC, Wood Lane and White City underground station. Above these community facilities sits the residential element of the scheme, 170 one, two and three bedroom apartments.

The strategic urban response of the development includes:

- create a new gateway to Wormholt Park on the Australia Road axis, establishing a very strong connection from the site to the heart of the White City Estate
- provide a new Collaborative Care Centre as part of a network of existing education, health and community facilities
- create a new urban civic space at the heart of the development, located on the western side of Bloemfontein Road, surrounded by the active facades of the Collaborative Care Centre and retail facilities
- create new retail facilities to the south of the site which are complimentary to those already established at Charnock House
- create a landscaping strategy which clearly connects the contrasting spaces of the park and the new civic space with a common language, and draws visitors into the park
- create a high quality landmark building, a new civic heart for the White City and Wormholt estates and the wider area

5.11.1. Scheme redesign

The design that was granted planning permission in 2009 is successful on many levels:

- appropriate streetscape and urban response
- positive contribution to urban realm
- accommodation for essential local facilities
- a community centre and meeting point
- much needed residential accommodation

This permitted scheme has been further developed by the new design team, under the instruction of the client stakeholder group including the housing partner NHHG, to ensure that the project is a deliverable and robust scheme that best fits the brief. This review highlighted the need to:

- re-evaluate the residential mix and numbers
- review the structural approach
- omit the 1st floor office accommodation and replace with residential units
- reduce the amount of retail space and realign the building at the southern end of the site
- review the servicing and environmental approach to reflect design changes and changes in current regulations

The design team has progressed the scheme to address these issues without increasing the permitted envelope and retaining the established architectural expression and identity. Moreover, the changes have maintained the original concept of the collaborative care centre within the overall development. Similarly the servicing, waste and fire strategies for the building remain unchanged in principle and the scheme resubmitted for planning approval in June 2011.

The finalised design for the CCC element has been generated by two key design drivers. Firstly, the layouts reflect the clinical functionality required by the brief in order to meet the healthcare objectives in an effective and efficient manner. Secondly, the layout has been designed to ensure that the patient and visitor experience is of the highest possible quality. There will be a wide range of users of the new facility and it is critical that the building is accessible to all, is easy to navigate and provides an uplifting and reassuring environment. A wide number of consultees have been involved in the design of the internal layouts including:

- representatives of the different services to be provided within the building, including:
  - General Practice
  - health visiting
  - anti-coagulation
  - family planning
  - podiatry
  - dental
  - Children with Disabilities
- infection prevention specialists
- service commissioners – PCT and Council

Whilst not specifically involved in the detailed layouts, a number of other groups have been consulted regarding the building design. These include:

- residents – via HAFFTRA
- voluntary sector including HAFAD, Nubian Life, MENCAP and MIND
- West London Mental Health Trust
- Hammersmith & Fulham Buildings Group, Hammersmith Society and other neighbouring Amenity Groups
- Bryony Centre and adult education
- Council Members
- the Local MP
- Business economy – Chamber of Commerce
- the Friends of Wormholt Park

Whilst the majority of the Centre consists of clinical spaces to satisfy the clinical brief, it is intended that the building is also a community resource with flexible spaces that can be used to promote a broader health agenda beyond simply treating illness. These spaces

include the public areas of the building together with additional areas that will be available on a bookable-basis when not used by patients for assessment, rehab and therapy activity.

5.11.2. Circulation Spaces

These have been designed to be non-institutional. This has been achieved by reducing the length of corridors as much as possible, avoiding dead-ends where possible, introducing passing places and by incorporating natural light and views, both external and internal, to aid orientation.

Circulation for the residential units above the care centre are formed by separate 'cores' with their own access from Bloemfontein Road. These cores have been designed with a view to minimise the impact on the footprint of the care centre and have been part of the complementary design approach to this mixed use development.

5.11.3. Provide Improved Accessibility for Patients

The building has been designed to be fully accessible to all. To that end, the design not only considers the needs of wheelchair users, but also those of children and their parents, those with poor mobility, particularly the elderly and those who are sensory impaired. The simple and logical layout of the building promotes easy way-finding for all. This will be complemented by appropriate signage and use of colour. The centralisation of the main entrance within the plan shortens travel distances within the building from the front door to each of the different areas, aiding those with mobility difficulties. In addition one of the lifts has been placed adjacent to the Children with Disabilities department to provided ease of vertical circulation for parents and children using this department.

A dedicated drop-off zone for both patients and ambulances plus proposals for dedicated 'blue-badge' parking provision to the front of the building have all been agreed with the Local Authority to enhance the accessible credentials of the scheme.

5.11.4. Flexibility and Adaptability

Long term flexibility goes hand in hand with sustainability. BBH's philosophy is for long life, loose fit buildings. BBH has designed the building to be able to adapt easily to changes in health provision requirements, and anticipate future change from the outset. To this end they have used standard grids and all the internal partitions are non-load bearing, independent from the structure, and all the mechanical and electrical services routes are very controlled so that these do not obstruct future internal rearrangement.

The need for a layout that incorporates these elements of adaptability and flexibility has been carefully considered during the design process, as it increases the longevity of the building and makes it more sustainable. The design and layout of the building reflects the most recent guidance published by the Department of Health regarding primary and community care facilities. One aspect of the guidance is to allow healthcare buildings to be more flexible, both on a day-to-day basis, increasing the utilisation of clinical rooms,

and on a longer term basis, to ensure that buildings have a longer lifespan by being able to flex in order to accommodate changes in the services delivered from them. There is a number of ways that the proposed layout maximises flexibility and adaptability.

Modular room sizes: Clinical rooms are sized so that they can accommodate a wide range of clinical activity. These also allow for the specialisation of room equipment but ensure that rooms can revert back to generic rooms in the future.

The intention is to provide a minimum number of room sizes in order to avoid bespoke solutions that cater to only a single clinical service. The building layout is based predominantly around the use of a systematic planning grid of 1.2m x 4.15m, enabling the creation of a suite of generic room sizes of 9, 14, 18m2 etc. These sizes are considered generous and appropriate for an array of clinical and non-clinical uses, allowing future flexibility in the potential relocation of services.

Accommodation clusters: The building has three main clusters of clinical accommodation, located either side of the rear atria and linked by a generous circulation zone running perpendicular to the main entrance. The GP cluster is located to the right (north) on the ground floor and is linked to the smaller cluster with the procedures suite. Above this cluster on the first floor in another cluster occupied by Children with Disabilities.

The third main cluster is located to the left (south) and is a generic clinic cluster for a variety of clinics. Between the main cluster two smaller sub groupings are located on the ground and first floor and are to be occupied by the GP's on ground and dentistry on the first floors.

5.11.5. Overall Building Mass

The form of the scheme has been informed by three key overriding principles:

- the first is to achieve a balance of land taken from the park against land that is given back to create an equilibrium of park area. The park is no smaller but its eastern edge will be defined by the proposed building
- the second is to ensure the new building as well as that all neighbouring properties are not overshadowed in a detrimental way so that rights to daylight are not affected. This has resulted in the building taking a linear form, simply set back on Bloemfontain Road which in turn creates a new urban square on to the street
- the third is to successfully integrate the circulation cores giving access to clusters of residential units with the footprint of the new health centre with a view to minimising circulation and reducing corridor lengths wherever possible

The ground level form uses two distinct components, the Collaborative Care Centre and the retail units, united by the residential building above. Their separation at ground level allows a route through to the park to be established whilst still retaining a strong edge to Bloemfontein Road. This link through to the park extends a well-used route along Australia Road from the BBC and is a gateway to the wider community. This enhances

the pedestrian and community links to the new Collaborative Care Centre which is a key component of the building's siting.

Sitting the building away from Bloemfontein Road creates a new space which forms a gateway to the park. The ground level uses address the new public open space creating animated frontages on to it. All elevations are publicly visible adding to the overall natural surveillance and security of the new centre.

On the park side the buildings are shaped to create a generous gateway to the park. These public elements enjoy a frontage directly on to the park. The boundary between the park and the development is integrated by bringing the park into the newly created CCC space, and allowing some of the development into the park. The eastern boundary of the park is redefined but with no net loss of park area, with the provision of the new space onto Bloemfontein Road there is a net gain of public open space overall.

5.11.6. Overall external materials palette

The materials selection further enhances the project objectives and aspirations. In order to achieve a high level of sustainability, material choices have been subject to review regarding their extraction, manufacture, delivery to site and disposal of resultant waste material. The material choices have also been made to give the building the characteristics of a modern healthcare building that represents the vision for improved service delivery. To this end, the building is composed of a series of simple and elegant volumes that manipulate light and shadow, giving depth to the facade. Elements of colour and texture are introduced along the residential block to provide interest and to introduce a human scale along this long facade.

5.11.7. Addressing the Park - Rear (west) Elevation

The proposal creates a gateway which connects Wormholt park visually and physically into the wider area; this should increase the use of the park.

All the residential units have balconies which are large and designed to be an extension of the living space. Around 50% of these overlook Wormholt Park which will create a sense of overlooking and security within the park and creates effective pedestrian links to the wider community using the new centre.

At ground and first floor levels the Collaborative Care Centre is designed to incorporate large glazed areas to allow a direct visual connection from the centre's waiting, circulation and play areas to the park. Privacy for the Collaborative Care Centre will be subtly provided by a landscaped buffer between the building facade and the public realm together with careful façade treatment and use of an appropriate palette of materials

The roof of the Collaborative Care Centre will be developed as ecology gardens, which will add a visual amenity as seen from both the park and the residential building, but will also improve the bio-diversity of the park and surrounding area.

5.11.8. Addressing the Street - Front (east) Elevation

The proposed siting and massing strategy addresses a number of key issues in relation to Bloemfontein Road and adjacent buildings. The townscape impact of the development is reduced by setting the building back from the street, which increases the sunlight and daylight provision within the immediate area. Furthermore, breaking the building form into five linked parts animates the facade and creates rhythm to the street elevation. Setting the building back also allows for a new public space at ground level, with a character that is distinct and different from the park.

The overall setting of the building and the maximisation of natural light are key benefits of the White City Collaborative Care Centre. The eastern edge of the space is defined by Bloemfontein Road and the new line of trees, which will reduce the impact of this busy road on the new space.

The lower parts of the building provide frontage to the proposed public space, with retail access to the south, and the entrance into the Collaborative Care Centre to the north. These uses are both intended to have long operational hours, and so provide lighting and animation to the street during the evening, all adding to the sense of secure, publicly accessible community facility.

The axis of Australia Road which links the scheme to local transport infrastructure, and the wider area is now provided with a clear focal point by the new development.

5.11.9. Side (north elevations)

The benefit of a corner location for the new Collaborative Care Centre with street frontage on two sides has been maximised by creating a separate service access for the centre off Bryony Road thus successfully separating the public and service entrances to the building, and improving operational functionality.

5.11.10. Centre Fenestration

Sitting the building away from Bloemfontein Road creates a new space which forms a gateway to the park. The ground level uses address the new public open space creating animated frontages on to it. The residential element of the building above further defines the space, and reduces the proximity of the new development to the adjacent buildings.

The residential element of the scheme overlooks this public space with an animated façade of residential balconies. Below this is a two storey high glazed façade which directly addresses the plaza and allows the public elements of the building to define the edges of the new space whilst maintaining a relationship with the park.

The façade has a rhythm of 1.5m bays which move around the building and change in character from a primarily glass elements to the front to a more solid element along the side and then opening up again to the park via two double height glazed courtyards. As well as full height glass metallic panels are used in combination to provide security and

privacy where required internally. On all elevations, the external doors and windows have been arranged to complement the materials and rhythm of the facades.

5.11.11. Internal Layouts

The internal arrangement of the building seeks to balance individual functions' requirements for street presence, access, security, confidentiality and complimentary co-location adjacency. This is achieved by:

- locating multi-use community facilities on the ground floor along the street frontage. This allows flexibility of access, street presence and an active street front
- locating high volume healthcare departments on the ground floor, with those functions mostly requiring immediate access lower in the building, and those least dependant, with low through put and longer appointment times on the first floor. All departments are arranged to be directly accessible from the atrium and courtyard waiting areas for simple way-finding within the Collaborative Care Centre
- locating staff and administration facilities on the first floor of the building to provide some separation from public areas and direct access to the staff areas
- locating incoming services, staff parking, deliveries, clinic waste pick-ups and as much plant as possible either in the basement or on the northern edge of the ground floor, preventing these support spaces from interrupting the community or healthcare provision and allowing direct access to the service lay-by on Bryony Road

The Collaborative 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 leads on to the vertical circulation. The building is then organised into a sequence of open ended fingers of cellular accommodation in between which are softer flexible top-lit space formed by the atria. 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 to the park beyond and bring natural light into the core of the building.

The floor layouts have been generated based on the principles outlined above, and through discussion with a wide range of stakeholders. Appendix 12 contains the signed off 1:200 drawings for the ground and first floors.

5.11.12. Basement

A large basement storey is located below the CCC, and projects under the plaza at the front of the building. This primarily contains parking for both the Centre and the residential units and is accessed via a ramp from Sawley Road.

In all 23 parking spaces are allocated for the CCC, 2 of which are disabled parking bays. and there will be sufficient bicycle spaces allocated to comply with local planning authority

requirements and to achieve the relevant BREEAM credit. In addition the basement contains plant rooms, service areas, and water storage for the building, thus maximising the space available for clinical / operational use on the principal ground and first floors

This level is well connected to the floors above via a dedicated stair and lift core at the northern end of the CCC, with access control to all areas for CCC staff.

5.11.13. Ground floor

The ground floor contains mostly clinical activity. This consists of the GP practice, and specialist community areas; with the local authority advice centre located close to the front entrance.

The public areas of the building are located centrally within the floor plan. It is critical that the entrance is located centrally within the building in order to afford simple access to each of the clinical departments without passing through other areas. This also promotes simple way-finding, minimises internal travel distances and maximises security when only specific areas are accessible out of hours. From the main entrance, through the use of extensive glazing and balcony areas, there is good visibility to the various destinations within the facility.

A 'meet and greet' area and the Centre reception are located at the main entrance with the General Practice reception located centrally with a commanding view over the associated waiting areas. The main circulation core, consisting of a lift and stairs to upper levels are positioned between the two reception areas. To maximise the provision of natural daylight into the building there are two large, double-height internal courtyards (formed by the atrium roof lights) adjacent to the main public areas that face towards the park offering view of trees. These are the main waiting areas for the various services.

The two main clusters of clinical accommodation, are located either side of the rear courtyards/atria and are linked by a generous circulation zone running perpendicular to the main entrance. The GP cluster is located to the right (north) with the larger waiting area and associated smaller sub-cluster of procedures & treatment area. The Specialist Community cluster is located to the left (south) and will be used for a variety of clinics.

The use of corridors has been limited wherever possible to the internal clinical spaces in the building, so that the public routes are more open and informal. Whilst there is only a single entrance area, there are a number of areas that have controlled access to external areas, for staff use, deliveries and means of escape.

The service routes (waste, supplies etc.) are located at the northern end of the building with direct access to the dedicated layby on Bryony Road. In addition a lift is adjacent to allow service movements between ground and first floor without moving through the main public areas of the building.

This location has been discussed in detail with the facilities management providers to ensure that this service can be provided efficiently with minimum disruption to the other activities taking place within the building.

5.11.14. First floor

The accommodation at this level is used for a limited amount of clinical services namely Dentistry and the Children With Disabilities service, which are clustered around the main waiting area above the GP spaces allowing direct access from the main feature stair and lifts. These services have the smaller through put and therefore have smaller localised waiting areas, with adjacent small reception / clinical office.

The Children With Disabilities service is contained around a central corridor and also has a lift located adjacent for ease of circulation which is specified as an evacuation lift to enhance the means of escape strategy of the building and which recognises the specific needs of the client group being served.

The remainder of the floor contains staff accommodation which includes administration offices comprising hot-desking for council services and permanent, dedicated workstations for the GP practices and includes interview rooms, meeting and training areas and staff facilities including staff changing and a rest room overlooking the park.

5.12. Future expansion

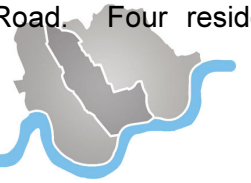
The layout of the building around the central space allows for a flexible arrangement of care zones/suites, each with direct access that avoids 'crossovers' between separate zones. This also generates floor-plates of optimal depths for the range of healthcare spaces required. Using a modular planning grid and generic design of consulting rooms allows for future changes in the care services to be accommodated, without major re-organisation, over the life of the building. The distribution of building services and utility spaces are also designed to allow for future flexibility.

The location of the community facilities in close proximity to the main street frontage allows these spaces to operate flexibly, either as independent units or as part of an integrated healthcare and healthy lifestyle facility, with out of hours / bookable useage being possible having local access to sanitary facilities and reception without the need to access the remainder of the Collaborative Care Centre.

5.13. External Areas

The objective of the landscape strategy is to extend the park to the western facade of the building and connecting it to a new public open space on Bloemfontein Road. This will create a transition between the scale of the residential areas to the east, the relatively dense urban character of the new development and the park to the west.

The Collaborative Care Centre and retail entrances are all arranged along the eastern facade addressing the new public space on Bloemfontein Road. Four residential



entrances are also located on the eastern facade addressing the new public space on Bloemfontein Road.

General issues: the paved surfaces will be arranged in bands to pick up the building grid, with subtle changes in laying patterns used to emphasise the separate, distinct entrances to the development. Regularly spaced London plane trees, linear benches and lighting columns provide a permeable edge between the pedestrian footway and the road.

The frontage will be designed with drop kerbs and rising bollards to accommodate disabled drop-offs and access for service and emergency vehicles.

A series of gates between the two ground floor building wings allow the park to be secured at night and provide additional security to the southern and western facades to the centre.

Pedestrian access: Pedestrian routes will be segregated from cycling and vehicular routes to maximise safety. The main entrance plaza, proposed as a shared surface, will be subject to particularly close attention to detail to ensure safety and accessibility to all users of this space.

Ramps and steps around the perimeter of the building have been designed out giving a level access entrance to the new centre and seating areas will be provided at pause points along the pedestrian access routes.

The pedestrian routes will be surfaced to provide an appropriate surface for wheelchair movement. These will include textured surfaces and rumble strips, where required, to indicate crossing points for visually impaired.

Whilst the site layout has been generated to produce a simple and logical route into the CCC, the positioning and design of signage will be developed to reinforce this concept.

Access routes and drop off areas will be adequately lit at night to provide security and a safe environment for all users. Light overspill will, however, be controlled, so as not to affect the neighbouring properties.

Parking and drop-off: Ambulances, taxis and patient transfer vehicles will be able to set down passengers at the pull in bay provided on Bloemfontein Road, directly opposite the CCC entrance, with drop bollards, kerb design will be developed to ensure safe transfer for all arrivals, and with textured surfaces.

Sufficient disabled parking bays exist close to the main building, along the adjacent side roads and the provision of additional disabled parking spaces has been agreed with the local authority as part of the planning obligations linked to the planning approval for the development. Within the basement 8% of the overall staff parking allowance will consist of disabled bays.

Cycle parking is provided in the front plaza for visitors and patients with a separate area of covered cycle parking located within the archway entrance to the park. Secure staff cycle parking facilities are also provided in the basement area.

Highways: the development works to the site require a substantial improvement to the public realm and works to the public highway to improve access and pedestrian safety all as part of the works outlined above. The scheme has been considered in detail by the local highways authority via the planning process and they have established a series of improvements necessary to the highway, the costs and obligations for which have been included in the section 106 agreement allied to the planning approval for the scheme.

Utilities: the site locality is provided with all main utility services including those that served the former leisure centre on the site. Formal enquiries and requests for service quotations have been made and received from the gas, electricity and water authorities. These are enclosed in Appendix 12. All utilities have confirmed the existence of sufficient capacity of services to supply the new development and all costs have been reflected in the construction cost plans.

5.14. Summary

The proposals for the new CCC have been developed through a process of wide stakeholder engagement over a number of years. Consequently, the project not only meets the aspirations of the PCT and the Council, but also provides a more far-reaching community resource with facilities that promote a broader wellness agenda.

All rooms are sized and positioned to reflect the principles of flexibility described in detail above so that the building is able to accommodate future change simply and easily whilst minimising the need for alteration to the building fabric.

Similarly, the proposals described above reintegrate the whole site into the local context and provide much needed housing, retail, a new healthcare and access to open space amenities that are open and accessible for all.

5.15. Design Development and Detailed Design Proposals

5.15.1. Interior design concepts and finishes (being developed at present)

The interior of the building has been designed as a pleasant, calming and easily navigable environment for patients and visitors and as an exemplary workplace for staff. Colours and materials will reflect all current legislation and guidance for accessibility, maintenance and control of infection in a public and clinical environment. The public spaces offer an opportunity for creative use of these products to create a welcoming and non-institutional space that reflects the function of the building as a community resource.

The cost plan currently allows for enhancement of both floor and ceiling finishes in the ground floor public areas – main entrance and waiting spaces – although the exact

specification and colour selections will be developed in conjunction with the architects and interior designers and form part of the Reviewable Design Data process.

Furniture and fittings are a key component of the interior and bespoke reception desks will be used that coordinate with the finishes in the atrium and waiting areas. Key equipment items such as waiting area seating, information points/ internet café and vending areas etc will be co-ordinated as part of the interior design proposals which will require collaboration between the design team, the PCT and council client groups to ensure an holistic approach to the interior look and feel of the new centre.

5.15.2. Way-finding

Clarity of way-finding for all, regardless of sensory, educational or cultural background, is a key driver for our design strategies. To this end it is imperative that the architecture supports this strategy without reliance solely upon signage.

The clustering of all departments and services around the unifying atrium and courtyards allows receptionists to direct all visitors to the relevant clinical zone which they can directly see from the main reception desk, itself clearly evident upon entering the building.

Highly visible stairs and lifts in proximity to the main reception desk are readily apparent as the means of reaching upper floors.

Each department or community services will be clearly branded by colour and large format graphics ensuring that language is no barrier to identification or directions. Large text will be legible to those with imperfect eye sight.

Within each clinical zone straight, relatively short corridor runs minimise the potential for losing bearings and the provision of windows with natural (or borrowed) lighting and views out not only makes a more enjoyable space but allows the visitor to orientate themselves in relation to local landmarks.

Room numbering allows the directing of visitors to specific rooms. The use of bolder colour to those rooms which serve visitors differentiates and prioritises these above staff and ancillary doors which will be downplayed. Magnetic name signs will be provided to each door allow the clinician in residence to be identified.

Statutory signage will be provided in accordance with all statutory requirements; the aesthetic of this signage will be stylish and professional, more akin to an office environment, as opposed to institutional whilst ensuring compliance with current DH guidelines.

5.15.3. Interior materials

One of the key elements of the design is the central double height spaces entered on arrival into the building. The location at the heart of the building means that it is the

organisational hub for the various clinical spaces and contains the reception areas; waiting spaces and the main accommodation stair.

This central space will be focus of the internal spaces leading to the two internal atrim 'courtyards' to the rear of the building that look out over the park. The two courtyards are topped by timber framed lanterns with a glazed roof light to allow diffuse natural light into the adjacent clinical spaces.

It is the intention to use a tiled material on the floor as an extension of the plaza at the front of the building and this will carry through into the courtyards to the rear.

The key factor in specifying internal materials is ensuring they enhance the staff, patient and visitors experience whilst also complying with accessibility (Building Regulations and DDA) and clinical guidance (HTMs and HBNs).

All surfaces will be easily cleaned and the initial specifications take into account life cycle maintenance costs. Whilst the selection of internal finishes has not yet been finalised, the intention is to maximise flexibility of spaces through the materials selection. For example, providing a rubber floor to group rooms, in addition to the inclusion of a wash hand-basin, allows a wider range of activities to be accommodated.

Wall protection in the form of IPS panels, proprietary splash-back products as well as impact protection to vulnerable corners and surfaces in key areas of the building will be provided to deliver an attractive, robust finish to the scheme

5.15.4. Artwork and memorabilia

It is widely acknowledged that the arts have a positive effect on physical, mental and emotional health. Incorporating the artwork into the new CCC will be beneficial to the wellbeing of patients and staff, and aid in the healing process.

The PCT and the Council are committed to working with the local community to develop suitable artwork and memorabilia for the WCCCC. A process will be put in place during the construction phase to seek out local artists and groups with an interest in contributing to this.

5.16. Planning Matters

In 2009 the London Borough of Hammersmith & Fulham gave consent to a mixed use development with health, retail, office, community, residential uses and the creation of a new piazza. Following a review of the scheme undertaken by Building Better Health and is housing partner, Notting Hill Home Ownership, in late 2010 a decision was taken to make some minor material changes to the scheme in relation to a reduction in the number of units, alterations to the residential mix and associated minor design alterations. Following consultation with the local planning authority it was decided to conclude these changes by way of a formal full application.

This revised full application was considered at committee on the 11th October 2011 and was granted conditional full planning approval subject to a series of conditions / reserved matters that very much mirrored those applied to the earlier approval.

None of these conditions / reserved matters is considered exceptionally onerous or unreasonable and the Liftco are in the process of seeking to discharge these conditions ahead of the target financial close date, concentrating on those conditions which are subject to "pre-commencement" obligations.

A full copy of the planning approval notice together with a tracker for the planning conditions noting the party responsible for their discharge and the progress made to date, is contained in Appendix 13.

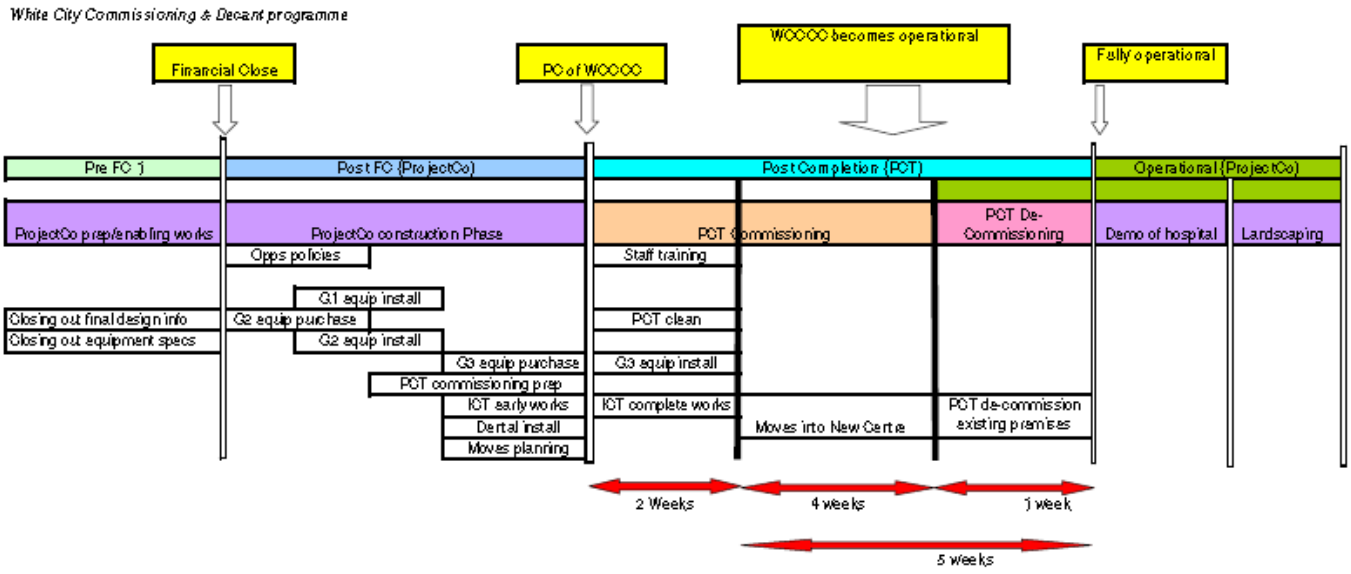
The planning approval granted is also subject to a section 106 agreement which places an obligation on the scheme developer to contribute towards the upgrade of the highway in the vicinity of the new centre (including traffic calming, access provision and new crossing points to serve the scheme etc) as well as for the provision of additional 'Blue Badge' disabled user parking bays located on the public highway to facilitate access to the new centre. In addition the planning obligations include for much needed improvements to the public realm about the site and moreover to Wormholt Park that the new centre backs onto and overlooks. The total planning obligation under the section 106 agreement has been equitably apportioned between the various elements to the overall White City development including the new health facility.

All costs associated with clearing reserved matters and the planning obligations under the section 106 agreement have been identified, quantified and factored into the financial model.

5.17. The Programme

The Liftco have developed a combined design, construction and commissioning programme which working with the Client also incorporates the commissioning and equipping activities of the PCT and local authority to ensure a fully integrated activity schedule which minimises risk by identifying each parties requirements and critical paths in the process of delivering the completed development

Figure 20: Programme



The full construction programme is included in Appendix 16. The key components of the programme between Stage 2 and Financial Close are summarised below:

Closing out final design information

Between stage 2 and financial close, the White City Project Team will be undertaking final reviews of the key components of the design in a series of engagements with Liftco's design team and the main contractor to ensure that full compliance with the Tenant's Requirements has been achieved in the proposed specifications and design drawings developed between Stages 1 and 2 and that any outstanding queries etc are closed out ahead of financial close.

This series of reviews will include the following:

- security strategy and access control proposals
- fire strategy proposals
- ICT installations
- call systems
- acoustic detailing
- dental department designs, servicing and layouts
- general finishes, wall protection
- reception desk designs
- kitchen layouts
- environmental review
- DDA review
- finalisation of derogations schedule
- wayfinding and signage designs

By undertaking these reviews between Stage 2 and Financial Close, the intention is to minimise the amount of information contained in the schedule of Reviewable Design Data (RDD) thus minimising the risk to the Clients by restricting RDD mainly to particular finishes and other non-critical design areas, unless specialist elements are involved. This is consistent with business case guidance and indeed the approach to clinical functionality responsibilities adopted by the project.

In addition to the above specific design reviews, the Project Team will also undertake a final review of all the 1:50 room plans for the building. For stage 2, to ensure completeness of the equipment schedules and to facilitate accurate costing of the scheme, the LIFTCo produced full 1:50 plans for every different room kind / variant which have been reviewed and updated during Stage 2. Post Stage 2, all the other rooms that are repeat versions of the standard room types will also be reviewed in order that a complete, final set of loaded room and floor plans is delivered for Financial Close.

Given the work undertaken in Phase 2 to refine the designs, LIFTCo will be responsible and bear the risk of managing this process through to Financial Close to maintain costs within the affordability cap set by the Stage 2 approval.

Post Financial Close project management

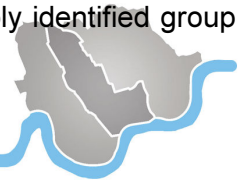
The project management arrangements of the LIFTCo post financial close will follow the requirements of the LPA with the appointment of the Employer's Agent and joint appointment with the Participants of the Independent Tester. These roles are well defined and LIFTCo has demonstrated through the delivery of all previous projects in the LIFT their ability to suitably co-ordinate and manage the supply chain through the financial close and construction phases. The main contractor is the principal party responsible for the successful management of the construction phase. The appointed main contractor Gallford Try is a well-established, experienced construction organisation with robust project management and quality assurance processes. Between stage 2 and financial close, LIFTCo will work with the contractor and the PCT to finalise all aspects of the project programme and management arrangements. Within appendix 12, the main contractors general management, quality systems and production process methodologies are included for general information.

Closing out equipment specifications

The finalisation of equipment specifications in both Groups 1, 2 and 3 will take place between stage 2 and Financial Close via a series of further engagement between the Trust and the LIFTCo.

Group 2 and 3 equipment procurement

The approach to procurement of group 2 and 3 equipment is consistent with the equipment categories identified in the equipment strategy. Post Stage 2 and Financial Close the Clients will develop and finalise the equipment specifications to provide to LIFTCo. The equipment strategy assumes that tenants will supply identified group 2 and



group 3 equipment. The specification of this equipment will be included in the services commissioning documentation.

Beneficial access for pre-completion works – Dental and ICT installations

Dates and periods for beneficial access are required for the installation of dental equipment and ICT systems. The details of beneficial access periods are included in the outline commissioning programme in Schedule 7 of the LPA

Tenant Commissioning Works

The outline commissioning programme included in Schedule 7 of the LPA includes both technical and services commissioning. A joint commissioning group will be established 12 months in advance of practical completion.

6. Commercial Case and Contract Structure

6.1. Introduction

This section describes the proposed commercial structure for the White City Collaborative Care Centre, which will be delivered using the LIFT initiative. The section demonstrates that the standard drafting for the Lease Plus Agreement (LPA) has been adopted, with a limited number of derogations which can be justified by reference to the relationship of the Centre to the wider development with Notting Hill Housing Association.

The section also describes the likely funding structure and cost structure for the funding, and demonstrates that this represents value for money for the PCT and the Council.

The process of allocating the space within the building to different departments / tenants can be described as follows:

- corridors & waiting space have been allocated to departments where appropriate
- on a room by room basis space has been divided between PCT & Council - either on a dedicated basis or a shared basis
- where space has been designated as shared it is either
    - 67% PCT & 33% Council
    - 80% PCT & 20% Council (CWD area only)
    - proportional to the desk space in the admin area

The PCT space has then been divided between the 4 departments (GP, Dental, Specialist Community, CWD) on either a dedicated or shared basis. Where PCT space has been designated as shared it is then divided between the 4 departments based on their % of dedicated space. Within General Practice, dedicated space has been allocated to each of the practices & shared space has then been divided based on the % of dedicated space for each practice

6.2. Project Specific Issues

6.2.1. Overview of the structure

The White City scheme legal structure during the construction and operational phases are shown in the diagrams below.

Figure 21: Legal Structure during the construction phase

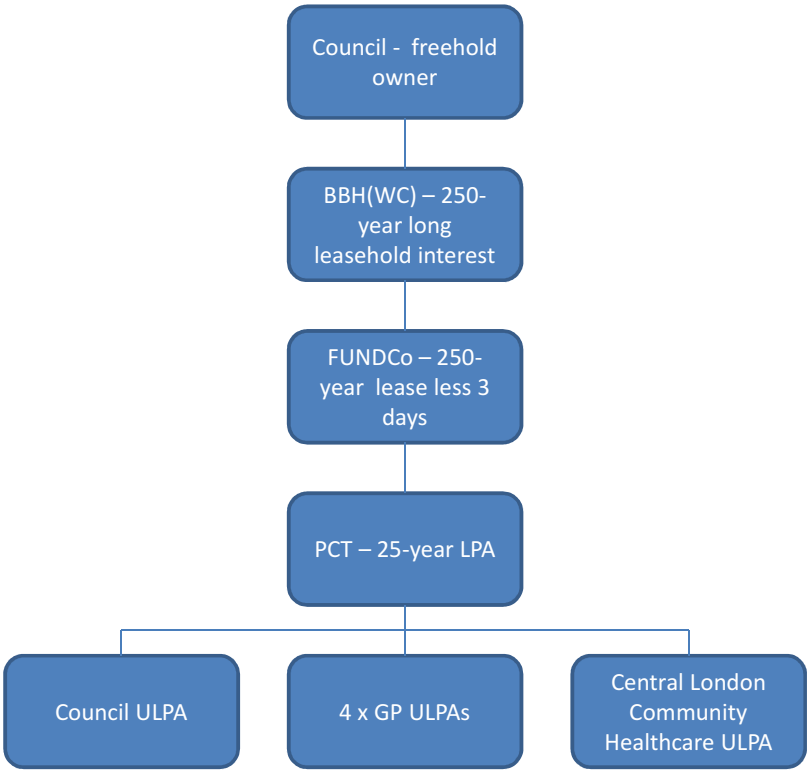
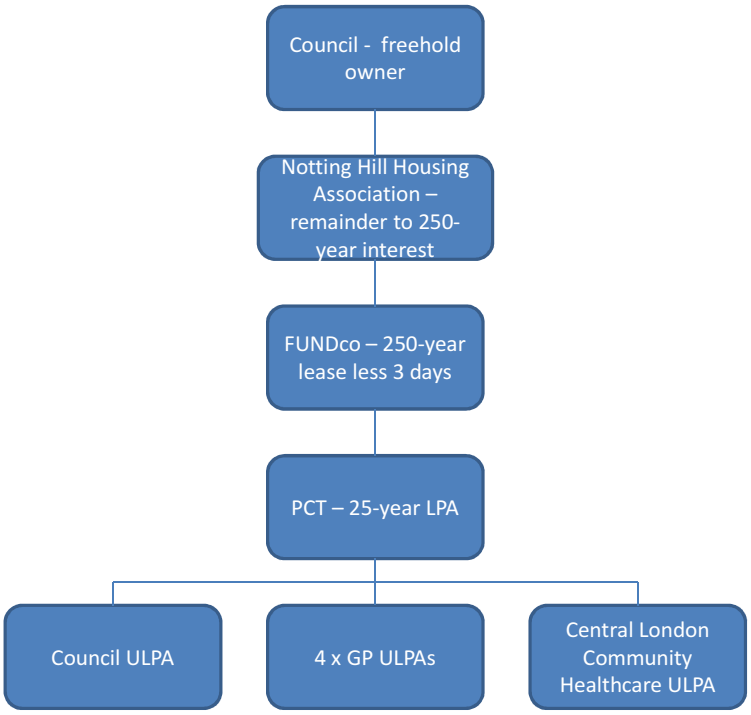


Figure 22: Legal structure during the operational phase



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BBH-White City Ltd will enter into the following agreements:

- a 250-year lease of the site from the London Borough of Hammersmith & Fulham (this lease is already in place)
- a 250-year lease to BBH-West London (Fundco 5) Ltd for the WCCCC
- development agreements with Notting Hill Housing Association and BBH-West London (Fundco 5) Ltd for the construction of the shell & core and external works
- a building contract with Galliford Try for the construction of the shell & care and external works

In addition, BBH-West London (Fundco 5) Ltd - referred to throughout this Business Case as LIFTCo – will enter into the following agreements:

- a 25-year LPA with the PCT
- a building contract with Galliford Try for the fit out of the WCCCC
- an estates management/FM contract with Integral

6.2.2. Detail of the agreements

Although the PCT is to be granted a standard form LPA by FundCo (LIFTCo's wholly owned subsidiary), project specific derogations are to be made to allow for the fact that FundCo's land interest is leasehold rather than freehold.

It is intended that at Financial Close:

- the lease from BBH(WC) to FundCo will be granted
- the LPA from FundCo to the PCT will be granted with the simultaneous granting of Underlease Plus Agreements to the subtenants of the PCT (the Council, Practice plc, three GPs and Central London Community Healthcare)

Although contractually the Works are split between shell and core and fit out works, using the same contractor, for the purposes of the LPA standard form drafting is used to ensure FundCo carries out all the Works necessary for the PCT to lawfully occupy the health and community care facility (these works therefore include works outside this facility).

The health and community care facility forms part of a larger building which also includes residential units. BBH(WC) is to enter into a development agreement with Notting Hill Housing Association to construct residential units.

On completion of the residential units Notting Hill Housing Association is to take an assignment of BBH(WL)'s leasehold interest. Notting Hill Housing Association will therefore become direct landlords of FundCo. Notting Hill will be responsible for managing the hard and soft FM services being provided for the Building (save for the health and community care facility). Notting Hill Housing Association will provide grounds maintenance, lifecycle of the building structure and maintenance of the basement for the

WCCCC. These costs are currently assumed as a Pass Through Cost in the LPA and they will be fixed (indexable by RPI annually) for the concession term.

Notting Hill will be taking out the insurance for the Building (which includes the health and community facility). However to ensure the insurance as detailed in the LPA are provided FundCo is to take out "difference in terms" insurance. It is not intended to vary the terms of the LPA in relation to insurance.

The form of the uLPA will be broadly similar. The uLPA to be granted to the GPs and Central London Community Healthcare will be a recognised national standards form. The uLPA to be granted to the Council is for a third of the WCCCC facility and they are to be granted a higher level of available remedies than the GPs and Central London Community Healthcare (CLCH) and a greater pass down of the rights the PCT have in their LPA – for example the ability to make representations during the construction phase (without the ability to prevent sign off of the building).

The PCT is to make a capital contribution within the Treasury Guidance threshold. The payment mechanism has therefore been weighted accordingly. FundCo will not be able to access the capital contribution until the completion of the Works. In the event the LPA terminates before the expiry of the term and the full benefit of the PCT's contribution has not been received then the LPA allows for a discount from the purchase price if the PCT exercise their option to buy back FundCo's leasehold interest. In the event the LPA terminates due to damage or destruction the LPA allows the PCT to be repaid any un-received benefit from any insurance proceeds left after the repayment of the senior debt.

6.3. Payment Mechanism

NHS Hammersmith & Fulham has agreed with LIFTCo that the payment mechanism will be in line with the standard LPA payment mechanism and meet the calibration metrics set out by the Department of Health.

The LPP is payable for 25 years and it will increase annually by RPI with a base date for indexation purposes of the Financial Close date. The LPP will be payable from practical completion of the WCCCC building.

The availability deductions are based on the notional LPP (set at a higher level which excludes the reduction in the LPP associated with the PCT capital injection). The Minimum Deduction has been set at £30.

The payment mechanism has been fully calibrated by the PCT in conjunction with the Council. The calibration fully reflects the detailed design of the buildings and the proposed service configuration to enable individual rooms to be grouped into functional units and areas. Weightings have been attached to reflect the PCT/Council views on the importance of each unit/area.

LIFTCo and their FM provider, Integral, have confirmed their acceptance of the payment mechanism principles and calibration

The technical due diligence advisers to Aviva, Davis Langdon, have also agreed to the core principles of the payment mechanism and associated calibration.

The following service failure point thresholds which trigger warning notices and remedial step in rights have been set and agreed with LIFTCo.

Table 11: Service Failure Points - ProjectCo

Service	Warning notice SFP threshold on rolling 1 month basis under clause 36.3.2	Tenant's Remedial rights step in threshold on rolling 1 month basis under clause 36.5.2
General	310	210
Utilities	60	40
Estates	200	150
Grounds	80	50
Helpdesk	350	200

In addition, response and rectification times have been included in the service level specifications for each element of the FM service. These are based on agreed response and rectification times as per the standard NHS Service Level Agreements subject to local departures which have previously been agreed on earlier LIFT schemes in the sector and which have proved to be robust, beneficial and value for money for the NHS. NHS Hammersmith & Fulham has also determined that there is no need for an overnight presence at the centre since it will be closed outside of core operational hours.

The detailed payment mechanism and service failure thresholds are included in Schedules 9 and 10 of the LPA.

6.4. Key Issues and Derogations Report - PCT

Appendix 17 contains the Derogations Report for the LPA prepared by Bevan Brittan, the PCT's legal advisors. Differences to the standard LPA have been kept to a minimum, but a limited number of amendments have been necessary to reflect:

- the developer-led nature of the scheme
- that the freehold of the site will remain in the ownership of the London Borough of Hammersmith & Fulham
- the replacement of BBH(White City) with Notting Hill Housing Association as holder of the headlease once the construction phase is complete
- the payment of the capital contribution by the PCT
- that the Collaborative Care Centre forms part of a larger development on the site

6.5. The Council's Contract

The Council will enter into an Under Lease Plus Agreement (ULPA) for its portion of the building which mirrors the provisions of the LPA. The Council and its lawyers Pinsent Curtis have reviewed the draft agreement and are content with the provisions therein.

6.6. Funding Terms

In broad terms the WCCCC project requires the senior lender to provide c.90% of the funding requirement of £15.1m (including construction costs, upfront costs, management during construction).

To ensure the best senior debt funding terms were achieved on the WCCCC, LIFTCo agreed to undertake a funding competition. LIFTCo developed an Information Memorandum providing details of the structure of the WCCCC project and requesting a response to a range of queries including funder margins and terms and period of commitment of terms. The PCT reviewed, amended and agreed the Information Memorandum with LIFTCo.

The overall objective of the funding competition is for LIFTCo and the PCT and the Council to jointly agree to a senior debt provider who offers the best value for money and deliverability for the WCCCC project. On 6 July 2011 the information memorandum was sent to four senior debt providers, who were:

- Aviva
- Barclays
- RBS
- Co-op

Consideration was also given to providing the Information Memorandum to Dexia, however, they confirmed they would only fund a Land Retained Agreement, ie a contract without Residual Value, which is not the preferred structure of the WCCCC project. All of the funders approached are active in the LIFT funding market and therefore they have a good understanding of the standard LPA and experience of closing LIFT projects.

Responses from funders were due on 22 July 2011. Only Aviva provided a response. The other funders all declined to provide terms, as we understand from Fulcrum.'s financial advisers that Fulcrum has run a number of funding competitions over the last 18 months and other funders have not been able to match the Aviva terms on any occasion and they believe they are unlikely to win the competition.

The PCT's financial adviser, Garnet Consulting Ltd, has compared the terms provided by Aviva to the current LIFT funding market and confirmed that the proposed funding package is on market. Their funding package letter is included in Appendix 18.

The Aviva terms are committed in principle up to the end of February 2012; however, they are subject to detailed due diligence and final credit committee approval, which is standard for a PPP project at this stage.

LIFTCo and Aviva have appointed all the funders due diligence advisers and they are now undertaking detailed due diligence.

6.6.1. Fundability

LIFTCo and their financial advisers, Elgar Byrne, have closed a number of NHS LIFT projects with Aviva over the last 18 months, and they are confident that the WCCCC project is fundable.

The PCT and the Council have discussed the current banking market with their financial advisers and recognise that there continues to be volatility in the banking market. The PCT's advisers consider the terms included in the LIFTCo model are reflective of the terms currently being provided and closed on in the LIFT market. Both Elgar Byrne and Garnet Consulting will monitor the banking market as the project approaches financial close, which is expected in late January 2012.

6.6.2. Interest rate buffer

It is accepted that underlying interest rate movements are outside of the control of LIFTCo and the PCT. Aviva will set the underlying interest rate based on a yield on the relevant reference Treasury Bond (or gilt) at Financial Close. This is different to commercial banks in the LIFT market who use LIBOR based inter-bank funding. A buffer of 25bps has been included within the LIFTCo financial model, in line with DH guidance.

At financial close the underlying interest rate buffer will be removed and replaced by the agreed reference rate.

6.7. Equipment and Information & Communications Technology

The development project is a key component in the delivery of modernised primary and community health care services in Hammersmith and Fulham. In initiating the project the key stakeholders recognise the requirement to provide equipment to meet the clinical and functional requirements of the new centre.

The development of White City Collaborative Care Centre takes place within an environment where the PCT is developing its commissioning strengths and divesting itself of direct responsibility for the delivery of patient care. The focus is more on ensuring the delivery of services that are appropriate to local population needs and on ensuring the quality of delivery.

During Stage 2, both the PCT and the Council have therefore tested the strategies established at Stage 1 to ensure that the most appropriate decisions are made in respect

of the procurement, maintenance and replacement of furniture and equipment in order to deliver a solution consistent with the organisations' services and design visions.

Equipment schedules have developed in more detail through Stage 2 reviews of the 1:50 room plans and the healthcare planning due diligence review. The PCT has also continued to ensure that best value for money is obtained by testing equipment assumptions both in terms of requirement, specification and procurement arrangements with an overall view of maintaining affordability within the overall capital investment envelope and driving down cost wherever possible

The PCT and the Council are therefore confident that the equipment proposals that are being developed at Stage 2:

- will support the delivery of the proposed new healthcare facility that is fit for purpose and provides the stated flexibility required to meet the demands of changing healthcare needs in the short, medium and long term
- will ensure that value for money is being maintained, with the specialist advisers conscious of the need to budget for equipment which will be judged by the PCT and the Council on the basis of technical specification, purchase cost, maintenance costs and level of service, warranties, availability of technology refreshment, and life cycles, together with compliance to the existing regulatory framework in accordance with the established equipment strategy
- place the responsibility for the supply, installation, maintenance and replacement with the parties best placed to manage the responsibility – this has included the categorisation of certain elements of equipment to meet this end
- promote sustainability through the selection of environmentally friendly products and materials by working with equipment specialist consultants
- provide sufficient equipment to meet capacity taking into account existing equipment provision
- embrace new technologies where this will promote new ways or improvements in working practice within the affordability cap
- provide equipment to complement the proposed environment to the benefit of patients and staff and which is safe and fit for purpose
- integrate with the interior design and technologies within the new building

The confidence in the equipment proposals presented in the Stage 2 business case is derived from the work undertaken by the project team over the last few months which has seen the equipment requirements become more precisely defined with the further development of:

- the Activity Database Room Data Sheets for all rooms and spaces within the new building which have been substantially developed with the assistance of stakeholders and expert advice to ensure fitness for purpose and flexibility of use in all areas of the new care centre

- cost plan reviews and updates of all equipment requirements to form a revised Bill of Quantities which aligns with the ADB sheets and the developed 1:50 room plans ensuring that all equipment has been identified
- refinement of the responsibilities for equipment procurement via categorization as well as grouping of equipment within the new scheme and by separately identifying equipment within shared areas where costs will be borne by the PCT and the Council proportionately in accordance with their overall dedicated space within the building
- the development of equipment procurement programme that is integral to the commissioning activities programme for the project

The work undertaken in refining the equipment inventories and cost plans has fed directly into the work of the financial team in relation to the strategy for the rental valuations which has also been developed further at Stage 2.

As part of this process the equipment workstream has had direct input into the completion of the schedules of the LPA to ensure that the contractual documentation reflects the practical approach taken to equipping the building.

6.7.1. Equipment Grouping and Ownership

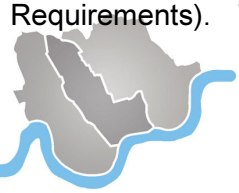
The equipment procurement principles will be underpinned by the requirements of the interfacing strategies identified in the Tenants' Requirements documentation

On this basis the proposal for equipment ownership is as follows:

- Group 1 equipment owned and maintained by Liftco
- Group 2 equipment split into two categories:
  - NHS H&F owned (2a)
  - LB H&F owned (2b)
- Group 3 equipment split into four categories:
  - NHS H&F owned (3a)
  - LB H&F owned (3b)
  - Joint NHS and LB H&F owned (3c)
  - Service Provider owned (3d)

Note there will be some equipment for example waiting area seating which is located in common / shared areas of the building which will be used to the benefit of all parties – in this instance it is proposed that the costs are apportioned between the PCT and Council in the same apportionment as that of their overall space in the building i.e. 2/3rd to 1/3rd

The above grouping of equipment and specifically the identification of Group 1 equipment for which the LIFTCo will be responsible for supplying, installing and maintaining is confirmed within that section of the Tenants' Requirements document which deals with the technical specification of the building (Appendix 5 of the Tenants' Requirements) as well as in the Equipment section (Appendix 8 of the Tenants' Requirements). These



principles will be reflected in the finalised Room Data sheets which will also identify equipment grouping (albeit not the separate ownership sub- categories). On this basis, all parties can be confident that the Contract Documentation for the scheme will align and responsibilities for procurement, ownership and on-going maintenance and lifecycle responsibilities are consistently applied and full understood

The table below identifies the above groupings and categories in more detail:

Table 12: Equipment categorisation

Group	Definition	Example	Owned by	Procurement	Installation	Maintenance	Replacement	Replacement installation cost
1	Items (including terminal outlets), which are supplied and fixed within the terms of the building/engineering contract	Ceiling mounted hoists, Cabinetry, ICT infrastructure	LIFTCo		LIFTCo			Fm & lifecycle cost plan
2a/b	Items that have specific requirements with regard to space and/or building construction and/or engineering services requirements; and are fixed within the terms of the building contract but are supplied under arrangements separate from the building contract.	Examples include Towel dispensers, diagnostic sets, Notice boards etc	NHS / Council	NHS / Council	LIFT Co	NHS/ Council	NHS / Council	NHS/ Council
3a/b/c	Items, which are supplied under separate arrangements from the building contract, possibly with storage implications, but otherwise having no effect on the requirements for space or engineering services.	Furniture associated with the interior design strategy and /or provided in sessionally utilised accommodation			NHS/ Council			
3d	This equipment is deemed to be service specific and therefore ownership and responsibility will be with the service provider and provided as part of the contract entered in to with the service provider.	Mobile imaging equipment (e.g.ultrasound) and other medical equipment			Service provider			

As part of the business case costs of equipment have been allocated across the capital cost plan and a separate bill of quantities that will be funded by the Tenants has been developed based on the accommodation schedule and room data sheets

6.7.2. From Stage 2 to financial close

During the post stage 2 period, the following workstream activities will be required to prepare the project for financial close and the construction / procurement phases of the programme:

- receiving and reviewing detailed specifications / supplier and manufacturer proposals for the scheduled Group 1 equipment from LIFTCo who will have comprehensive vendor lists for the equipment specified. As far as is beneficial, the intention is to maximize standardisation and volume purchases by having vendors take full room, system or functional responsibility for installation packages where appropriate
- developing and confirming detailed specifications of individual items of Group 2 equipment with stakeholders for issue to LIFTCo for design co-ordination / information and to purchasing departments for procurement to accord with the services commissioning strategy, interior design strategy, ICT strategy and Security Strategy as applicable. This process will follow the protocols set out in the Tenants' Requirements, the Equipment and Furnishing Strategy
- the PCT and the Council have the right to set the specification for all medical and specialist equipment. The specification for each piece of equipment will be agreed by the organisation's project team by confirming the technical specifications and banding required of each item
- maintaining close control over the capped equipment costs set at Stage 2
- an updated review of the current equipment asset registers of the PCT and Council to ensure equipment schedules are further refined to accord with existing fit for purpose equipment at all existing localities prior to procurement
- a separate exercise will be undertaken to identify equipment and furniture currently available from other facilities. In tandem with the interior design proposals the best use of these available items in the new facility will be agreed with the relevant donating bodies
- refinement as necessary of the agreed commissioning programmes which have been jointly developed with LIFTCo during Stage 2 to create co-ordinated / integrated design, construction and commissioning plans which incorporate equipment procurement and installation activities

Post-financial close equipment procurement principles will be underpinned by the requirements of the interfacing strategies identified above.

Procurement of equipment: Consistent with the Stage 1 approach to equipment procurement, it has been confirmed at Stage 2 that the inclusion of Group 1 equipment in the rental arrangements and the exclusion of Group 2 & 3 and specialist equipment is consistent with the general expectation that all occupiers will be expected to cover the

cost of equipment that is fixed to the building. The cost of specialist equipment (such as the dental equipment installations for example) will be reflected in an additional charge to Tenants / Providers who will also be charged for the maintenance of the equipment.

The separate calculation of Category a, b, c and d costs in the detailed equipment inventories have allowed the financial team to allocate costs to the Building Contract (Group 1), to the PCT and Council's respective equipment funding budgets (Groups 2a/b and 3a/b) and to the separate service provider contracts (Group 3d).

LIFTCo maintenance and lifecycle cost plan maintenance assumptions remain the same at Stage 2 in that maintenance costs are based on the assumption that only group 1 equipment will be the responsibility of the maintenance contractor so no allowance is included for the maintenance of group 2 or 3 equipment.

It is not anticipated that the majority of group 2 items (e.g. pin boards, coat hooks, soap dispensers etc.) will require much in the way of maintenance. There are a few exceptions where some maintenance may be required (e.g. refrigeration); stage 2 activities have included a review of the equipment schedule and have quantified this requirement. It was on this basis that the decision to retain group 2 equipment within the maintenance responsibility of the tenants was made.

At stage 1 it was recognised that some equipment will be required in areas of the new care centre where the service provider has not yet been identified. In reviewing the detailed equipment schedules at Stage 2 and their categorisation, decisions have been made regarding how these areas will be equipped to meet the intended use but also reflect the PCT's and Council's intentions to minimize capital asset bases and focus more funding to direct patient care.

In this regard, all equipment which enables the flexible use of the clinical space and which relates to the provision of furniture that delivers the "front of house" vision for the interior design strategy have been incorporated into the Group 3c category identified above. All front of house equipment and furniture and that which is located in shared space within the new centre will be jointly funded by the PCT and the Council in the same 2:1 ratio as per their overall space allocation within the building.

In order to reflect the PCT's and Council's commitment to putting the patient first, this equipment will be precisely specified and provided for use at maximum intensity to deliver the highest possible levels of efficiency and flexibility.

6.7.3. Transfer of equipment

Medical equipment: The PCT's Asset Registers will be further reviewed as part of the finalisation of the transfer policy between stage 2 and financial close. However, as part of the process of separation of the provider arm from the PCT, it is anticipated that most, if not all, of this equipment will become the property of CLCH.

It will therefore be the responsibility of CLCH to undertake a transfer assessment on the medical equipment asset registers to determine the anticipated equipment available for transfer should the organisation provide services in the new facility.

CLCH clinical staff have been involved in the 1:50 review process to ensure that Group 3 equipment to be supplied by the chosen provider will fit in the clinical space.

Non-medical equipment: An estimate has been made that a small amount of the future requirement for this type of equipment will be available from transfers. As part of the process of separation of the provider arm from the PCT, it is anticipated that most, if not all, of this equipment will become the property of CLCH.

It will therefore be the responsibility of CLCH to undertake a transfer assessment on the non-medical equipment asset registers in order to determine the anticipated equipment available for transfer, should the organisation provide services in the new facility.

When considering viability of equipment transfer, account will also have to be taken of practicality issues in respect of the need to maintain seamless services and the lead-time potentially involved in decommissioning and re-commissioning.

Maintenance: Responsibility for the maintenance of equipment transferred to CLCH will also be transferred to CLCH.

Interim procurement arrangements: Consideration will be given to whether contracts placed for new equipment purchased before the operational date for the new facility will include provision for the equipment to be transferred to the new facility during its lifetime of operational use. This requirement will also be made clear to the service providers currently working out of existing facilities. The equipment team will maintain close links with providers and tenant staff responsible for equipment procurement during the construction phase to ensure that all schedules of existing equipment are up to date before new purchasing commences.

Operational Management: The PCT and the Council are aware that an operational management plan for Category a, b and c equipment needs to be agreed and implemented to manage equipment in an appropriate manner. The responsibility of ownership links to operational responsibilities and therefore comes with obligations for maintenance of equipment to optimise safety and also to manage issues such as replacement. This activity will take place during stage 2 and beyond.

Training on use of equipment will be organised with service providers prior to commissioning of the facility. Ongoing training will be the responsibility of the service provider.

Operational Stage: The role of the project team will change once the new facility is fully operational. This can be summarised as:

- agreeing the annual equipment replacement plan

- agreeing any service and specification changes as result of technology change and service demands
- ensuring full consultation and sign off of specific procurements through Specialist Clinical Teams utilising the existing clinical structures
- review of any maintenance specification changes and their implications
- ensuring full availability of equipment for clinical services and that optimum value for money is provided for the PCT and the Council

6.7.4. Information and Communications Technology

The PCT and the Council re-affirm the intention to take an innovative approach to the delivery of Information and Communications Technology (ICT) which it perceives as a set of technologies and service that together play a part in most aspects of both the health services to be delivered from the new White City Collaborative Care Centre as well as the operation and management of the facility, security, telephony, call systems.

The common infrastructure used to support these technologies is based on a standard communications protocol (Internet Protocol or IP) enabling users to exploit a common means to communicate across a Wide Area Network between sites and on to the wider NHS network, LA networks and Internet.

This approach is the basis for the work undertaken at Stage 2 to continue to ensure that:

- the technology supporting the delivery of patient care can be delivered in the simplest manner consistent with expectations of efficiency and effectiveness
- lessons are learned from recent previous projects
- requirements reflect differing user needs
- integration between tenant's systems can be facilitated as far as in possible / desirable allowing for future flexibility and change
- the strategy recognises the full implications of the flexibility of use that the facility will need to support
- the outputs of the strategy are reflected in the equipment requirements

To this end, the PCT and the Council have engaged their respective ICT teams to develop a technical brief to facilitate the detailed design by the LIFTCo of the necessary infrastructure within the new building to support the overall ICT strategy.

This technical brief is an addendum to the main ICT strategy and now forms part of the enhanced Tenants' Requirements, developed from the Tenants' Requirements submitted with the Stage 1 Business case.

At Stage 2 the following specific work has been undertaken and reflected in the LIFTCo's detailed design proposals and within the PCT's and Council's commissioning programme:

- confirmation of structured cabling requirements
- confirmation of redundancy and interconnectivity within the new care centre

- development of a design and technical brief for LAN / hub room fit out and servicing
- clarification of environmental parameters and security related issues regarding the installation of IT equipment and telephony
- clarification of equipment specifications and costs
- confirmation of incoming mains services / communication circuits

In addition to the above, the PCT and the Council have worked to develop a project plan which will deliver not only the installed ICT equipment at the new care centre but which will facilitate the various moves and relocations necessary during the commissioning phases to relocate the incoming clinical services and providers into the new building.

This project plan, which will be further developed between Stage 2 and financial close includes for:

- **network design of the new care centre:** the Detail Level Design (DLD) of the network infrastructure required for the new centre, also the Bill Of Material (BOM) required to install the equipments
- **design and planning for the relocation of users and services**: the cost and planning for the relocation of all existing services out of existing locations and the re-provision of IT and telephone services to the users at their new locations
- **planning the re-provision of IT services to the newly redeveloped centre**: this entails the resource cost and planning for the re-installation of services based on the detail level design for the commissioning of all IT and telephone services
- **planning for the relocation of users and services back into the new care centre**: based on the information regarding the space allocation and the floor plans for the services and users that will be housed in the new care centre

At Stage 2, with the additional work undertaken to define the technical brief and to schedule the costs of identified equipment and project management services, the PCT and the Council remain confident that the infrastructure and equipment implications of the ICT strategy are included in either the capital cost plan, the equipment Bill of Quantities or the project management costs included in the business case.

Post Financial close, a joint ICT project team will become an integral part of the Commissioning Team and work has already commenced on developing the organisations' commissioning programmes.

6.8. Subcontracts and Supply Contracts

It is not expected that anything in the subcontracts, supply contracts or funding documents will affect the allocation of the risk under the LPA. However, these documents are still in preparation and this review has not yet been carried out. The review will be completed before financial close.

6.9. Employment Matters

Currently, the maintenance (hard FM) of the PCT's buildings is carried out on an out-sourced basis, using a contract established by West London Health Estates. The contract provides for the addition and removal of sites, and the contract will move from the current buildings to the new White City building.

TUPE would only apply in this case if any one person spent 50% or more of their time working at one site. There is one centre manager at White City Health and Care Centre who may have TUPE rights.

7. Financial Impact for the London Borough of Hammersmith & Fulham

7.1. Introduction

This section will demonstrate that the WCCCC project is affordable to the Council.

The Council has compared the WCCCC project to their current costs to understand how additional costs and savings can be made through moving into the new WCCCC development.

Two elements of affordability have been considered:

- revenue
- capital

7.2. Position at OBC Addendum

The Council set out the revenue affordability implications of the WCCCC within the OBC Addendum dated August 2010.

The PFI credits calculation was updated to reflect the changes in the scheme, and an overall revenue affordability gap was identified of c£43.1k pa. The Council provided confirmation of Cabinet commitment to meeting this gap.

At the OBC stage it had been envisaged that equipment capital costs would be negligible as equipment would be re-used from existing Council buildings.

7.3. Revenue Affordability

The detailed revenue impact of the WCCCC development proposed in this FBC is set out below. The analysis assumes a January 2012 price date and the baseline revenue costs for the existing estate are extracted from the 2011/12 budgets.

The figures below show a full year's impact of the new WCCCC development.

Table 13: Full Year Revenue Affordability Analysis

Annual Revenue Affordability Analysis	Do Nothing/ Current Position £000s	New WCCCC Costs £000s
Occupancy costs		
LD Integrated Team (Stamford Brook)	98.9	0
Assessment and Care Mgt (King St)	126.5	0

Annual Revenue Affordability Analysis	Do Nothing/ Current Position £000s	New WCCCC Costs £000s
LPC for WCCCC	0	379.6
Running Costs		
Annual running costs	Incl. above	220.6
Optimism bias	0	11.4
FM cost contingency	0	11.0
TOTAL ANNUAL COST	**225.4**	**622.6**
Variance from Do Nothing		397.2
PFI Credits annuity		(335.2)
Council annual affordability gap		62.0

The LPP assumes that the Council will accommodate one-third of the WCCCC. The remaining two-thirds of the accommodation and associated LPP will be payable by NHS Hammersmith & Fulham.

This agreement represents a PFI arrangement which under International Financial Reporting Standards (IFRS) requires any assets associated with it to be recognised on the Council's balance sheet. These assets would, in turn, be matched by a long-term liability which would represent a credit arrangement. This would attract Minimum Revenue Provision (MRP), however this would effectively be funded by the budget for this project. The assets would be depreciated but these costs are neutralised by statute and do not impact on the General Fund. Ultimately, with regard to project as a whole, the impact on the General Fund is no different from treating all costs as revenue (as they previously would have been).

7.4. Optimism Bias

Optimism bias was calculated at OBC stage and has been reviewed for this FBC.

As part of the typical optimism bias calculations a percentage increase to capital costs is given as an 'upper bound' (the maximum percentage increase to capital costs without mitigating any of the contributory factors) for project appraisal; this has been calculated using the model developed by the Department of Health.

Upper Bound figures for the WCCCC development have been calculated at 19% with 16% of the contributory factors unmitigated. Overall this provides an optimism bias figure of 3.0%.

Appendix 25 provides details of the upper bound and mitigation calculations.

7.5. Revenue Affordability

The changes in revenue affordability between OBC Addendum and the FBC are set out in the table below:

Table 14: Comparison between OBC Addendum and FBC Annual Revenue Affordability

£000	FBC	OBC Addendum
Funding gap (excl. PFI credits)	397.2	391.4
PFI credits (annuity)	(335.2)	(348.3)
Council annual affordability gap	62.0	43.1

The new WCCCC will enable the LD integration team to move from their existing accommodation at Stamford Brook as well as the Assessment and Care Management teams relocating from King Street. The savings from vacating these properties in combination with the PFI credit allocation identified in the OBC dated November 2009, result in a revenue affordability gap of £62k pa. The Authority will fund this gap through the implementation costs budget, which has been paying for costs incurred in developing the WCCCC project to date. These current services/costs will not be incurred once the WCCCC construction is complete and the LPP becomes payable. The Council has previously committed to fund the revenue gap of £43.1k. When the FBC is put to the Cabinet on 5th December it will be asked to approve that the implementation costs budgets is used to cover the £62k gap. The Council's Executive Management team, including the Director of Finance, have reviewed the affordability position and the associated risks and they have accepted the allocation of this budget. Council Members have been actively involved in this project and Council officers consider that it is highly unlikely that the Cabinet would not agree to this, as the political desire and commitment for the WCCCC to be built is so strong.

It has been assumed that associated service costs will remain the same as the Council do not foresee cost movements as a result of moving into the WCCCC.

7.6. PFI Credits

Within the WCCCC OBC dated November 2009 the Council provided detailed PFI credit calculations. The OBC Addendum dated August 2010 subsequently updated the OBC including revisions to the PFI credits calculations. Although the OBC Addendum was subsequently approved by the Department of Health we understand that the PFI credit allocation is as per the original OBC. The key parameters for the calculation of the PFI credit annuity are as follows:

- total level of PFI credits £4,533,290
- interest rate 5.4%
- scaling factor of 100%

The annuity calculation has been re-calculated due to slippage in timescales. The key differences between OBC Addendum and FBC are set out in the table below.

Table 15: PFI Credits Annuity Calculation: Timescales

	FBC	OBC Addendum
Start of operations	March 2014	January 2013
End of operations	February 2039	December 2039

The revised PFI credit annuity grant is £14,078 in Year 1 and £335,201 years 2 – 24 with a final payment of £293,301 in year 25. The revised PFI Credit Annuity calculations are included in Appendix 26.

At the OBC stage the level of PFI credits was driven by the breakdown of the LPP. The variances between the OBC addendum and FBC LPP breakdown is set out in the table below:

Table 16: Changes in LPP Breakdown

£000	FBC	OBC Addendum
Inputs		
Annual LPP	391.5	383.2
Capital element	345.2	327.8
Revenue element	36.1	36.9
General element	10.3	18.5

Although the actual level of PFI credits would increase using the FBC LIFT model the Council understand that the PFI credits have been agreed at the OBC level and will not increase. Therefore the calculations in this FBC are based on the PFI credits levels and assumptions identified in the OBC dated November 2009.

7.7. Sensitivities

The LIFTCo financial model and underlying costs have been reviewed in detail by the joint PCT/Council financial and technical advisers and reported on the appropriateness of the costs and funding terms. Their reports are included in Appendix 20 and Appendix 29. An optimism bias contingency has been included to provide a risk buffer.

The running costs, including soft FM services, have been developed by the West London Health Estates & FM department's experience of LIFT and non-LIFT facilities in conjunction with the joint technical advisers. Within the revenue affordability the Council has included a contingency of £11k pa (5% of the running costs).

7.8. Capital Affordability

The WCCCC will require capital for equipping the centre with furniture and IT. Re-using items from other council buildings was considered, but would create a poor visual impression in the new building and would not allow the optimum use of space. The Council's portion of the capital equipping and IT costs have been estimated by the joint technical advisers at £269k, which will be incurred in 2013/14. The table below provides a summary of the equipment and IT costs:

Table 17: Equipment and IT capital costs

	Capital budget £000
Council proportion of general equipment and furniture (group 2 and 3)	81.5
Council proportion of jointly-owned equipment and furniture (group 2 and 3)	20.5
ICT costs	167.4
Total	**269.4**

The Community Services Department in the Council is currently forecasting that it will end the 2011/12 year with a favourable revenue variance of £1.5m and is proposing that £269k of that is carried forward to be spent as capital on equipping the WCCCC building. When the Council considers the FBC for approval on 5th December 2011, it will also be asked to approve the carry forward of £269k for capital equipping. The Community Services Department has successfully carried forward underspends in previous years. There are no restrictions in local government on using revenue funding for capital expenditure.

7.9. LIFTCo Project Funding

The LIFTCo financial model has been reviewed by the Council's financial advisers. Their report is included in Appendix 29. The Council's financial advisers have assessed the LIFT funding terms and confirmed these are in line with current market conditions.

LIFTCo will be funding the whole of the WCCCC construction and land costs through a series of funding sources, which are set out in the table below.

Table 18: Sources and Uses of Funding

Sources	£'000s	Uses	£'000s
Senior Debt	13,639	Capital expenditure	10,472
Equity	5	Bid costs	2,418
Subordinated Debt	1,511	Bank fees	321
		Interest	1,426
		Operating costs	123
		Prefunding reserves	395
Total	**15,155**	**Total**	**15,155**

Senior debt borrowing: Senior debt represents 90% of the total debt raised to finance the project. The terms agreed with Aviva, are set out below:

Table 19: Senior debt key terms

	Terms
Underlying Gilt Rate	3.09%
Interest rate buffer	0.25%
Margin over interest rate	1.75%
Arrangement fee	1.00%
Commitment fee	1.75%
DSRA	3 month DSRA

In modelling the LPP LIFTCo has used an underlying interest rate buffer of 25bps.

Aviva uses a private placement finance bond solution which uses a Gilt rate to fix the underlying interest rate at financial close. The current underlying interest rate is 3.09%, based on a long term gilt reference rate, which is used by the Aviva product.

Equity: LIFTCo's equity investors will all be requested to provide equity and sub-ordinated debt into the WCCC project. The key equity investors are:

- Fulcrum Infrastructure Management Ltd (60% shareholder);
- Community Health Partnerships (20% shareholder);
- NHS Hammersmith & Fulham (20% shareholder).

The key terms for the equity and sub-ordinated debt are set out below.

Table 20: Key Equity/Sub-debt Terms

Term	Rate
Sub-ordinated debt coupon	12.75% pa
Blended equity IRR (post tax nominal)	15.00%

7.10. Cabinet Support

The WCCCC scheme has been regularly discussed in detail at Cabinet meetings with Members, including affordability and risks. The Council Leader and the Cabinet Member for Community Care both agreed in November to adopt an urgent reports process to ensure that the Cabinet can formally approve the FBC at its meeting on 5th December 2011.

8. Value for Money

8.1. Introduction

This section describes how the value for money of the White City project has been demonstrated, both quantitatively and qualitatively.

It starts by summarising the analysis carried out at Stage 1/OBC which established that the most advantageous option was the development of a Collaborative Care Centre at White City. This includes an updated value for money calculation for the preferred option and the Do Nothing comparator, using the Generic Economic Model.

The section then sets out the way the PCT and the Council tested LIFT to establish whether it was the best procurement route, and summarises the analysis carried out in early 2011 which showed that LIFT with a capital contribution would be the procurement route which would provide the best value for money for the public sector.

There then follows value for money analysis of the underlying costs of the scheme – construction costs, fees, facilities management, equipment and funding

8.2. Quantitative Value for Money Analysis

At Stage 1, the following options for delivery of the service objectives were considered:

1. Do Nothing

This option would require the PCT and the Council 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, musculo-skeletal and psychological therapies not being permanently 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.

2. White City Collaborative Care Centre

This option would see the opportunity to deliver the borough's primary and community services to 50,000 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.

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. The new space would not be large enough to accommodate social or voluntary services and the benefits of integrated working could not be realised.

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 not cover the cost of the new development and 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 valuation for the site given by Savills (see Appendix 19) is up to £2 million, but with a more likely receipt of £1 million.

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. Grouping Primary care provision in this way, without a central hub, does not allow patients the range of services and access they require or the PCT wishes to commission.

6. Development of Hammersmith Hospital Site as a collaborative care centre

The PCT has done this successfully, to an extent, 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 complement existing General Practice and community services, or to serve as a hub. It has also demonstrated less appeal to residents than the White City based Canberra Centre for Health.

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

Table 21: summary of impact of each option at stage 1 on each investment objective

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

Thus the PCT and the Council agreed that the only feasible option for change was a new-build in the White City area.

The site proposed for this development was sold (on a long lease) by the London Borough of Hammersmith & Fulham to BBH in 2006, 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
- S106 contribution to works on Wormholt Park

A search was carried out by Knight Frank in February 2011 for suitable alternative sites. The report is contained in Appendix 5. This showed that no suitable alternative sites were available. Therefore the only options open to the PCT and the Council are to remain as presently, with services delivered from a variety of locations and integration not achieved, or the construction by BBH of the Collaborative Care Centre.

The economic cost of these two options to the PCT only has been calculated using the Department of Health's Generic Economic Model (GEM). The key assumptions used in the GEM are:

- sites for disposal on completion of the WCCCC are White City and Milson Road
- the "Do Nothing" option assumes the White City and Milson Road are used throughout the period of the analysis

- in order to keep using the White City and Milson Road sites, maintenance work would need to be carried out in the first five years of the Do Nothing analysis, totalling £333,500 for the White City Health Centre and £279,000 for Milson Road
- the "Do Nothing" option uses the same replacement costs for equipment and IT as the LIFT option
- optimism bias has been added to the LIFT option
- double running costs equating to 2 months of current running costs have been included in the LIFT option
- quantified benefits of moving to the WCCCC are a reduction in non-elective admissions of £630,000 per annum, reductions in A&E attendances of £120,000 per annum and reductions in outpatient activity saving £790,000 per annum, building over 3 years from the first full year of operation of the Centre

The discounted cost of the "Do Nothing" option over 28 years is £11.3 million and the discounted cost of the LIFT option is £3.1 million. Therefore the LIFT option provides the best quantitative value for money for the PCT.

8.3. Qualitative Value for Money

At Stage 1, the investment objectives for this project were set 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

Providing this investment will deliver the following high level strategic and operational benefits (arranged by investment objectives):

Table 22: investment objectives and benefits

Investment Objectives	Main benefits
Objective 1: Improve integration between health services and health and social care services	• Co-location will allow the Local Authority to fulfil its 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 • 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 needs. Navigating services and coordinating

Investment Objectives	Main benefits
	inputs is a challenge. Fully integrated teams can focus on users' needs rather than scope and coverage of separate teams, hand offs and handovers
Objective 2: Improve primary care access	• 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
Objective 3: Improve service quality	• 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 clinicians 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
Objective 4: Improve service productivity	• 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

8.3.1. Stage 1 option appraisal

The Stage 1 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 the London Borough of Hammersmith and Fulham. The site was sold to BBH by the London Borough of Hammersmith and Fulham in 2006. 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 Council 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.

There is no land value attributed to the Collaborative 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.

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, musculo-skeletal, 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 Collaborative Care Centre: This option would see the opportunity to deliver the borough's primary and community services to 50,000 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. The new space would not be large enough to accommodate social or voluntary services and the benefits of integrated working could not be realised. 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 not cover the cost of the new development and 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.

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 collaborative 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.

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

Table 23: summary of impact of each option at stage 1 on each investment objective

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

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.

The Council carried out a similar analysis, using a system of weighting and scoring the shortlisted options (Do Minimum and Collaborative Care Centre). The Do Minimum option scored 58 points and the Collaborative Care Centre scored 102 points.

Both the PCT and Council's analysis found that the LIFT option offers the best qualitative value for money.

8.4. Consideration of an alternative procurement route

The PCT thoroughly explored the value for money an alternative procurement route, which would have involved the PCT contributing £9 million towards the cost of the building and then entering into a 25-year contract with BBH to deliver the building. Although the intention was to mirror the main contract terms of a LIFT deal, for example the payment mechanism, the PCT was advised that this "internal repairing and insuring lease" (IRI) structure would not be LIFT.

Initially the structure appeared financially advantageous. However, detailed discussions on the way the structure would work with the PCT's lawyers and tax advisors and the Council's lawyers revealed that risk adjustments should be made to the IRI option for:

- additional costs during procurement
- debt funding margin higher than expected
- additional Stamp Duty Land Tax payments due to more complex lease structure
- higher VAT rate
- land sales income lower than expected or delayed
- availability (lower protection through payment mechanism)
- management costs
- interaction between PCT and Council contracts
- engagement with BBH
- termination risk (loss of prepayment)

The value for money analysis was carried out on three options:

- the IRI option with a £9 million contribution
- a LIFT option with a £2.8 million contribution
- a LIFT option without any capital contribution

The table below sets out the results of this analysis.

Table 24: Economic analysis of alternative procurement routes

	IRI lease with £9m premium £'000s	LPA with £2.8m contribution £'000s	LPA – no contribution £'000s
Total undiscounted cost excluding risk	10,718.7	13,004.8	15,043.7
Additional risk due to procurement route	1,446.7	0	0
Discounted cost including risk and tax adjustment	13,752.3	11,718.3	12,219.1

Following this analysis, the PCT and Council agreed to follow the standard LIFT route, with a capital contribution – note that the contribution is now expected to be £3.8 million.

8.5. Construction costs

The construction and development costs of the White City Collaborative Care Centre are summarised in the Financial Advisor's report in the appendix.

At this stage, BBH has presented cost information in the form of elemental analysis of the various components of the scheme which have been compiled by the main contractor. These cost plans have been developed alongside the planning submission and technical proposals for the scheme as they have developed between stage 1 and stage 2.

LIFTCo has embarked on a two stage tender process with the first stage based on an competitive competition to select a main contractor based on a submission of overheads and profit, preliminaries and an initial cost plan for the new development.

On selection of the main contractor offering the best value for money in relation to the stage 1 criteria, a process of open book market testing has been undertaken with production information for the various subcontractor packages having been issued for tender in order to market test the developing elemental cost plan.

At this time, at the submission of the Stage 2 Business case, sufficient progress has been made in the competitive open market testing of the main subcontractor packages for the main contractor to be able to confirm a guaranteed maximum price for the development to LIFTCo which has been assessed in value for money terms and reported on elsewhere in this business case. On-going work continues on refining the cost plan and undertaking further market testing with a view to improving the position at Financial Close with the safeguard to the Clients of the GMP underwritten by LIFTCo's main contractor

Beyond stage 2, negotiations will continue with the appointed main contractor to agree a finalised contract sum for the works where any saving against the cost plan will be flowed down into the financial model for the benefit of the Clients in the form of a reduced LPP. Should costs exceed the GMP cost plans following conclusion of the second stage tender, then these additional costs will be borne by the LIFTCo via the main contractor in the form of a reduced return.

A breakdown of the main elements of the construction costs are set out below. The construction costs for the scheme comprise a combination of the two main development contracts; the construction of the shell and core space which LIFTCo will be purchasing from BBH White City as the main developer and the separate fit out contract that LIFTCo will be entering directly with the main contractor, all of which will be encompassed in the LPA. These figures have been refined over the preceding weeks moving from the original cost plans to a LIFTCo GMP to a main construction contractor GMP which forms the basis of this business case.

Table 25: Construction Costs

Shell and Core Elements	BBH LIFTCo Cost Plan July 2011	GMP Figure at Stage 2	GMP figure following Tender with main contractor	Construction Cost Benchmarked at Stage 2
Construction cost	3,401,000	3,401,000	3,356,157	3,356,157
External works	145,000	145,000	109,952	-
Design contingency	84,368	84,368	Included	-
Fees	544,500	544,500	519,916	519,916
Financing Costs	417,450	417,450	0	-
Development Management Costs	261,000	261,000	261,000	-
Subtotal	4,852,950	4,852,950	4,247,025	3,876,073
Developers Profit	970,590	647,050	849,405	-
SUB TOTAL	5,823,540	5,500,000	5,096,430	3,876,073

Fit Out Cost Elements	BBH LIFTCo Cost Plan	GMP Figure at Stage 2	GMP figure following Tender with main contractor	Construction Cost Benchmarked at Stage 2
Construction cost	3,470,650	3,470,650	3,609,379	3,609,379
Fees	520,000	520,000	520,000	520,000
SUB TOTAL	3,990,650	3,990,650	4,129,379	4,129,379

Total Construction Cost	BBH Liftco Cost Plan	GMP Figure at Stage 2	GMP figure following Tender with main contractor	Construction Cost Benchmarked at Stage 2
Construction cost	**9,814,190**	**9,490,650**	**9,225,809**	**8,005,452**

The final column in the above table shows those elements of the construction cost that have been benchmarked against comparator projects and the national benchmarks

compiled by Community Health Partnerships for LIFT projects. These benchmarks necessarily remove abnormal elements which can otherwise skew direct comparison.

The process by which these costs have been market tested and validated in set out in this Section and the PCT's technical advisers report is in Appendix 20. This compares the White City scheme to four comparators – note that given the nature of the scheme is it difficult to find direct comparators. The White City costs have also been compared to national data published by Community Health Partnerships.

The benchmarking exercise found that the White City project sits within 5% of the blended rate of the three comparable reference projects selected as benchmarks and is within 1% of the national average range of CHP benchmarks.

Given that the historic CHP cost data precedes both the introduction of BREEAM and the new Part L Building Regulations, both of which have had documented cost pressures on construction costs, this result is considered to re-enforce the value for money benchmark demonstrated by comparison with the White City scheme. This is also the case for the Benchmark 4 project which was delivered on a NEAT assessment as opposed to the new BREEAM requirements which are documented to add anywhere between 3 and 8% to the cost of project.

The current state of the construction market place with reducing work-loads coupled with material cost inflation does mean that indexation of historic costs does need to be treated with a degree of caution. Given however the very close comparison of the White City constructions costs (excluding the abnormal elements) to both indexed national benchmarks as well as individual comparator projects where detailed cost information is available, then it can reasonably be concluded that the current capped construction costs submitted by BBH may said to represent value for money for the Clients at this Stage 2 of the project.

8.6. Land costs

A 250 year lease was purchased by BBH (White City) from the Council for the site which will be the location of the WCCCC. BBH (White City) purchased the lease in February 2007 for a total cost of £3,300,000 which covers the entire development site (i.e. that land required for all aspects of the mixed use development including residential, retail, public realm as well and the WCCCC). Following the purchase of the site BBH (White City) has cleared the site, including demolition of the old Leisure Centre and has incurred rolled up interest costs on the original purchase which have been reflected in the sale price of the land to the LIFTCo.

The sale price to LIFTCo has been calculated on the basis of that proportion of the land for which is required for the development of the WCCCC and incorporates the rights to use the basement area of the development which sits outside the demise of the LPA and confers right to use 23 parking spaces for the duration of the LPA term. This agreed land value is in the sum of £940,000 for a 250 year lease subject to a peppercorn ground rent

The District Valuer has been provided with all information in relation to the land purchase costs and on costs associated with its development as contained in the financial model and has undertaken a review of these overall land costs allocated to the WCCCC, in the context of the overall site value and has confirmed that, in his opinion, the current market value for the long leasehold interest is fairly reflected in the purchase price of £940,000 reflecting the nature of the scheme and the share of the basement and car parking provision for the scheme

A copy of the DV's valuation report dated 21.10.11 is contained in Appendix 21.

8.7. Equipment

A breakdown of the main categories of equipment to be purchased by the PCT and Local Authority is included in the table below. It should be noted that Group 1 equipment is included in the construction costs and as such is not identified here as a separate cost, it being incorporated within the overall Lease Plus Charge. LIFTCo are responsible for the purchase, commissioning and maintenance of all Group 1 equipment.

The total cost of equipping the WCCCC is c£0.6m (including VAT). Approximately 25% of this equipment will be paid for by the Local Authority. The capital costs for equipment are set out in the table below.

Table 26: Equipment capital costs

Item	Budget (£000)
PCT Specialist Equipment (G2 and G3)	171
PCT proportion of general equipment and furniture (G2 and G3)	163
PCT proportion of Jointly owned equipment and furniture (G2 and G3)	41
TOTAL	375

General Group 2 and 3 Equipment: The budgets for general equipment have been compiled by the PCT's technical advisers and cover all items of equipment that have been identified during the production of the ADB Activity Database sheets for each room in the new collaborative care centre.

Cost estimates for the equipment have been taken from a range of sources but primarily from recently obtained purchase quotations from other LIFT projects using NHS supply chain providers thus giving a relatively good indication of current market costs for equipment. Some specialist equipment costs such as dentistry, have also been sourced from recently completed projects with an allowance for inflation.

Value for money in respect of the Group 2 and 3 equipment purchases for the scheme will be delivered through the use of the NHS procurement protocols including competitive tendering via the PCT procurement department.

ICT Equipment Capital Costs: A budget for the development of an ICT solution for the new collaborative care centre has been compiled by the project advisers from recent experience on several LIFT projects in the south east and are reflective of current market price expectations for both active equipment and project management costs to deliver the IT and telephony solutions. The principal heads of cost in this regard which have been developed on a centre wide basis (i.e. joint costs for the PCT and Local Authority) and have then been apportioned on a pro-rata basis to reflect the occupation levels within the building. An outline technical specification and project implementation issues have been discussed with the ICT leads at both client organisations to ensure that all aspects of the delivery of an building wide IT solution have been allowed for.

As with general equipping of the building, value for money in respect of the IT and telephony equipment purchases for the scheme will be delivered through the use of the NHS procurement protocols including competitive tendering via the PCT procurement department.

These budgets have been compiled by the PCT's technical advisers and cover all items of equipment that have been identified during the production of the ADB Activity Database sheets for each room in the new collaborative care centre.

Cost estimates for the equipment have been taken from a range of sources but primarily from recently obtained purchase quotations from other LIFT projects using NHS supply chain providers thus giving a relatively good indication of current market costs for equipment. Some specialist equipment costs such as dentistry, have also been sourced from recently completed projects with an allowance for inflation.

8.8. ICT Equipment Capital Costs

A budget for the development of an ICT solution for the new collaborative care centre has been compiled by the project advisers from recent experience on several LIFT projects in the south east and are reflective of current market price expectations for both active equipment and project management costs to deliver the IT and telephony solutions. The following table shows the principal heads of cost in this regard which have been developed on a centre wide basis (i.e. joint costs for the PCT and Local Authority) – these have then been apportioned on a pro-rata basis to reflect the occupation levels within the building:

Table 27: ICT capital costs

Item	Joint ICT Budget (£000)
Access switch	130
Wireless access points	25
Core switch	40
UPS	40
WAN connection (LES, N3 and ISDN circuits)	60

Item	Joint ICT Budget (£000)
VOIP telephone installation (incl. handsets)	20
Desktop PCs (new installation)	60
Desktop PCs (existing relocated)	5
Printers	15
Analogue lines – note that these will be needed for the lifts. Redcare lines, to fire alarm, intruder alarm and panic alarm (external connection) and possibly to BMS	3
Relocation of GP practices' clinical systems into new building	25
Telephone management system for the incoming GP practices and PCT provider departments	20
IT Project Management Costs	
IT Project Manager Cost – establishing initial brief/blueprint design	10
IT Project Manager Cost – new set up	12
IT Engineer Cost – new set up	24
IT Project Manager cost – for GP relocations/set up	12
TOTAL COST FOR ICT AT WCCCC	502
Cost to PCT Cost to LA	334 167

8.9. PCT Costs

The PCT and Council have appointed joint advisers for the project team, except legal advisers, which have been appointed to separate legal firms. This approach enables the PCT and Council to share associated costs.

These fees are provided to construction completion, and the total costs and PCT proportion are set out in the table below.

Table 28: PCT costs

Item	PCT Budget (£000)
Project management	200
Legal (PCT only)	80
Technical	185
Financial	70
Commercial	26
Decant & decommissioning	40
TOTAL	601

These fees and costs are being financed directly by NHS Hammersmith & Fulham.

8.10. Facilities Management Costs

The benchmarking report at Appendix 20**Error! Reference source not found.** also comments on the cost of the hard facilities management proposed by BBH. In reviewing the costs for the hard facilities management elements of the White City scheme (comprising the reactive maintenance revenue costs) regard was had to three main cost information sources to establish a benchmark against which the submission could be assessed; firstly the cost of FM services for three recently completed schemes in the South East which whilst of a smaller size, comprise a similar range and mix of services within the scheme including mechanical ventilation and which have been designed to achieve BREEAM excellent ratings and to current building regulations. In addition a fourth scheme of similar size which pre-dates BREEAM and is more naturally ventilated solution that the White City scheme and finally the national FM cost data published by Community Health Partnerships.

LIFTCo has undertaken a tender exercise to appoint a preferred FM provider from their current supply chain and have now provided a figure for FM service costs based on the results of this tender exercise which was based on the same agreed Service Level Specifications as previous projects in the LIFT. At this time, the benchmarking has been undertaken in relation to these costs which are now included in the Stage 2 financial model

Table 29: Hard FM costs

Scheme	Financial Model - FM £ cost p.a.
White City	84,000
Annual cost per m2	23.60
Whole Life Cost for term of LPA per m2	589.88

The report concludes that the FM costs put forward for White City sit within a reasonable range of the schemes used as a benchmark. Whilst the scheme does not include for grounds maintenance (given the situation of the health centre within a larger development) the fact that the scheme will be totally mechanically ventilated (there being no openable windows within the 100% curtain walled façade and a number of internal rooms within the scheme design) this acts to counter the expected cost savings as the mechanical and electrical component of FM services is proportionately higher.

These costs are as noted, based on a BBH capped GMP figure and will potentially be subject to price reduction as part of the competitive open book tender process currently being administered by the LIFTCo.

In addition to the construction costs, the lifecycle costs/expenditure for the same benchmark comparators has been utilised as the benchmark for the lifecycle elements of the White City project.

Whilst the expenditure profile for these comparator schemes were smoothed to assist with cash flow and address any potential concerns surrounding the sensitivity of their respective financial model, the resultant programme was supported by the respective

funders and their FM service provider and remained realistic in terms of delivering the requisite maintenance resource required under their Lease Plus Agreements.

The figures provided by BBH Liftco at this Stage 2 of the business case financial model are based on a detailed lifecycle cost modelling exercise undertaken by their consultant advisers David Langdon and are derived from previous BBH projects and are effectively capped at Stage 2.

The Whole Life Cost Model has been prepared by BBH using the main contractor's Cost Plans for the works (shell and core and fit out) along with the relevant drawings and specification details on which the construction costs were based

Liftco have confirmed that the lifecycle replacement periods and work intervals used in the model are based on published data, research, feedback from comparable buildings in use, and experience. Replacement periods assume that the appropriate planned maintenance is carried out, in accordance with good industry practice and manufacturers' recommendations. Work items have nominally been allocated to a specific year within the model but it is acknowledged that in practice, it is likely that the work items will most likely be spread across a number of years to minimise the operational disruption to the facility. In some instances, the model attempts to reflect this 'smoothing', although this will be driven in practice by the operational requirements prevailing at the time.

This exercise showed a close comparison with the benchmark scheme figures and a favourable comparison with the national data set. Therefore the total lifecycle cost package for the White City project may reasonably be considered to represent value for money for the Clients.

8.11. Partnering service costs

The LIFTCo on-going management costs have been agreed by the PCT. Details of these costs are included in the PCT's financial advisers financial model report.

8.12. Value for Money conclusion

The PCT and the Council have carried out extensive work which has established that:

- a new Collaborative Care Centre is the best way to deliver their strategic and service intentions for health and social care in the White City area
- the White City Collaborative Care Centre can be shown to provide the best quantitative and qualitative value for money of the options considered
- LIFT provides the best route for delivery of the WCCCC
- the individual elements of the cost of the WCCCC can be shown to be value for money through benchmarking and reports of external parties such as the District Valuer

9. Project Management, Risk and Benefits Realisation

9.1. Introduction

The PCT has approached the delivery of the WCCCC by establishing a project structure to ensure that both key organisations are kept up to date with developments and take part in decision-making, risks are appropriately identified and managed and communication between the PCT and the Council is maximised.

Management and delivery of the project has taken place in the context of changing organisational structures, developing policy and a challenging financial climate; the approach to mitigating the risks inherent in these issues is addressed under 'Key Risks' in this section of the Business Case.

Moreover, the project represents one element of a larger development, comprising residential and retail facilities. This has required close examination of the construction programme, risks associated with the operation of the WCCCC whilst the remainder of the development is still under construction and on-going service charges payable to the owner of the residential units.

The critical success factors that have driven the project in the period January to October 2011 include:

- Programme:
  - delivery of a programme that recognises the challenges associated with the long gestation period of the project whilst ensuring that the key deliverables are appropriately managed and closed out
  - early identification of the project risks and close management
- Design:
  - underpinned by a strong, integrated brief (Tenants' Requirements)
  - consistent demonstration of intimate links between the brief and the design
  - close monitoring to ensure the delivery of Key Performance Indicators (KPIs)
- Contracts:
  - interrogation of construction /fit-out risks
  - interrogation of early operational risks
  - delivery of signed-up occupiers
- Affordability:
  - focus on value for money judgements
  - focus on robustness of the financial model
  - focus on robustness of affordability assessments

The activities that have taken place in preparation for the joint Stage 1 and Stage 2 submission are summarised in the table below.

Table 30: Activities

Project management
Management of programme of work Co-ordination of activity profiles, joint project board & joint project team Management of risks
Health and social care services work-stream
Activity/capacity reviews completed Programme of commissioning activities Benefits realisation plans
Design /construction work-stream
KPI monitoring & reporting Site planning review Building externals & facades review Room layouts & Room Data Sheets reviews Interior design development reviews /way-finding interfaces programme Schematics proposals: healthcare planning technical reviews
Communications
External communications meetings Engagement activities
Financial /commercial work-stream
Affordability analysis Capital cost analysis Lifecycle & FM costs Capital charge & overheads review Balance sheet opinion Tax & VAT review Development of rental strategy Value for Money review Financial Model Funding competition
Legal /contractual work-stream
Re-assessment and final decision on contracting route All elements of LPA reviewed; all schedules developed uLPAs for all tenants
Equipment /ICT work-stream
Categorisation of equipment Room Data Sheets /1:50 equipment review programme ICT programme
Design team
Design development Planning requirements interfaces
Decant work-stream
Confirm staff /departments to be relocated, costs and programme
Commissioning /decommissioning work-stream

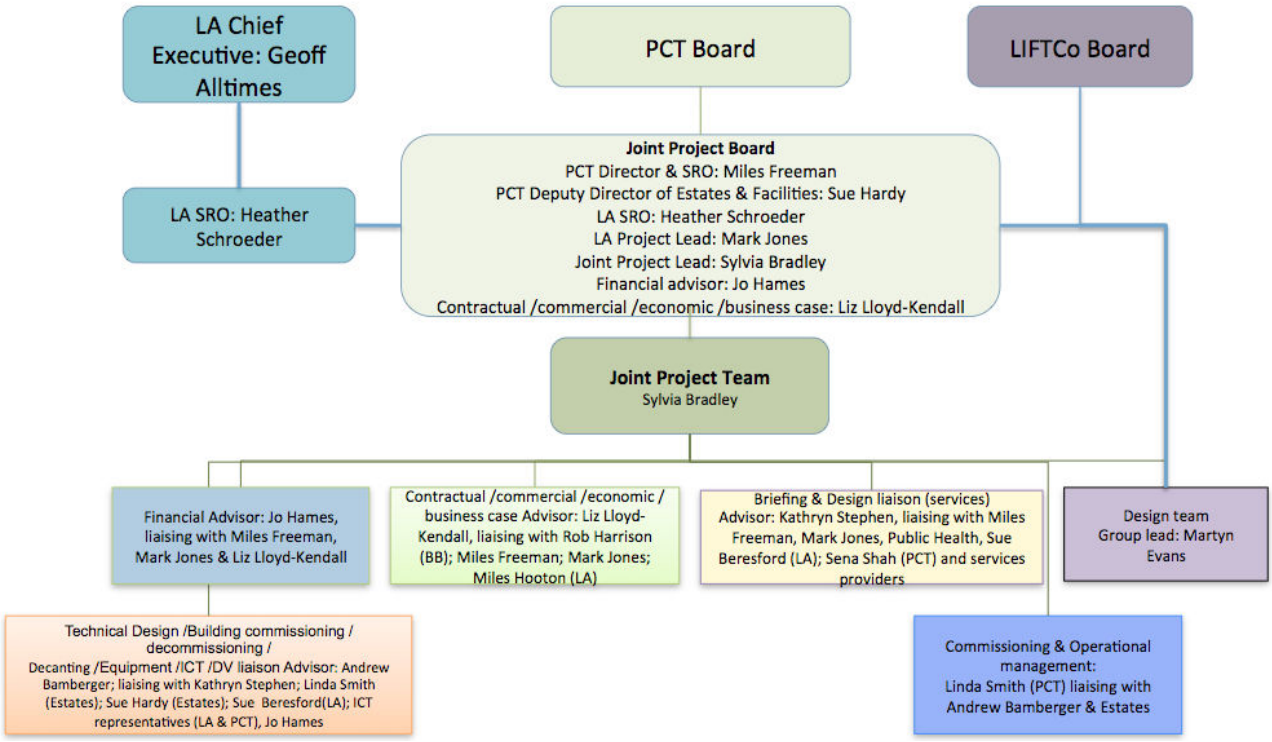
Soft FM confirmation of current position on services & providers, contractual arrangements; proposals for delivery of services to new build including procurement proposals and interface with clinical services Programming and interfaces with decant proposals

Leaders of all activity profiles have coordinated their activities to ensure that there are no gaps or overlaps and progress has been reviewed on a fortnightly basis at Joint Project Team meetings; these meetings have taken place weekly over the last 2 months.

Any high level risks have been reported to the Joint Project Board, for agreement of mitigating action intentions.

9.2. Project Organisation and Plan

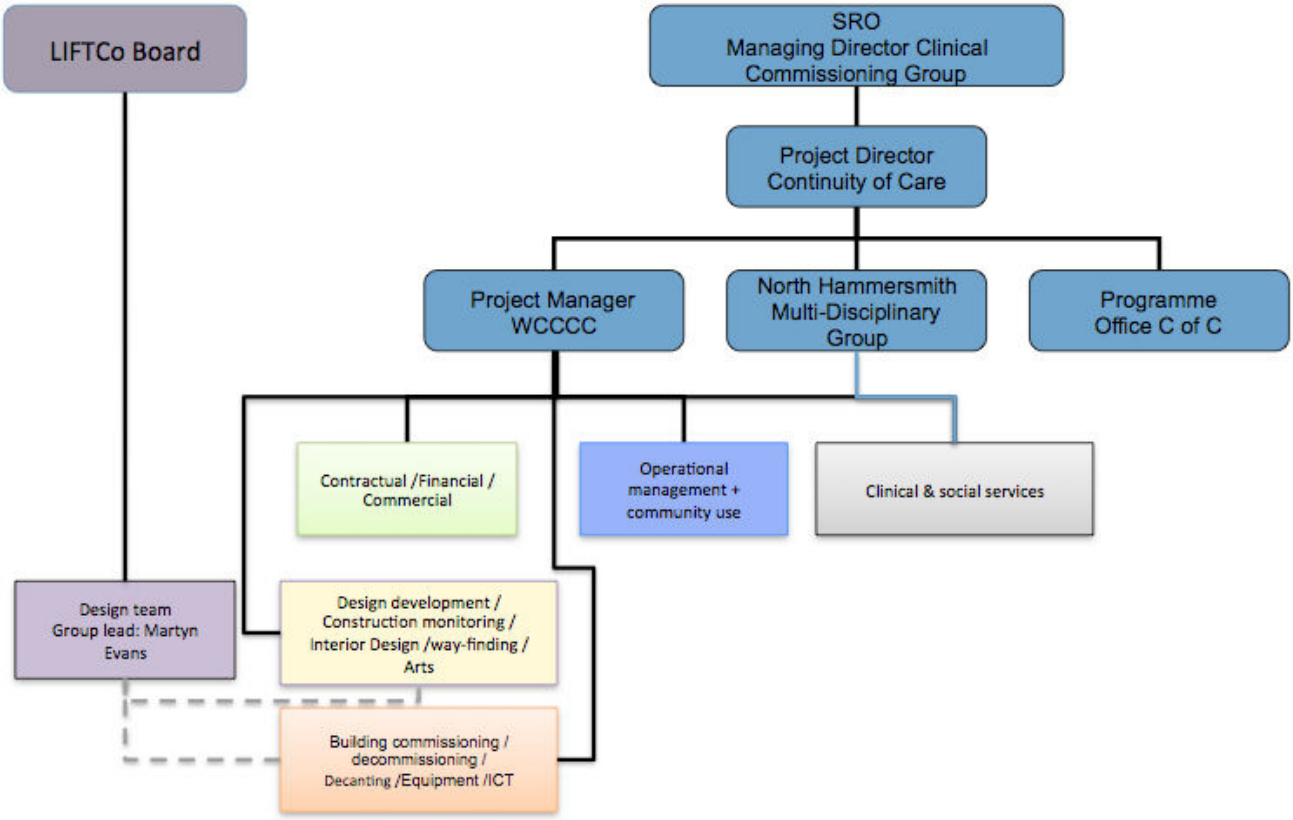
Figure 23: Project Structure



Details of the project's organisational arrangements for delivery of the Business Case can be found in the Project Inception Document (PID) at Appendix 22.

Post-Financial Close Management Arrangements: Post-financial close the project management arrangements will be as follows:

Figure 24: Project Structure post-financial close



The PCT has defined the work involved in delivering the WCCCC as part of the overall Continuity of Care Programme due to the imperative to ensure that the redesigned models of services delivery are delivered when the WCCCC opens. The programme of work within the project comprises two inter-linking strands:

- Integrated services delivery
- Delivery of a fully operational facility that continues to comply with the expectations set out in the Tenants' Requirements

The PCT has appointed a Technical Representative who is familiar with the detail of the project, and who will have responsibility for monitoring design and construction progress in the post-Financial Close period. Simultaneously the role will be to work with the PCT's commissioning manager to ensure that the facility is ready for operation. The WCCCC Project Team that will be responsible for the realisation of the capital procurement benefits expectations will continue with its oversight of the programme and the Technical Representative will be a member of this team.

As an integral part of the duties of the Technical Representative, regular meetings will take place with senior design and construction representatives representing LIFTCo with the principal line of communication via LIFTCo's Employers Agent.

Further information on programmes can be found in sub-section 9.8 below.

Post-Financial Close Management Arrangements – LIFTCo: The post-financial close project management arrangements for LIFTCo will remain the same as they are now, with the addition of Galliford Try as the construction contractor. Galliford Try will provide a Construction Manager with whom the Technical Representative of the PCT will liaise.

9.3. Key Risks

A risk profile was agreed in March 2011 that identifies which organisation has responsibility for which risks and at what level those risks lay, a copy of which can be found in Appendix 23.

9.3.1. Corporate risks

The table below summarises in graphic format the risks as they applied to the project in March 2011 and the position as reported in October 2011.

Of a total of 168 risks profiled, the change between March and October 2011 is as follows:

Table 31: Risk Summary

	March 2011			October 2011		
Programme Development	3	6	1	-	4	6
Design Risks	-	16	2	-	-	18
Construction Risks	-	24	12	-	1	35
Operational Risks	-	28	16	-	17	27
Variability of Revenue Risks	-	3	6	-	2	7
Finance Risks	-	13	11	-	8	16
Contract Risks	-	4	5	-	4	5
Disposal Risks	-	3	1	-	2	2
Regulatory Risks	-	10	1	-	-	11
Miscellaneous Risks	-	2	1	-	-	3

These risks have been managed /mitigated by the Joint Project Team in the first instance, with reference to the SROs /Joint Project Board as required.

More detail on the management of risk can be found in the sub-section below headed 'Managing Risk'.

9.4. Key Benefits

Key benefits have been expressed in services commissioning terms as follows:

- improvements in patient care and experience
- improvements in access to services and choice

- ensuring patients only go to hospital when necessary
- avoiding unnecessary acute hospital admissions
- achievement of value for money in commissioned services

Further details on the development of the vision for the WCCCC can be found in the Tenants' Requirements at Appendix 10.

Two benefits realisation profiles, one each for services and for facilities are illustrated in the sub-section headed 'Benefits Realisation'.

9.5. Managing Risks

9.5.1. General

This sub-section of the Business Case describes how the programme of work has been managed from a risk perspective.

The overarching approach to managing risk has been one of pro-actively placing management responsibility with the organisations and individuals best placed to manage it and monitoring progress. Appendix 23 identifies the high level risks and the process /activity associated risk allocations within a risk matrix; this matrix has been managed by the Project Lead and progress reviewed at joint project team meetings.

The table below illustrates how responsibility for managing risk has been allocated:

Table 32: Management of risk – allocation of responsibility

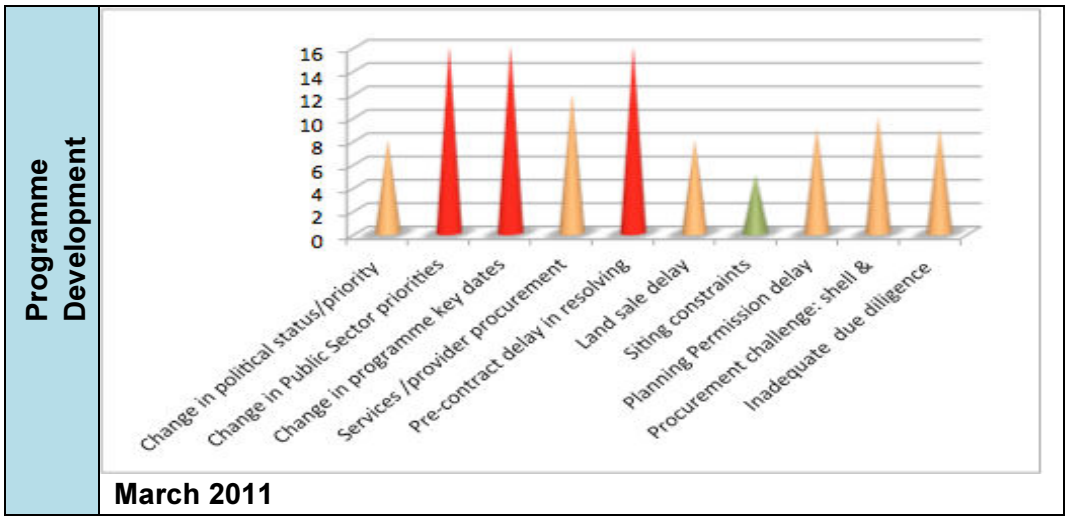
Risk section	PCT & Council	LIFTCo
Financial & commercial	Miles Freeman; Tim Tebbs; Sue Hardy; Mark Jones; Jo Hames; Liz Lloyd-Kendall	Martyn Evans
Approvals	Miles Freeman; Mark Jones; Sylvia Bradley	Martyn Evans
Communication issues	Sena Shah; Mark Jones	Sylvie Pearce
Services delivery	Miles Freeman; Heather Schroeder; Sena Shah; Kathryn Stephen	
Building commissioning / decommissioning	Sena Shah; Linda Smith; Mark Jones	

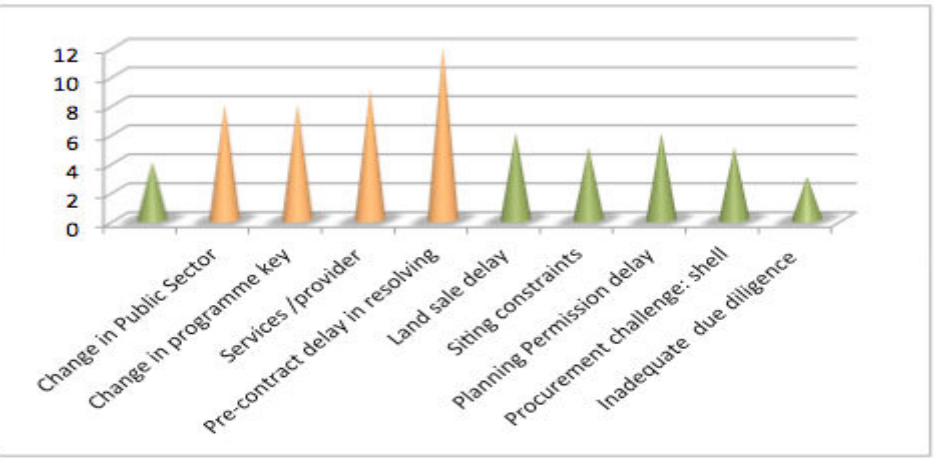
Design matters	Andrew Bamberger	Martyn Evans
Design KPI monitoring	Kathryn Stephen; Andrew Bamberger	Martyn Evans
Governance	Miles Freeman; Mark Jones	Martyn Evans
ICT	Andrew Bamberger; Sena Shah; Mark Jones	Martyn Evans
Furniture & equipment	Kathryn Stephen; Andrew Bamberger	Martyn Evans
Land & property		Martyn Evans
Legal & contractual	Rob Harrison (Bevan Brittan: PCT); Liz Lloyd-Kendall; Kevin Boa (Pincents: Council); Mark Jones /Miles Hooton	Martyn Evans; Peter Hardy (Addleshaw Goddard)
Partnership	Miles Freeman; Heather Schroeder; Sylvia Bradley	Richard Ashcroft
Planning	Mark Jones	Martyn Evans
Programme	Sylvia Bradley	Martyn Evans

The key risks have been mitigated as follows.

Programme Development:

Figure 25: Programme Development Risks





October 2011

Of the ten items identified, five are the responsibility of the public sector to manage and the three high-risk items identified in March relate specifically to the potential for delays arising from the organisational and transactional changes that resulted from the White Paper '*Liberating the NHS'*. The Joint Project Team has taken a two-pronged approach to mitigating these risks:

- close liaison with NHS London's capital investment leads as well as establishing links with the Department of Health to ensure that it understands the revised expectations of these approving organisations.
- close collaboration between both public sector organisations in order to ensure robust development of integrated services profiles that reflect current strategies

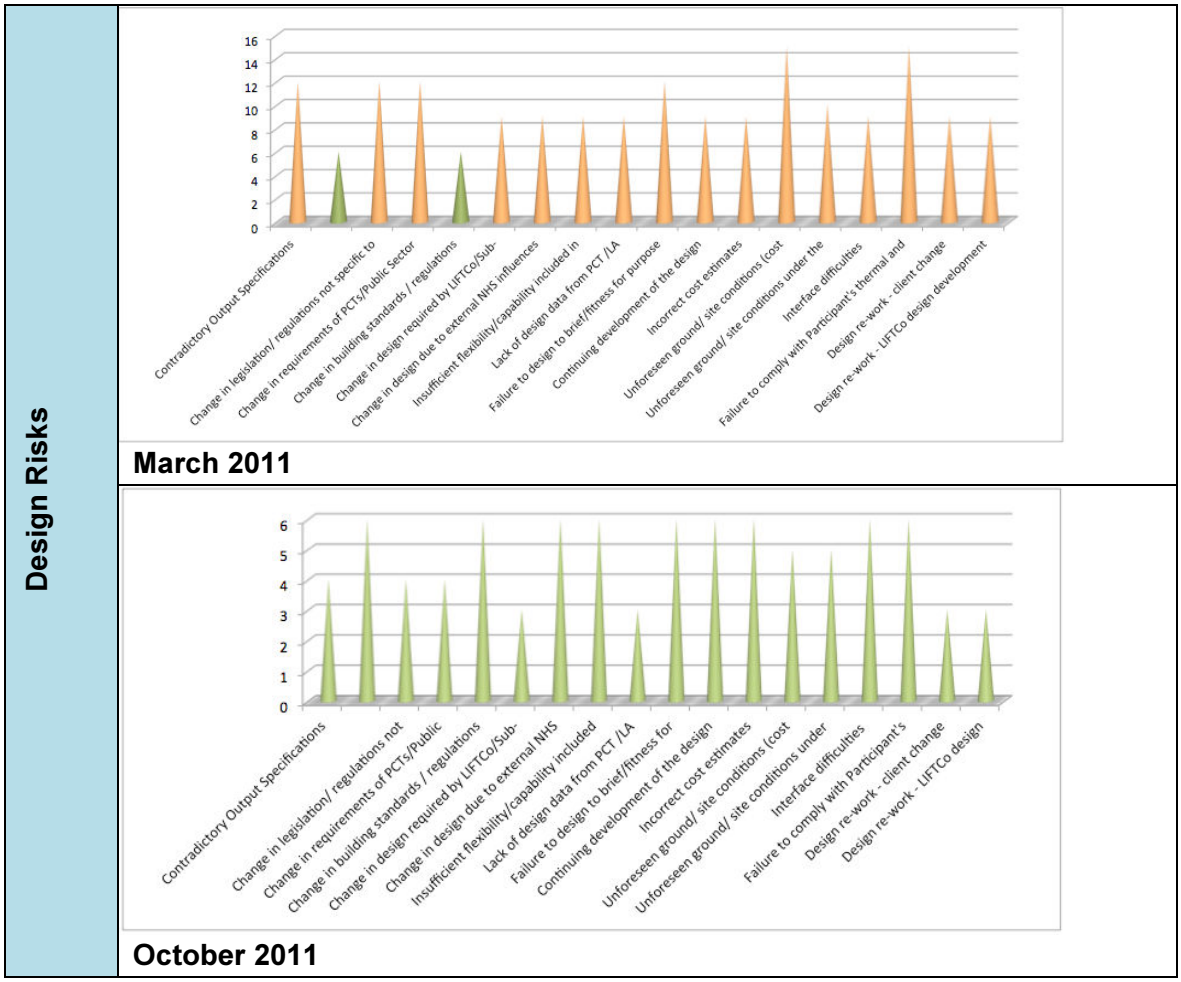
By October the risk rating had shifted from 3:6:1 (red: amber: green respectively) to 0:4:6.

Brief /design development: Six of the eighteen (18) risks in this category are the responsibility of the public sector. These risks relate to availability, and robustness of briefing information and the ability to sign-off design proposals within tight timescales.

The Tenants' Requirements (TRs) have been substantially enhanced to ensure added clarity of functional requirements and built-in flexibility. Value for Money judgments have been applied to these enhancements and in each case it has been considered that the risks of non-achievement of functionality outweigh the risks of increased costs.

By October therefore, all of the public sector owned risks had been mitigated, as well as remaining design risks having reduced, from a total profile of 16:2 (amber: green) to 0:18.

Figure 26: Design Risks



Services delivery: The requirement to provide 'confirmation by the boards of all public sector organisations taking a lease that they support the affordability analysis, to demonstrate that they can and will meet their financial commitment to the scheme' ('*Business case approval guidance for Primary Care Trusts with existing Local Improvement Finance Trusts*' published by the Department of Health in May 2009) has been superseded by the requirement to demonstrate that all providers have agreed the contents of under-leases and are in a position to sign uLPAs at Financial Close.

The services providers will be as follows:

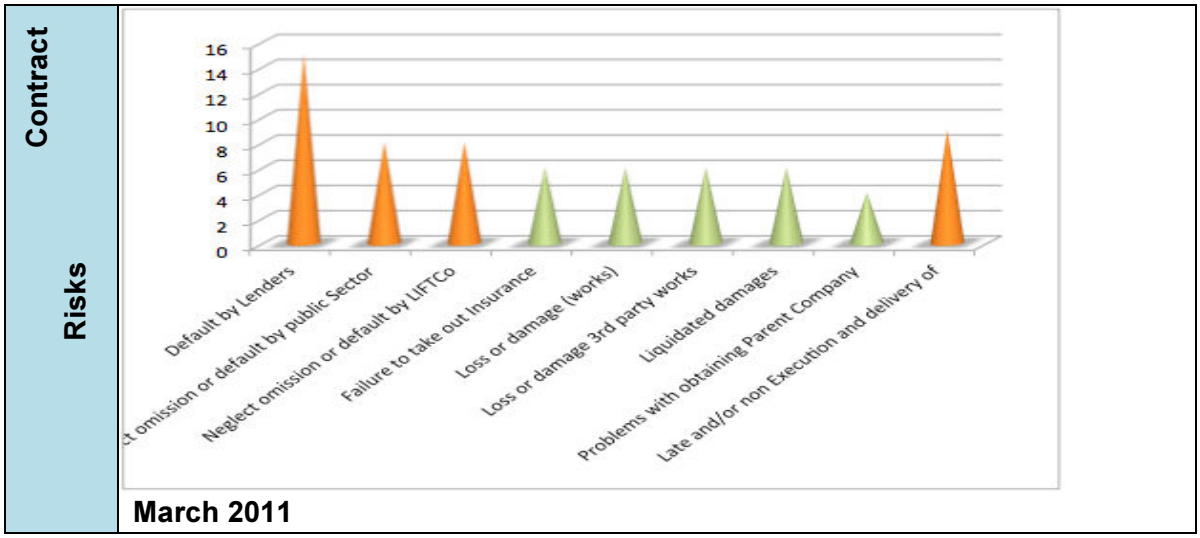
Table 33: Service providers

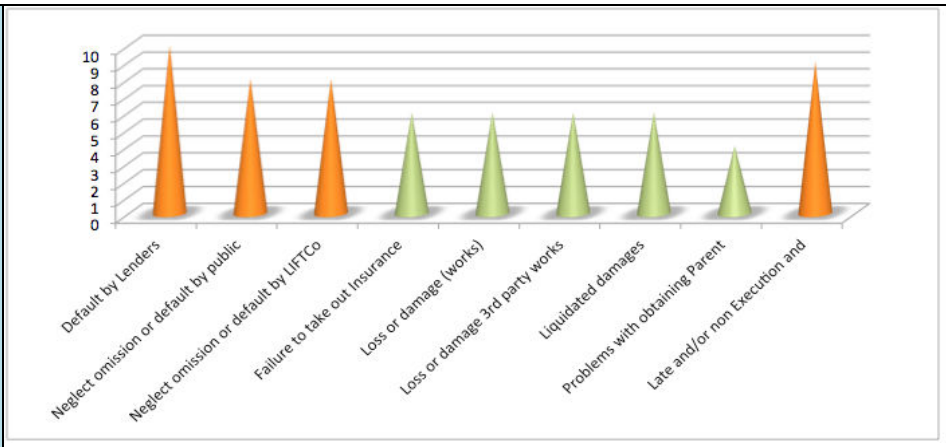
Services	Providers with whom uLPAs will be signed
General Practice services	The Practice plc Dr Dandapat & partner Dr Mirza & Dr R Kukar Dr Uppal & partners
Specialist Community Health Services, on a	CLCH

Services	Providers with whom uLPAs will be signed
sessional basis (including diabetic care, podiatry, tissue viability, musculo-skeletal, respiratory, maternity, paediatrics)	
Dental Services	CLCH
Children with Disabilities Service	CLCH /Council
Adult Social Care including Advice, Assessment teams, Social Workers, Community Nursing & Occupational Therapy, Mental Health services (IAPS), Community team consultations, Learning Disability Community team sessions	Council
Training programmes, including Expert patients programmes, Health trainers, Health Promotion & Illness prevention (e.g. smoking cessation). Sessional bookings from other services such as Interpreter and Advocacy Services, Welfare rights and citizens advice, Self-help groups, Alternative Health provision.	Delivered by a range of providers on a sessional basis utilising Council accommodation

In terms of contract risks as they relate to readiness of prospective providers to sign uLPAs, it has always been recognised that availability of detailed charging profiles would form the biggest risk within the programme. All providers have confirmed willingness to occupy and so the availability of service leads to agree the content of each uLPA has been the greatest challenge.

Figure 27: Contract Risks



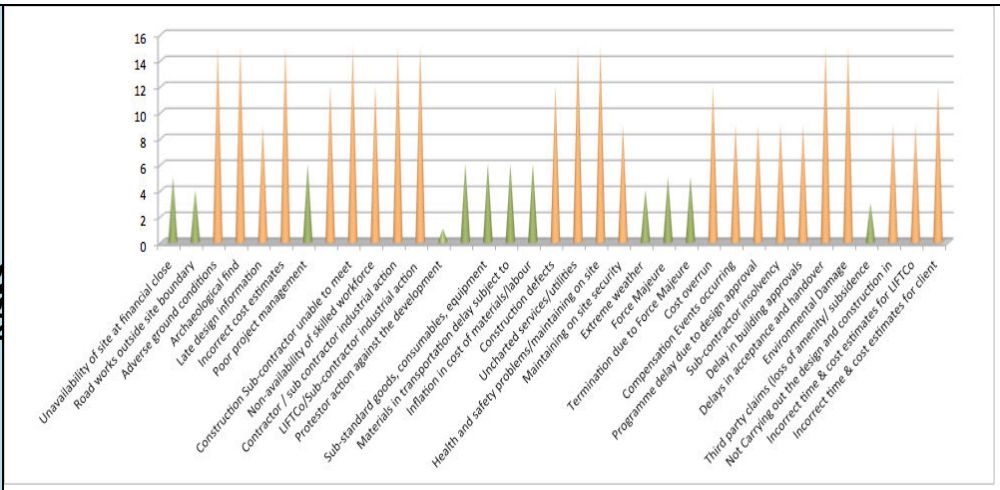


October 2011

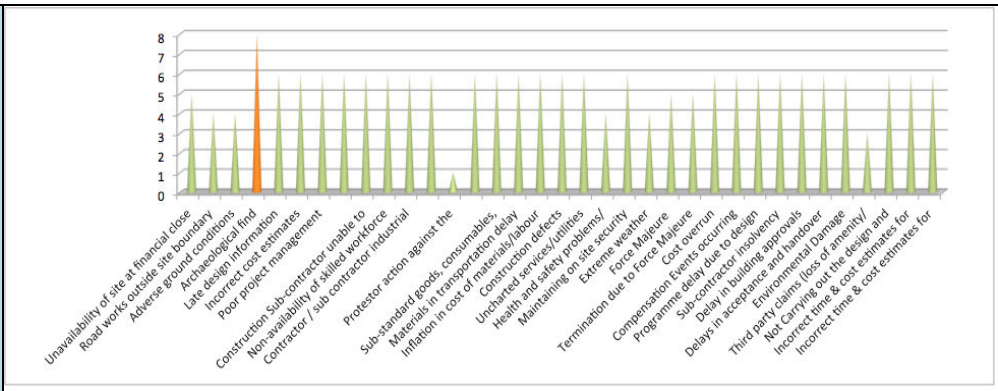
Construction risks: Identifiable risks in March totalled thirty-six (36), of which four are the responsibility of the public sector.

The risk profile between March and October has been reduced from 24:12 (amber: green) to 1:35. The remaining medium risk item relates to the possibility of archaeological finds disrupting construction. LIFTCo has confirmed that it has undertaken a number of detailed surveys with negative results; however, this risk can be no further mitigated until excavation is complete and therefore remains at medium.

Figure 28: Construction risks



March 2011



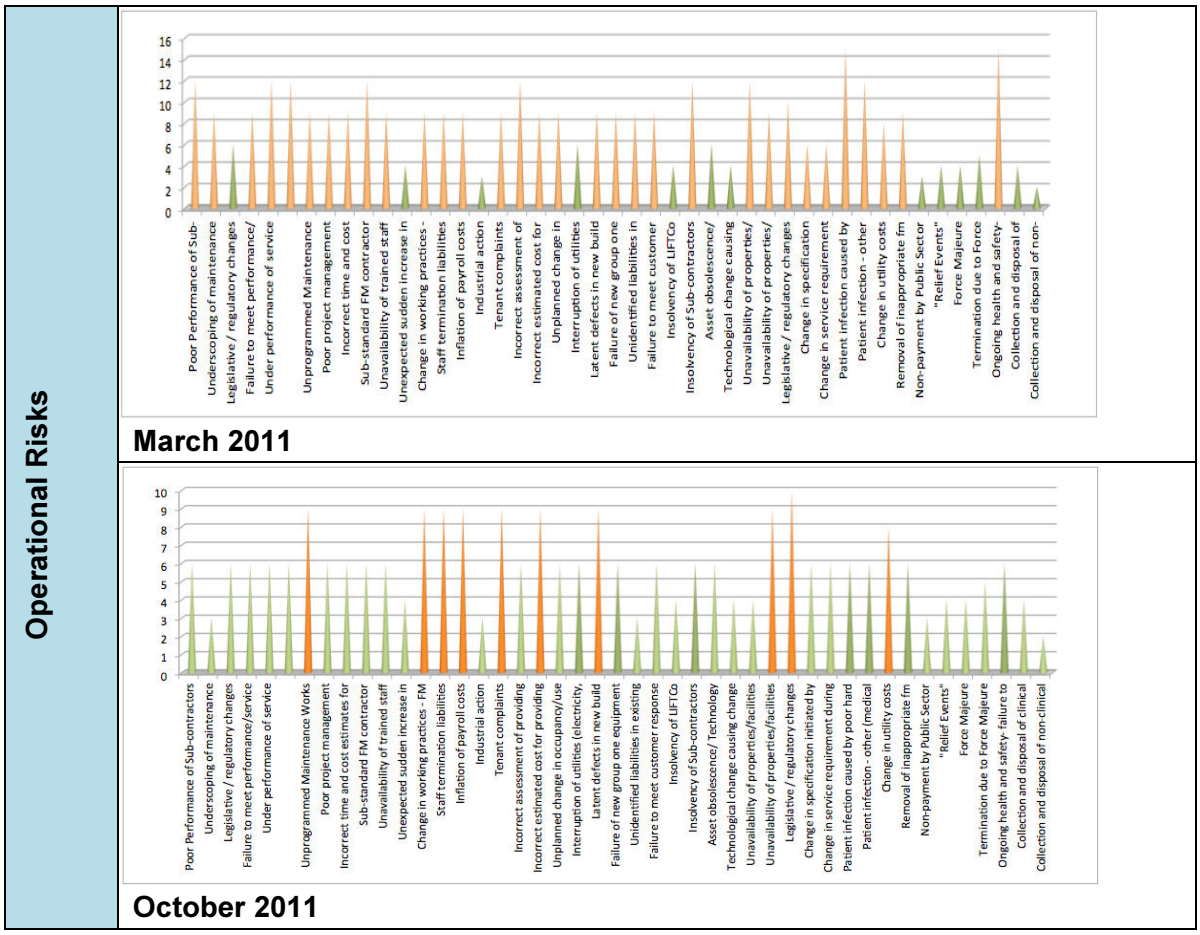
October 2011

Construction-associated risks that remain the responsibility of the PCT include detailed design development approvals, commissioning and input into clearance of certain of the conditions on which planning approval has been granted, specifically those that are a pre-requisite to occupation of the new facility.

As part of the joint project management approach and in order to mitigate the potential for conflicts between the PCT and LIFTCo programmes the LPA will contain integrated schedules of activities for both design and construction that include commissioning activities. The post-financial close project structure also contains arrangements for managing out pre-operational planning requirements.

Operational risks:

Figure 29: Operational Risks



Of the 45 risks identified in March, five are shared and 12 are the responsibility of the PCT. The ratio of amber to green ratings was 30:15 and this ratio has now moved to 10:35, of which one of the PCT's risks remains amber.

This risk relates to 'Change in utility costs'; any increases in utility costs will be passed on to service providers.

The five shared risks are as follows:

- unexpected sudden increases in demand due to major incident
- interruption of utilities
- technological change /asset obsolescence
- force majeure
- termination due to force majeure

The risks associated with three of these issues have been addressed through the Lease Plus Agreement. The approach to risk mitigation for the other two items is illustrated below:

- **unexpected sudden increases in demand due to major incident**: the Disaster Plan (a Schedule to the LPA) will be prepared by the PCT and the FM Operator will be bound by its requirements
- **technological change /asset obsolescence**: this facility will essentially provide a low-tech environment and so the PCT has identified ICT as the major contributor to this risk. ICT requirements have been developed to future-proof the facility as far as is feasible by allowing for wired and wireless solutions to be adopted throughout the facility. Mobile imaging equipment will be the responsibility of clinical services providers to provide, operate, maintain and replace

All of the PCT-owned operational risks are now considered low risk and have been mitigated by a combination of testing of public health data, delivery of a robust brief / flexible design solution and introduction of operational management solutions.

For completeness the responses are included below:

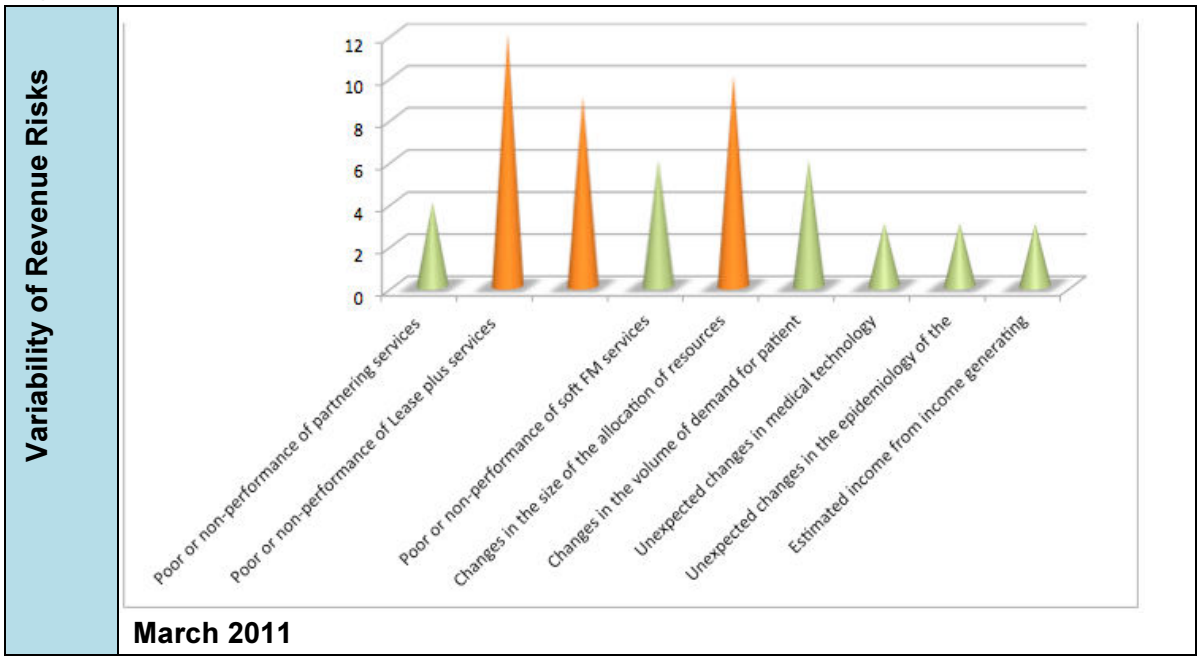
- **unplanned change in occupancy /use /demand**: the PCT will enter into contractual arrangements with each provider of clinical services that will aim to minimise the risk of unplanned change and place the responsibility for managing such risks with the organisation most capable of managing it
- **incorrect assessment of providing clinical services**: the PCT has placed a high priority on ensuring the accuracy and appropriateness of its assessments of clinical services, as demonstrated in Section Three of this business case and considers the risk of inaccuracy to be small and suitable mitigated by the contractual arrangements agreed with each service provider
- **technological change causing change to DH standards**: the WCCCC will be an essentially low-tech environment. All technology will be mobile and will be the responsibility of each service provider
- **legislative /regulatory changes having capital cost consequences – NHS specific**: the design for the WCCCC has been briefed from a flexibility of use perspective; current legislation will be fully complied with and due consideration has been given to current guidance, especially in relation to patient-focused care initiatives. Any future changes in legislation /regulation will be considered by the PCT from a value for money perspective and where appropriate the cost of changes will be referred to the District Valuer for judgment on the appropriateness of passing those costs on to providers as part of the rental costs
- **change in specification initiated by the client**: it is acknowledged that over time the specification of services may well develop in response to the changing needs of the population. The PCT has made all appropriate, value for money judgments in specifying the requirements for the facility, including those related to flexibility of use. Any future changes in specification during the operational phase would arise from changes in services requirements and would be considered in line with the response below
- **change in service requirement during operating phase**: the PCT's service delivery intentions for the WCCCC are clearly set out in Section Three of this

business case and the facility has been planned to be able to be flexible to change. Any other changes that might require significant change to the facility will be considered in the context of the full range of facilities available locally, to ensure that services continue to be provided from the most appropriate location

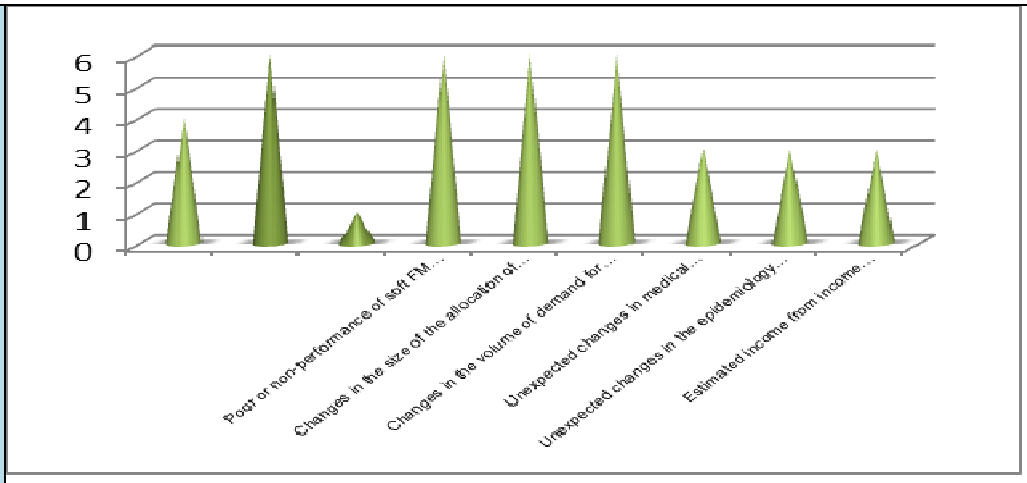
- **patient infection /other (medical negligence/unforeseen outbreak):** clinical responsibility for the management of patients with infections will remain with the provider of services, who will be expected to demonstrate membership of the relevant bodies including the national medical negligence contribution scheme. Unforeseen outbreaks will be managed as part of standard protocols that individual providers will be expected to comply with
- **change in utility costs**: utility costs will be passed on to individual services providers and will be the responsibility of those providers to pay
- **collection and disposal of waste**: the established approach to management of this service is not envisaged to change with the opening of the WCCCC

Financial and variability of revenue risks:

Figure 30: Financial risks



Finance Risks



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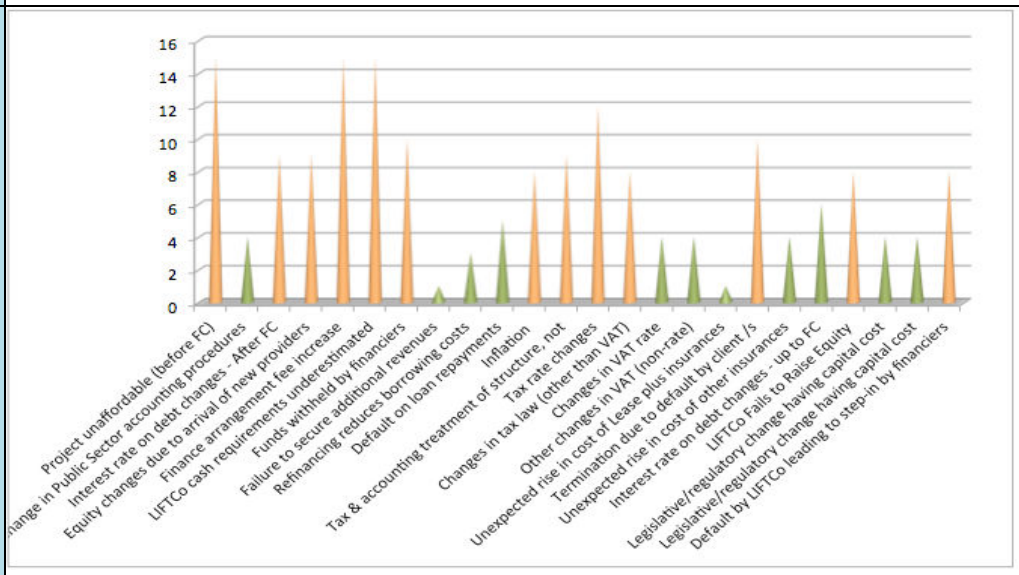
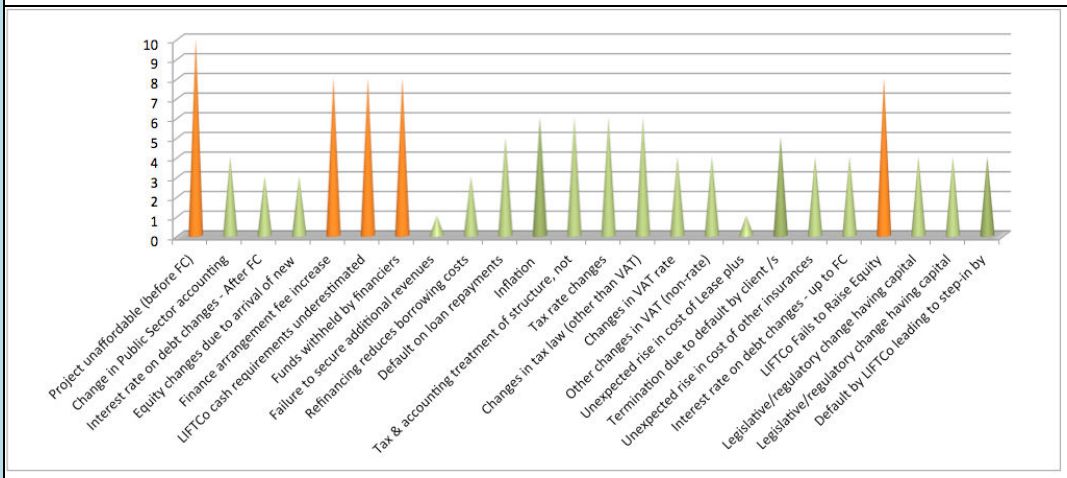


March 2011



October 2011

There are 33 identified risks in these two categories.

Mitigation activities in the period March to October 2011 have improved the profile of risks from 16:17 (amber: green) to 5:28.

The 'variability of revenue risk' risk profile contains wholly low risk items and the following risks that will remain the PCT's responsibility:

- **poor or non-performance of soft FM services not provided by LIFTCo**: this scenario is no different to the position the PCT currently manages. There are robust escalation procedures in place to manage poor performance
- **changes in the size of the allocation of resources for the provision of health care**: reductions in resources have already been identified in the system. The project aims to minimise the impact of the cost of the new facility by selling vacated properties to assist in capital cost implications
- **changes in the volume of demand for patient services due, for example, to the provision of a new alternative health care provider, leading to a reduction in demand**: the facility has been designed for flexibility of use; any reductions in volume of demand for one service is considered to be likely to offer the opportunity for other service provision
- **unexpected changes in medical technology leading to a need to re-scale or reconfigure the provision of services**: this will be a low-tech environment treating non-acute patients; it is not anticipated that any changes in technology will result in requirements for change to the building fabric
- **unexpected changes in the epidemiology of the people in the catchment area leading to a reconfiguration or re-scaling of the provision of services**: the PCT and the Council have prepared their projections on the basis of strong multi-agency data. The risk of unexpected changes is considered to be very low and would be an unprecedented event that would require multi-agency review
- **estimated income from income-generating schemes is incorrect**: there is no built-in expectation of third party income

In terms of financial risks, LIFTCo owns the majority of these risks; financial risks can be categorised as:

- those associated with the financial model and the Lease Plus charge that apply either pre or post financial close
- those risks that are outside the control of the project and that relate to Government / banking policy

Pre-financial close risks associated with the financial model have been closely monitored in the lead up to the business case submission, resulting in a reduction of risk profiles through a combination of negotiation and agreement between the parties and the appointment of the Funder.

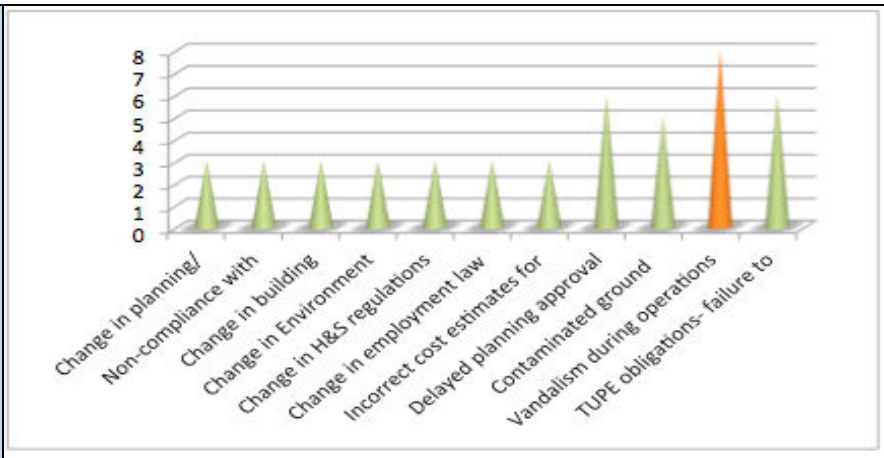
In summary, the PCT is confident that the financial risks for which it is responsible are manageable within the parameters it has set out above.

Other risks:

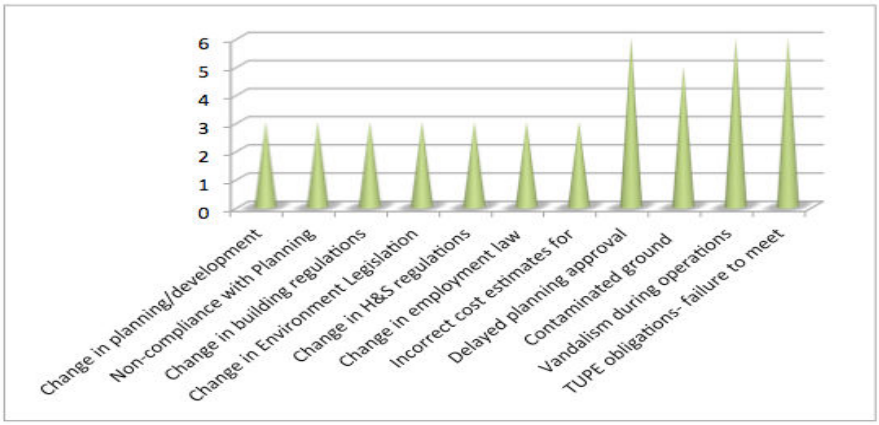
The remaining risks relate to disposal, regulatory and cultural issues. The graphics below illustrate the profile of these risks over the period March to October 2011. Of the 15 risks listed, only two remain as medium, both of which are the responsibility of LIFTCo and both of which relate to disposals and the risk that any tenant wishes to vacate the building after 25 years.

Figure 31: Other risks

Disposal Risks

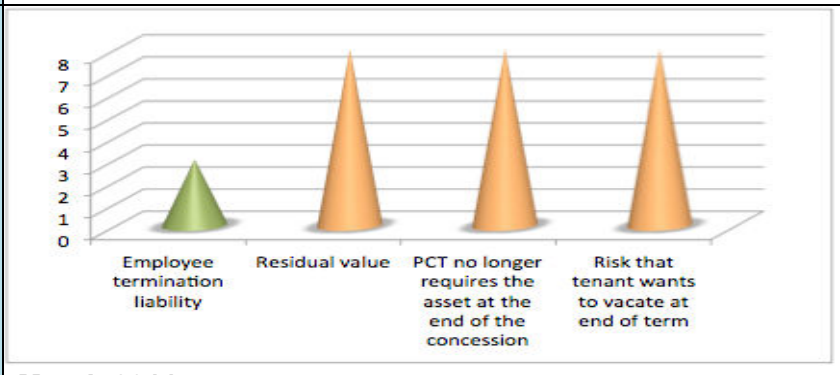


March 2011

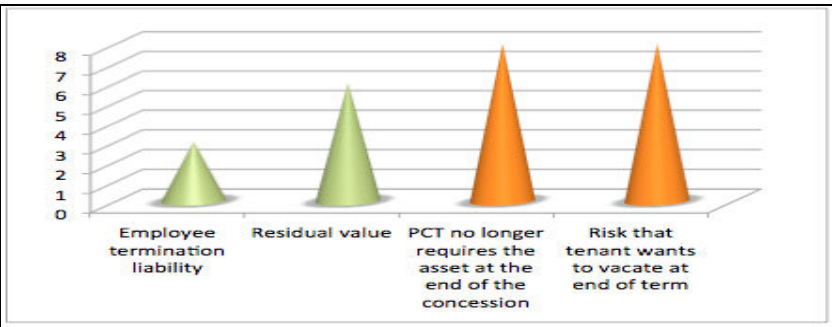
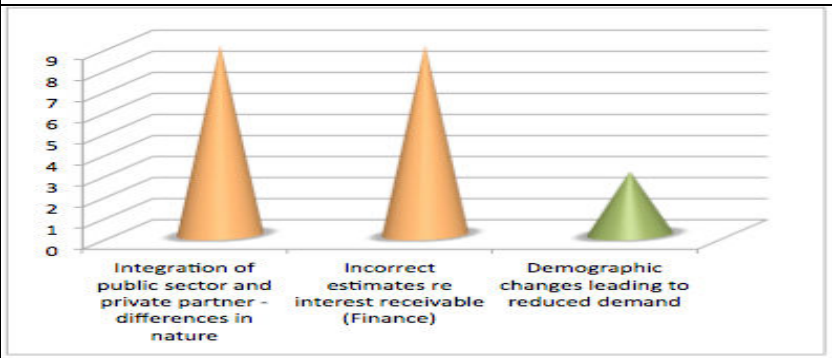
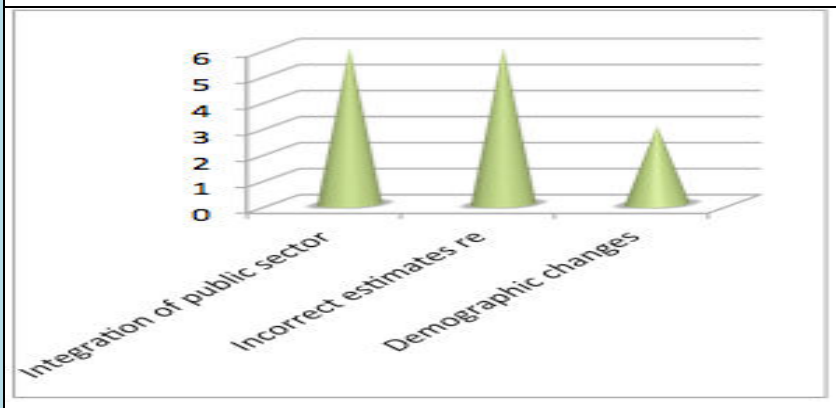


October 2011

Regulatory Risks



March 2011

	 **October 2011**
Miscellaneous Risks	 **March 2011**
	 **October 2011**

9.6. Gateway Review

The PCT and Council requested a Health Gateway Review 3 in August 2011. There are two teams that undertake reviews using the same framework; Local Partnerships provides one at cost to Local Authorities and the Department of Health offers one free of charge to healthcare organisations. Both public sector organisations were concerned to ensure that only one Gateway Team undertook the review due to the duplication of effort and time constraints; it was agreed, following a teleconference with both review team leads that the Department of Health team would be requested to undertake the exercise.

This was agreed for three reasons:

- two-thirds of the space will be occupied by the health sector

- the Council Business Case is submitted to the Department of Health for approval of PFI credits
- the Department of Health review is non-chargeable

The primary purpose of a Health Gateway Review 3: "Investment decision", is to confirm the business case and benefits plan now that the delivery process has been confirmed and check that all the necessary statutory and procedural requirements were followed throughout the process.

The Gateway Team will complete its review in November 2011 and a summary of its findings will be issued as an appendix to the Business Case.

9.7. Benefits Realisation

Design: The vision and high-level objectives for the WCCCC were translated into design Key Performance Indicators (KPIs), each of which was linked with specific elements of the Tenants' Requirements. The benefits realisation plan for the capital investment is intimately aligned with post-project evaluation arrangements and utilises not only the KPIs but also the agreed LPA clauses and schedules in the identification of elements subject to monitoring.

A full benefits plan can be found at Appendix 24.

Clinical services delivery intentions: the intentions of the delivery strategy are clearly identified in Sections Three and Four of this Business Case. The PCT's approach to monitoring the delivery of benefits has been based on the expectations described in Sections Three and Four and defines three high level benefits that the changes aim to deliver.

These are continuing improvement in:

- the **effectiveness** of the health services provided across primary and secondary prevention, acute services, and the management of long term conditions
- the **efficiency** and unit cost (cost-effectiveness) of services in order to maintain affordability in the face of rising need and new treatments
- the **satisfaction** with health services on the part of both individual patients and the wider health economy

Performance against all three of these benefits will be tracked as the programme is developed, implemented, and operated. The metrics will be appropriate to the stage of development and follow the sequence of:

- **structure** e.g. are commissioning arrangements in place to implement the new health services and associated care pathways?
- **process:** e.g. are the new services operating, and are the intended activity levels being achieved?

- **outcomes** e.g. do the services, overall, deliver the expected: 1) quality of care, 2) financial impacts, and 3) service satisfaction?

The measurement of performance at the three stages falls broadly into three types:

- **structure (now up to 2014):** progress against the Commissioning Plan to define, design, and commission services and care pathways from providers up to the opening of WCCCC in 2014, and the subsequent development plan as the community's health and social care requirements and the use of WCCCC evolve
- **process (from 2014 and continuing annually)**: comparison of health and social care services activity and financial performance against expected levels, for both services commissioned at the WCCCC and the intended 'decommissioning' of services in other settings e.g. that services are transferred and not unintentionally duplicated
- **outcomes (from year 2 and continuing on 1 to 3 year cycles):** clinical audit of services and overall outcomes, the cost-effectiveness of services and the sustained overall financial impact across the PCT and Council, plus studies and surveys of patient, user and other stakeholder satisfaction

Wherever possible, the performance metrics will be based on routine activities that form part of standing operations e.g. activity and financial reporting, and the clinical audit of services. Particular developments may however be required to conduct satisfaction surveys in the early days until routine methods become established.

Appendix 24 presents the specific performance indicators against the intended benefits. It is in three sections divided by the three phases of realisation: structure, process, and outcomes. This means there is an approximate time sequence from top to bottom. Within each section the performance indicators are generally grouped by the main areas of benefit, being effectiveness; efficiency, and satisfaction. The exception is for measures of Structure in which the measures are against progress to implementation and hence start of delivery of benefits.

Social care delivery intentions: The WCCCC brings together social care assessment and care management staff, general practices, and NHS community staff, to serve a particularly deprived part of the borough. More widely, the Council and the local NHS are developing new ways of working together for the benefit of people in the borough. This will happen, for example, by adopting a single assessment process, rather than the separate multiple assessment processes that currently operate. GPs will take full responsibility for the community rehabilitation phase of a patient's recovery, leading to a lower usage of residential care homes. Much more effective, rapid responses will be developed in the community to prevent unplanned admissions to acute hospitals.

The WCCCC will enable the local development of these approaches in this particular part of the borough, and will have a particular impact because the relevant staff will be co-located.

The WCCCC also forms part of the wider plans to regenerate the White City Estate, which is a deprived area of many measures. The Council uses a wide range of indicators, economic and social, to monitor the 'well-being' of each part of the borough, and the impact of regeneration initiatives.

9.8. Programmes

The key milestones for the project are now scheduled as follows:

Table 34: Key milestones

Milestone	Current Planned Dates	Anticipated Dates
Planning meeting	11/10/11	11/10/11
SPB Stage 1 approval	20/09/11	20/09/11
NHS INWL Board Stage 1 approval	29/09/11	29/09/11
Business case submission	11/11/11	11/11/11
Judicial review ends	13/02/12	13/02/12
NHS London Business case approval	19/01/12	19/01/12
DH approval (PFI credits)	16/12/11	16/12/11
Treasury approval (PFI credits)	10/02/12	10/02/12
Financial close	Mid February 2012	Mid February 2012
Start on site	Early April 2012	Early April 2012
Handover	February 2014	Early December 2013
Operational date	April 2014	January 2014

The PCT, Council and LIFTCo are working together as follows:

- Business Case submission to Financial Close: technical, financial, legal, insurance, valuation, model audit due diligence exercises
- Design Programme (LIFTCo Proposals)
- Financial Close to Operational Date: integrated construction, decanting, decommissioning, equipment and commissioning programme

A Services Delivery Programme is being separately developed by the PCT and the Council and will need to be reviewed under the post financial close project management arrangements to ensure integration with the Continuity of Care Programme. This will ensure the delivery of a fully occupied facility by the operational date.

9.9. Post Project Evaluation

The approach to delivering this project has been informed by the lessons learned on previous LIFT projects, as follows:

- project management arrangements to ensure that on opening, the facility is appropriately occupied

- Joint Tenants' Requirements developed to an appropriate level of detail
- the design KPI monitoring approach

Both public sector organisations have also tackled the challenge of delivering services in a rapidly changing environment and the perennial challenge of determining ICT requirements in a sustainable manner that will positively support the development of such proposals in all future projects.

Table 35: Summary of approach to PPE

Evaluation Stages	Approach
Stage 1: plan and cost the scope of the PPE work at the project appraisal stage. This should be summarised in an Evaluation Plan.	Tenants' Requirements with relevant equipment, security and ICT strategies included, linked to design KPIs; clearly defined pathways of care for delivery by the opening date of the facility (formative issues).
Stage 2: monitor progress and evaluate the project outputs on completion of the facility.	Programmed for mid-2014
Stage 3: initial post-project evaluation of the service outcomes six to 12 months after the facility has been commissioned.	Programmed for mid-2015
Stage 4: follow-up post-project evaluation to assess the longer-term service outcomes two years after the facility has been commissioned	To be advised

The post-project evaluation of the building will be based on the expectations set out in the Capital Investment Benefits Realisation Plans contained in this Business Case. Services Delivery expectations will be translated from the Services Delivery Benefits Realisation Plans into service level agreements and will be monitored as part of the normal performance-monitoring regime.

A proposal setting out the PCT's and Council's approach to post project evaluation will be developed post financial close.