Haringey Council

Adults and Health Scrutiny Panel

TUESDAY, 5TH MARCH, 2013 at 18:30 HRS – 21:30 HRS.

MEMBERS: Councillors Adamou (Chair), Mallett, Stennett, Erskine and Winskill

CO-OPTEES: Claire Andrews (HFOP), Helena Kania (LINk), Kevin Dowd (HAVCO)

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at item 11 below).

3. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:
i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.
A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Member's Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.
Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Member's Code of Conduct.

4. OVERVIEW OF CHANGES TO HEALTH

A brief overview of the changes to the health service structure.

Jill Shattock, Director of Clinical Commissioning, Haringey Clinical Commissioning Group (CCG)

5. UNSCHEDULED CARE (PAGES 1 - 2)

The Panel will receive a presentation on:

- Changes to the unscheduled care system in Haringey, including the introduction of the new NHS 111 phone number
- Change in provider for Out of Hours services in Haringey and what this means for residents.

Attendees

- Jill Shattock, Director of Clinical Commissioning, Haringey Clinical Commissioning Group (CCG)
- Dr John Rohan, Haringey GP and Haringey CCG Governing Body member (unscheduled care lead)
- Alison Blair, Senior Responsible Officer for the NHS 111 programme
- Sarah McIlwaine, Senior Programme Manager, NHS 111 programme
- Annette Alcock, Deputy Chief Executive, Barndoc
- Dr Anuj Patel, Medical Director, Barndoc
- Christine Callender, Director of Operations and Nursing, Barndoc

6. WHITTINGTON HEALTH ESTATES STRATEGY (PAGES 3 - 114)

Dr Yi Mien Koh, Chief Executive, Whittington Health

7. FRANCIS INQUIRY (PAGES 115 - 126)

Panel Members will consider the implications of the Francis report comments and recommendations on Health Overview and Scrutiny.

8. MINUTES (PAGES 127 - 138)

To approve the minutes of the meeting held on 10th January 2013.

9. AREA COMMITTEE CHAIRS FEEDBACK

10. FUTURE MEETINGS

Tuesday 2nd April 2013, CR1, Haringey Civic Centre

11. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted at item 2 above

David McNulty
Head of Local Democracy
and Member Services
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Melanie Ponomarenko
Senior Policy Officer
Level 7
River Park House
225 High Road
Wood Green
London N22 8HQ

0208 489 2933
Melanie.Ponomarenko@Haringey.gov.uk

This page is intentionally left blank

Agenda Item 5

Haringey Clinical Commissioning Group

Unscheduled Care in Haringey

Health scrutiny panel meeting

Tuesday 5 March 2013, 6.30pm

Aims of the session

1. To understand the changes to the unscheduled care system in Haringey, including the introduction of the new NHS 111 phone number

2. To share the outcome of the recent procurement process for the out of hours GP service in Haringey and discuss what this will mean for Haringey residents

Background briefing

1. Unscheduled care is any unplanned contact with the NHS by a person requiring or seeking help, care or advice. It follows that such demand can occur at any time, and that services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and emergency care.

2. Improving unscheduled care services is an agreed priority across both NHS North Central London (the cluster) and Haringey Clinical Commissioning Group (CCG). The overall position for unscheduled care services remains one of great complexity with a number of factors all heavily influencing, including behaviour and expectations of the public, national targets and existing resources.

3. The nature of unscheduled care services also means that many agencies are involved. For example, general practice, NHS Direct, ambulance services, acute hospital trusts, walk in centres, major trauma centres, community services, social services, mental health services and GP out of hours providers all have key roles to play.

4. Demand for unscheduled care is relatively predictable, as detailed in the Warwick Report (Modernisation Agency 2003) and provision could be more carefully planned. Whilst there are some exceptions, services have tended to develop in an ad hoc and relatively uncoordinated manner.

5. Developing a local coordinated and integrated model for unscheduled care in Haringey has, to date, focused on work to implement a primary care-led Assessment and Urgent Care Centre (AUCC) at North Middlesex Hospital (NMUH). NMUH sub-contract the GP element of the AUCC to a primary care provider to operate within the hospital's emergency department and assess, treat or re-direct patients to primary care as appropriate.

6. The above Urgent Care Centre service is complimented by a GP out of hours service for primary care. This service is currently delivered by HARMONI through a consortium contract which includes Haringey. The current contract with HARMONI expires on 31 March 2013 and has therefore been subject to a recent re-procurement process. BARNDOC has won the new contract and will start providing the service for Haringey residents from April 2013. GP out of hours services provide care and advice for patients when their GP surgery is closed, from 6.30pm to 8am Monday to Friday, over the weekend and 24 hours on bank holidays. The out of hours GP service call centre provides a number of options for ongoing care after a detailed discussion with an experienced call handler. Options include: a GP appointment when the patient's surgery is next open, another NHS service such as pharmacy, phone advice by a nurse or doctor, a face to face appointment with an out of hours GP, or an emergency ambulance, if required.

7. The other most significant development within the unscheduled care landscape is the implementation of the new NHS 111 phone number. This has strong strategic links and cross cutting issues with Haringey CCG's integrated care and primary care strategies. 111 is a new NHS free telephone number that will make it easier for patients to access the most appropriate local health service. 111 will replace NHS Direct and the out of hours GP call centres so that all calls are dealt with via one system and covered 24 hours a day, 7 days week, 365 days a year.

Lead presenter

- Jill Shattock, Director of Clinical Commissioning, Haringey Clinical Commissioning Group (CCG)

Other attendees

- Dr John Rohan, Haringey GP and Haringey CCG Governing Body member (unscheduled care lead)
- Alison Blair, Senior Responsible Officer for the NHS 111 programme
- Sarah McIlwaine, Senior Programme Manager, NHS 111 programme
- Annette Alcock, Deputy Chief Executive, Barndoc
- Dr Anuj Patel, Medical Director, Barndoc
- Christine Callender, Director of Operations and Nursing, Barndoc

Agenda Item 6

Whittington Health NHS

Philip Ient
Direct Line: 020 7288 5560
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

23 January 2013

Title:	**Trust Estates Strategy and 5-yesr capital investment strategy**		
Agenda item:	**13/011**	**Paper**	**6**
Action requested:	***for agreement***		
Executive Summary:	From April 2013, the trust estate will comprise of 17 Freehold or Head Lease premises, with a further 16 buildings being in occupation under leasing arrangements with 3rd party landlords. The attached estate strategy sets out how the trust will manage its estate over the next five years in order to deliver on its clinical and education strategies. The Whittington Health estate will be rationalised to release cash to support the trusts financial position going forward of c£7m. This will be achieved by; • Ward closures at the main hospital, and a general reduction in outpatient services located on the acute site • of community premises by improving utilisation of clinic space • Location of undergraduate education to the Highgate Wing • The implementation of space charging • Capping births at 4,000 allowing redevelopment of maternity accommodation within the current CRL over a five year period • Reduction by 20% of back office accommodation and rationalisation of acute staff based on the acute site into community properties • Implementation of EPR and paperless working reducing storage of records To support the delivery of the estate strategy, a 5-year investment plan has been prepared and is attached to this document. The plan has been prepared to address the investment needs for the Whittington Health estate, and to address associated strategies including the IT strategy and the Carbon reduction strategy.		
Summary of recommendations:	This strategy has been ratified by the Finance and Development Committee and is recommended for approval by the Trust Board. The 5-year investment plan is due to be ratified by the		

	F&D on 21 January and is recommended for approval subject to this ratification						
Fit with WH strategy:	Whittington IT Strategy; Whittington Carbon Reduction Strategy; Whittington Health Clinical Strategy; Whittington Health Education Strategy						
Reference to related / other documents:							
Date paper completed:	14 January 2013						
Author name and title:	**Philip Ient; Director of Estates and Facilities**		**Director name and title:**		**Richard Martin; Director of Finance**		
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Trust Estate Strategy and 5-year Capital Investment Plan

1 Introduction

This strategy is required to direct the management of the trust estate to support the trust clinical and education strategies and the trust Foundation Trust application.

This strategy supports existing or emerging strategies including;

- Whittington Health Strategy 2011 – 2016 this states;

  "*Change the way that we work to build a culture of innovation and continuous improvement, working flexibly and in new ways to achieve efficiency and effectiveness…"* page 3. And,
  "…we intend to…ensure that the hospital provides services that only the hospital can provide. In turn we will transfer a significant part of the demand for hospital services to more appropriate community care settings…." – page 9.
- Foundation Trust application
- Education strategy including the provision of undergraduate education through the Special Increment For Teaching (SIFT)
- IT Strategy including the implementation of the Electronic Patient Record (EPR)
- Workforce Strategy
- Records management Strategy

2 Description of the Strategy

The Current Position

The trust currently owns the freehold to one premise (The Whittington Hospital, Magdala Avenue) and from April 2013 will receive the freehold or head lease title to a further 16 premises. In addition the trust will provide services from 16 premises where it will have leases from 3rd party landlords. In addition, we occupy buildings on the St Ann Hospital site that are subject to the Barnet, Enfield and Haringey MHT strategy that requires rationalisation of services. These will be occupied under an SLA with BEHMHT.

The Reason For Change

The clinical services are provided from premises that range in age from those built in the mid 19th Century to those constructed in the last five years. This, coupled with a wide range in condition and functional suitability means that a clear strategy is needed to ensure that going forward the right care is provided from the right location and from premises that are fit for purpose. By embarking on a five year plan to modernise and rationalise, the trust can expect to see a capital receipt in the region of £7m (net), a reduction on the acute site of approximately 8,375m^2 of which only 550m^2 is clinical. Further there will be a reduction in the revenue cost associated with running a diverse and large estate of £2m backlog and £600k revenue. The strategy consists of a number of propositions that have been tested and hold true regardless of external and internal influences. These propositions translate into the following actions;

- A rationalisation of the main acute site with services currently provided from premises north of the service road being either located into community premises, or into modernised buildings on the south side of the road. After rationalisation of the main site, all buildings north of the service road will be vacant and available for disposal or for alternative clinical use. The challenges of the rationalisation process

should not be underestimated and will involve managing down, relocating and in some instances discontinuing some functions such as, Residential accommodation.

- A reduction in back office space of 20% by implementing the EPR, ESR and SMART working
- A reduction in records held by adopting the Records Strategy that provides from long term off site storage
- Provision of undergraduate education required under the SIFT agreement in new accommodation on the Highgate Wing supporting the trust's education strategy
- A reduction in the number of wards on the acute site and a reduction in the number of outpatient contacts seen on the main hospital site
- Capping of births in Maternity at 4,000 thereby allowing the trust to complete the modernisation of the maternity wing from within its own CRL over a five year period
- To work with Barnet Enfield and Haringey Mental Health Trust to assist in their own estate strategy with regard to rationalisation of the St Ann's hospital site. Whittington Health has services located on this site that in some instances need to be moved from buildings targeted for disposal into the retained portion of the St Ann's site. NCL have advised they will not pay for service relocations. BEH MHT have agreed to relocate Sexual Health and Clinical Audiology at their own cost. The question as to who pays for relocating other Whittington Health services on the St Ann's site has yet to be resolved.

How will the strategy be embedded into the organisation?

This strategy has been developed with consultation of a wide range of stakeholders, including the full trust Executive Committee, the Trust Operational Board, and the directors of HR and IT.

The vehicle for it's development has been the Estates Transformation Group, who have tested versions of the strategy as they have been developed. Importantly, this has included testing the propositions that were intended to provide a solid foundation for the strategy, holding good regardless of external and internal influences.

Once the strategy has been approved, its delivery will be managed by the ETG and overseen by the F&D Committee.

The 5-year investment plan

To support the delivery of the estate strategy, a 5-year investment plan has been prepared and is attached to this document. The plan has been prepared to address the investment needs for the Whittington Health estate, and to address associated strategies including the IT strategy and the Carbon reduction strategy. In addition, it includes schemes that have been considered by the executive committee to warrant use of trust capital resource for investment purposes. These schemes have either been approved as funded, or approved, subject to funding. The investment strategy as a whole was considered by the Finance and Development Committee during the passage of the Estates Strategy through the committee stage to approval

The plan considers;

- The five years from 2013/14 through to 2017/18.
- Schemes that have been bought forward from 2013/14 into the current financial year to accommodate the ambulatory care centre project planned for 2013/14
- Notes a commitment to support key investment projects pending appropriate funding sources

3 Impact on the work of Whittington Health

Benefits to the organisation

By adopting the strategy, the organisation will benefit from an estate that is rationalised, modernised and fit for delivery of the trust strategy. Utilisation of premises will be increased and the premises overhead will be reduced thereby improving service line costs.

Careful reinvestment of the proceeds from the sale will be used to improve the residual estate on the acute site and create a cash surplus to support the trust's financial position going forward.

Risks

The challenge for the trust going forward is to ensure that the propositions are applied to changes in strategy. Failure to do this will mean that the strategy will not be delivered in it's entirety leading to a continuance with a sub optimal estate, higher than necessary premises overheads and poorly utilised space.

The challenge is for trust management to deliver the changes in clinical care that will reduce the need for in patient beds leading the closure of the wards identified in the strategy and for the number of outpatient contacts to be reduced as clinical care takes place closer to the patients home.

For staff the impact will be that SMART working becomes more widespread with adoption of paperless office environments, use of hot desks and where appropriate home working

Implications and effect on governance

The strategy has been developed with the full involvement of senior management and executive directors. It has been widely discussed at the ETG, and has been developed to reflect strategies that in themselves have been the result of wider stakeholder consultations. For this reason there is no anticipated effect on trust governance.

Cost and other implications

To achieve the desired outcomes, the trust must reinvest some of the proceeds of sale of land into redevelopment of legacy estate. The total land sale receipt is anticipated to be £17m with £10m required for re-investment. The bulk of this re-investment is in reprovision of education and training, on call and offices displaced as a result of the closure if Jenner Building, together with the conversion of wards to accommodate functions flowing from the north part of the site. Most importantly, there is a reduction of £2m in backlog and £600k in revenue costs associated with the legacy estate.

Levers for achieving the desired result

The assurance and governance framework to ensure the strategy remains relevant and delivered over a five-year period is will be via the F&D committee through the ETG. Membership of the ETG reflects the make up of operational services and consists of those managers responsible for delivering the clinical strategy, the educational strategy and the IT strategy. Where targets slip, or change, these will be managed by the ETG, with reference to the full executive at the EC.

4 Next steps

Once approved the trust will embark upon a programme of schemes that culminate in delivery of the strategy by 2018. From 2013 to 2015 this means;

- Adopting a risk reduced strategy of consolidating and managing the subsumed community properties to maximise efficiency.
- To introduce SMART working and space charging to act as a catalyst to reduce dependency on the built environment

In terms of the built environment this means;

- Conversion of L1 and L3 of HGW for delivery of undergraduate education
- Conversion of L5 HGW for delivery of the EPR for two years
- Subsequent conversion of L5 and L6 HGW for SMART working
- Relocation of Procurement to an off site location and use of the released space for SMART working from Jenner
- Conversion of L3 old stores for SMART working from Jenner
- Creation of an ambulatory care centre
- Conversion of the old boiler house for medical records (until 2014)

From 2016, all Jenner occupants will be relocated, all on site residences (apart from on call) will be closed, and residual clinical services (currently in the Nurses Home) will be relocated

Management and implementation of the strategy will be monitored bi monthly at the ETG and reporting to the F&D committee will be bi-annual. Management of the investment strategy will be through the Capital Monitoring Group reporting to the Executive Committee.

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

Financial Summary

Sources	2013-14 schemes brought forward to 2012-13	2013/14	2014/15	2015/16	2016/17	2017-18
Available CRL (Estimated by year)	**£ 970,000**	**£ 9,938,000**	**£ 9,195,000**	**£ 9,417,000**	**£ 9,188,000**	**£ 9,667,000**
Additional CRL	**£ 350,000**					
Ambulatory Care Centre	**£ 2,900,000**					
CRL (Estimate based upon community properties) £600k not included to preserve cash position in 2013/14			**£ 600,000**	**£ 600,000**	**£ 600,000**	**£ 600,000**
Totals	**£ 4,220,000**	**£ 9,938,000**	**£ 9,795,000**	**£ 10,017,000**	**£ 9,788,000**	**£ 10,267,000**

Applications	2013-14 schemes brought forward to 2012-13	2013/14	2014/15	2015/16	2016-17	2017-18
Main Programme						
Premises, Health and Safety, Backlog and DDA	£ 1,418,000	£ 300,000	£ 1,875,000	£ 2,785,000	£ 2,595,000	£ 4,264,500
Medical Equipment	£ 917,000	£ 457,000	£ 1,204,000	£ 908,000	£ 755,000	£ 755,000
IM&T	£ 1,545,000	£ 250,000	£ 775,000	£ 776,400	£ 777,500	£ 675,000
Estates Strategy	£ 340,000	£ 6,265,000	£ 3,210,000	£ 3,630,000	£ 1,300,000	£ 2,200,000
Business Case Required		£ 500,000	£ 900,000	£ 400,000	£ 400,000	£ 500,000
Project Management Costs		£ 500,000	£ 500,000	£ 500,000	£ 500,000	£ 500,000
WFL lifecycle costs		£ 670,876	£ 321,446	£ 467,960	£ 708,361	£ 904,523
Asteral life cycle costs		£ 994,316	£ 1,009,182	£ 549,559	£ 2,752,117	£ 467,837
Cumulative Total	**£ 4,220,000**	**£ 9,937,192**	**£ 9,794,628**	**£ 10,016,919**	**£ 9,787,978**	**£ 10,266,860**
Over / under commitment	0	808	372	81	22	140

You

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

Estates Backlog, Plant Replacement and Legal & Statutory

Scheme	2013-14 schemes b/f to 2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Rolling Replacement Programme						
Roofing	80,000		80,000	80,000	80,000	80,000
Fixed wiring backlog	50,000		50,000	50,000	50,000	50,000
Security equipment	40,000		40,000	40,000	40,000	40,000
Flooring replacement	40,000		40,000	40,000	40,000	40,000
Legionella Works	40,000		40,000	40,000	40,000	40,000
H&S miscellaneous arising from risk assessments	50,000		40,000	40,000	50,000	50,000
RRO 2005 regulations/ fire risk assessments	50,000		50,000	50,000	50,000	50,000
Soil and Vent Stack Replacement	20,000		20,000	20,000	20,000	20,000
Carbon reduction	300,000		300,000	295,000	240,000	350,000
Medical Gas Compliance work			50,000	50,000	50,000	50,000
External roadway repairs and resurfacing	50,000		50,000	25,000	30,000	65,000
K' rolling refurbishment			100,000			300,000
Fire escape refurbishment	50,000		50,000	50,000	50,000	50,000
Split System Replacement Programme + backlog works	25,000		25,000	25,000	25,000	25,000
AHU Replacement programme			460,000			300,000
Various schemes to help comply with DDA			20,000	20,000	20,000	20,000
Wayfinding	10,000		10,000	10,000	10,000	10,000
Pest proofing	10,000		10,000	10,000	10,000	10,000
Asbestos management programme	10,000		10,000	10,000	10,000	10,000
Laboratory compliance works			50,000	50,000	50,000	50,000
Working at Height Compliance	10,000		10,000	10,000	10,000	10,000
Nurse Call ward by ward replacement	20,000		20,000	20,000	20,000	20,000
Lift replacement/lift replacement programme			250,000	250,000		424,500
ED refurbishment	100,000		100,000		100,000	
Catering	28,000					
Medical gas Compliance and Plant Replacement	150,000					
Pathology Autoclave	250,000					
Theatres		100,000				
Simmons House	35,000	200,000				
Generator Replacement				100,000	100,000	
Boiler replacement 'P' block						200,000
Replacement endoscopy unit				1,500,000	500,000	
External façade; K Block and C, D, and E block					1,000,000	2,000,000
Total	**1,418,000**	**300,000**	**1,875,000**	**2,785,000**	**2,595,000**	**4,264,500**

Replacement or backlog

Legal and Statutory

Strategy

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

Medical Equipment

Scheme	2013-14 schemes brought forward to 2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Medical Equipment						
Trust wide						
Rolling replacement programme						
Moving and handling equipment	20,000		20,000	20,000	20,000	20,000
Plinths	20,000		10,000	10,000	10,000	10,000
Monitor replacement	190,000		60,000	60,000	60,000	60,000
Weighing scales			5,000	5,000	5,000	5,000
Medical equipment library stock replacement	50,000		50,000	50,000	50,000	50,000
Respiratory equipment	20,000		20,000	20,000	20,000	20,000
Camera stack replacements	200,000			260,000	130,000	130,000
Endoscopes	150,000		150,000	150,000	150,000	150,000
THEATRES general replacement fund	50,000		50,000	50,000	50,000	50,000
NICU general equipment replacement fund			50,000	50,000	50,000	50,000
Diathermy machines (general)	35,000		35,000	35,000	35,000	35,000
Dinamaps*10	10,000		10,000	10,000	10,000	10,000
Ventilators		60,000	60,000	60,000	60,000	60,000
Surgery and Cancer						
Ophthalmology slit lamps	20,000		20,000	20,000	20,000	20,000
Ventilator			50,000	25,000	25,000	25,000
Theatre Trolley Replacmement	10,000		10,000	10,000	10,000	10,000
Theatre tables	30,000		30,000	30,000	30,000	30,000
23 x Anaesthetic Machines (approx£30k each) [£230k - all purchased 2012/13]						
Ambulatory Syringe Pumps	25,000					
Womens and Childrens						
CTG monitors			50,000			
Colposcope	40,000					
Ultrasound scanner(Paeds Outpats)			50,000			
Diagnostic and Scheduled Services						
Retinal Camera(Diabetic Screening)						
Medicine and therapies						
6 x Patient Trolleys	20,000		20,000	20,000	20,000	20,000
Laboratory Equipment						
Ultrospec Spectrophotometer	5,000		10,000			
2 x Laboratory Centrifuge	10,000		20,000			
Exhaust protective cabinet	12,000					
Tissue Processor			50,000			
O2 Cabinet			20,000			
Cell Washer (priority 1)			20,000			
CL3 Centrifuge			6,000			
2 x Centrifuge			12,000			
Microscopes				17,000		
Spectrophotometer				6,000		
Pharmacy						
Replacement dispensing robot		250,000				
	917,000	457,000	1,204,000	908,000	755,000	755,000

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

Information Technology

Scheme	2013-14 schemes brought forward to 2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Rolling replacement project						
Infrastructure renewals (network and servers)	195,000		250,000	250,000	250,000	250,000
Purchase of PCs & Infection Control keyboards\mice			250,000	251,400	252,500	250,000
Purchase of replacement of PACS/RICS system	1,200,000					
Roll out of VoIP			100,000	100,000	100,000	100,000
Electronic Document Management system	100,000					
Implementation of EPR		250,000	100,000	100,000	100,000	
Telecommunications upgrade and resilience	50,000		75,000	75,000	75,000	75,000
	1,545,000	250,000	775,000	776,400	777,500	675,000

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

Estates Strategy Investment

Short term minor works

Work Strand	Project	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
1	Goswell convert to SMART working	£ 120,000					
2	Relocate MSK to Finsbury HC	£ 50,000					
	HGW L6 to SMART working (b/f)	£ 130,000					
	HGW L5 EPR Project floor	£ 80,000					
	HGW L5 to SMART working				£ 130,000		
	HGW L4 to SMART working (b/f)	£ 130,000					
	HGW L2 Minor works (b/f)	£ 30,000					
	HGW L2 to SMART working			£ 110,000			
	HGW L1 and L3 to UGC Training	£ 400,000	£ 1,500,000				
	Relocation of Procurement and reoccupation		£ 25,000				
3	Minor reorganisation of Jenner	£ 35,000					
4	Boiler House conversion for Medical records	£ 130,000					
5	General Works to Facilitate TPE (b/f)	£ 200,000		£ 100,000	£ 100,000	£ 100,000	
	Ambulatory Care	£ 350,000	£ 2,540,000				
6	Maternity premises improvement	£ -	£ 2,000,000	£ 2,000,000	£ 3,000,000	£ 1,000,000	£ 2,000,000
7	Convert Murray to SMART working			£ 200,000			
8	Convert Old Store to WEC extension			£ 400,000			
9	General provision for SMART working			£ 200,000	£ 200,000	£ 200,000	£ 200,000
	Property Disposal Charges		£ 200,000	£ 200,000	£ 200,000		
		£ 340,000	£ 6,265,000	£ 3,210,000	£ 3,630,000	£ 1,300,000	£ 2,200,000

Long term major schemes

Work Strand	Project	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
	Boiler house redevelopment - 4 floors			£ 3,640,000	£ 3,640,000		
	Relocate physiotherapy to OPD			£ 600,000			
	Convert vacant wards (Betty Mansell, Coudelsey, Meyrick) to SMART working to accommodate Jenner staff				£ 1,500,000		
		£ -	£ -	£ 4,240,000	£ 5,140,000	£ -	

WHITTINGTON HOSPITAL

5 YEAR CAPITAL PROGRAMME

	Business Case Investment				
Scheme	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Estate Infrastructure and Construction					
EPR additional investment (above original business case £250,000)		400,000	400,000	400,000	500,000
Sexual Health Bus (approved subject to funding source being agreed)					
Improving Outpatient Pharmacy Experience (£200k funding to be sought from winter pressures capital)					
e-document management licenses plus Mobius licenses	500,000	500,000			
	500,000	900,000	400,000	400,000	500,000

Whittington Health NHS

Estates Strategy 2013-2018

Prepared by P Ient - Director of Estates and Facilities

November 2012

Version 9.0

Executive Summary

This strategy is written at a time of considerable environmental uncertainty. The abolition of PCTs and the establishment of Commissioning Groups, together with the wider impact of Government policy changes presents challenges and opportunities. Whittington Health (WH) is transforming from a single-site acute Hospital into a multi-site Integrated Care Organisation (ICO) providing seamless care across acute and community services. This is an exciting period in the development of WH.

The transformation is ongoing; the transfer of qualifying community properties to WH is planned for 31st March 2013. At present we do not possess full information relating to all of these properties. The due diligence process is ongoing. A lack of detailed information across the community estate, combined with a turbulent environment, means that our estate strategy needs to be flexible so that it can adapt as circumstances dictate. A considerable part of the strategy is therefore focused upon developing a series of propositions (principles) and policies that provide a clear frame of reference for ongoing decision-making. These basic principles and policies will therefore give a decision-making "anchor' in a changing world.

The principles and policies are applied to key parts of the estate in high-level development plans which show the "real world" implications of the overall strategy.

The *'Whittington Health Strategy'* (December 2011) guides the estates strategy. We aim to deliver integrated services across the acute and community boundaries. This entails moving services from acute centres into the community so they are delivered as close to patients as possible. We will focus upon changing the way that we work so that we can truly provide flexible, effective services across a multi-location organisation. Combined with these internally driven objectives we face some "known" challenges driven by external forces. The impact of these upon the estate need to be taken into account as they include the disposal, by third parties, of sites upon which WH services are accommodated.

Our strategy takes account of uncertainties by looking over two broad time horizons. The initial phase commencing summer 2012 focuses on the integration of the estate into a cohesive whole, relocating services from acute centres to the community, implementing modern SMART and paperless methods of working, implementing key clinical service initiatives insofar as they impact upon the estate and resolving key externally driven issues. In this way we hope to fully exploit the full benefits of an ICO whilst not exposing the organisation to undue risk in its early development phase. Work has begun in anticipation of Whittington Health becoming a Foundation Trust and therefore this strategy commences from summer 2012 in order to cover this important lead-in period.

Longer-term, the strategy focuses on some transformational estate development projects. Lack of funding has blocked the progression of essential capital projects, such as significant renovation and improvement of clinical buildings on the Whittington acute site. The poor condition of the Maternity building on the acute site has been identified as a key issue to address. The creation of the ICO and the relocation of services from the acute site into the community offers opportunities to release space on the main acute site that could be used to accommodate increased clinical activity, or to facilitate land sales which generate additional revenues or capital sums to invest in improving the retained estate.

Our strategy is designed to align the estate with the strategic goals of the transformed organisation in order to help deliver effective high quality services to our patients.

Table of contents

Executive Summary ..... **[p2]**
Introduction to Estates Strategy ..... **[p8]**

PART 1: The Existing Estate ..... **[p9]**

[sec 1] Introduction ..... **[p9]**

Part 1(a): The Whittington Estate ..... **[p9]**

[sec 2] Background ..... **[p9]**
[sec 3] Service Profile ..... **[p12]**
[sec 4] Site Usages and Block Coding ..... **[p13]**
[sec 5] Planning Context ..... **[p15]**
[sec 6] **Six-Facet Survey** ..... **[p16]**
[sec 7] Estate Key Performance Indicators ..... **[p21]**
[sec 8] Environmental Impact ..... **[p22]**
[sec 9] **Historical Investment** ..... **[p23]**
[sec 10] Estate Occupancy Costs ..... **[p24]**
[sec 11] Estate Value ..... **[p24]**
[sec 12] **Occupational Rights of Third-Party Education Providers** ..... **[p24]**
[sec 13] **Estate CRL Expenditure Objectives** ..... **[p27]**
[sec 14] **Key Site Issues** ..... **[p28]**

Part 1(b): The Community Estate ..... **[p30]**

[sec 1] **Background** ..... **[p30]**
[sec 2] **Location of Community Properties** ..... **[p31]**
[sec 3] **Services Operating from Community Properties** ..... **[p31]**
[sec 4] Baseline ..... **[p32]**
[sec 5] **Property Responsibilities** ..... **[p32]**
[sec 6] **Property Condition** ..... **[p36]**

[sec 7] **Backlog Figures** ..... **[p37]**
[sec 8] **Backlog Responsibility** ..... **[p40]**
[sec 9] Impending Backlog ..... [p40]
[sec 10] NBV of Transferring Properties ..... [p40]
[sec 11] The St Ann's Site ..... [p41]
[sec 12] Significant Community Estate Issues ..... [p42]

PART 2: Developing a Strategic Estate Policy Framework ..... **[p44]**

Part 2(a): Propositions ..... **[p44]**

[sec 1] **Introduction** ..... **[p44]**
[sec 2] **Key Propositions** ..... **[p44]**

Part 2(b): Estate Policies ..... **[p48]**

[sec1] **The Estate: Key Strategy Drivers** ..... **[p48]**
[sec2] **Whole Estate Policies** ..... **[p55]**

PART 3: Site Specific Development Plans ..... **[p61]**

Part 3(a): Whittington Hospital Estate ..... **[p62]**

[sec 1] **Introduction** ..... **[p62]**
[sec 2] **Short-Term Development Plan – Work Strands** ..... **[p62]**
[sec 3] **Site Development Plans** ..... **[p72]**
[sec 4] **Short Term Investment Programme** ..... **[p74]**
[sec 5] **The WhittingtonHospital Acute Site – Long Term Development Plan** ..... **[p76]**
[sec 6] **The Community Estate Development Plan** ..... **[p88]**
[sec 7] **The St Ann's Site Development Plan** ..... **[p91]**

Appendices ..... **[p93]**

[sec 1] **Appendix 1 – The Existing Estate Base Information (where are we now?)** ..... **[p93]**
[sec 2] **Appendix 2 – Draft SMART working Operational Principles** ..... **[p99]**
[sec 3] **Appendix 3 – Site Specific Development Plan Information** ..... **[p101]**

Table of Figures

Part 1

Figure 1.1 – Aerial View of Whittington Site ..... [p10]
Figure 1.2 – Floor Area Deployment ..... [p11]
Figure 1.3 – Patient Activity Levels ..... [p12]
Figure 1.4 – Block Codes ..... [p14]
Figure 1.5 – Age Profile of Estate by Percentage ..... [p14]
Figure 1.6 – Key 6 Facet Survey Data ..... [p15]
Figure 1.7 – Vacant, Surplus & Potentially Moveable Areas ..... [p19]
Figure 1.8 – 2010/2011 Key Performance Indicators ..... [p21]
Figure 1.9 – Overall CO2 Emissions ..... [p22]
Figure 1.10 – CO2 Emissions Arising from Gas Consumption ..... [p23]
Figure 1.11 – Capital Investments ..... [p23]
Figure 1.12 – Estate Occupancy Costs ..... [p24]
Figure 1.13 – Estate CRL Expenditure Objectives ..... [p27]
Figure 1.14 – Indication of Key Services Provided from Managed Properties ..... [p31]
Figure 1.15– Indication of Key Services Provided from Non-managed Properties ..... [p32]
Figure 1.16 – Freehold and Leasehold Community Properties Expected to be Transferred to Whittington Health ..... [p33]
Figure 1.17 – Backlog Maintenance [Table] ..... **[p36]**
Figure 1.18 – Summary of Backlog [Table] ..... **[p37]**
Figure 1.19 – Combined Backlog per Property (Ranked) [Table] ..... **[p38]**
Figure 1.20 – Backlog Maintenance – Comparison of Full Backlog with Risk-Adjusted Backlog [Table] ..... **[p39]**
Figure 1.21 – NBV Freehold Properties Expected to Transfer on 31st March 2013 [Table] ..... **[p40]**

Part 2

Figure 2.1 – Strategy Concept Diagram - Flow of Departments and Services Between Estate Properties ..... **[p54]**
Figure 2.2 – Departmental Location Criteria ..... **[p56]**

Part 3

Figure 3.1 – Additional Functions to be accommodated – Short Term Plan ..... **[p62]**
Figure 3.2 – Whittington Hospital Site – Short Term Development Plan ..... **[p72]**
Figure 3.3 – High Level Investment Programme – Short term Plan ..... **[p74]**
Figure 3.4 – Outline Site Valuations ..... **[p78]**
Figure 3.5 – Base Data – Schedule of Areas and Potential Floor Areas Reductions – Functions located on Northern Strip ..... **[p79]**
Figure 3.6 – Schedule of Released Space Areas as part of Ongoing Strategies ..... **[p80]**
Figure 3.7 – Example Site Development Option – Long Term Master Development Plan ..... **[p83]**
Figure 3.8 – Planned Floor Areas – Stack Allocation ..... **[p85]**
Figure 3.9 – High Level Financial Outcomes – Sale & Compression Scenario ..... **[p86]**

Introduction to Estates Strategy

The paper contains three main sections:

Part 1: examines the "where are we now" for both the existing estate – (the Whittington Hospital Trust - WH) and the additional estate including additional community properties that are envisaged to transfer to WH as part of the transfer of the PCT Estate on 31/03/2013

Part 2: builds our estate strategies, by:

- Examining the general environment from external and internal perspectives
- Identifying "fixed points" i.e. those events that we have to plan for and respond to
- Drawing directional guidance from existing strategic plans and objectives

From this analysis propositions are developed which encapsulate "our corporate view of the world." The propositions are then developed into estate strategies or policies.

Part 3: the developed estate strategies are then applied to key sites, and where appropriate high-level site development plans are drawn up. Details are given of key management and development projects together with significant investments and disposals. Where appropriate the timeframe is in two parts:

- Short/medium-term – where a period of management action will take place focused upon consolidating, integrating and harmonising the additional properties into the existing estate
- Longer-term – significant projects and directions that will need to be examined in detail nearer the time in question but need to be set down here to establish a long term framework for estate decision-making

PART 1: The Existing Estate

1. Introduction

Whittington Health has evolved with the joining up of Islington and Haringey community services, including social care in Islington, and Whittington Hospital.

We service a catchment population of circa 440,000, with a turnover of circa £277m and over 4000 staff.

At the point of formulating this strategy the transfer of community properties to Whittington Health under DoH guidance ("PCT Estate - *Future Ownership and management of the estate in the ownership of Primary Care Trusts in England*", issued 4th August 2011) will take place on 31st March 2013. WH expects to take on a variety of additional property interests, including full management responsibility (freehold and head lease interests) for some 14 Health Centres, and further obligations under various occupational arrangements for a further 20 properties. This will drive significant changes to the estate profile, presenting opportunities and challenges. Only limited information is available for the community properties as the due diligence process has not as yet been completed. Work to date has however enabled us to build up a "snapshot" of the estate. After formal transfer of the properties, over time a more detailed database of information will be built up. The information in this strategy relating to the community estate is therefore limited but represents our understanding at this point in time.

This strategy will therefore review the existing estate in two parts:

a)The Existing Whittington Estate
b)The Community Estate

Part 1 a): The Existing Whittington Estate

2. Background

The Whittington Hospital is the main acute site, situated in the London Borough of Islington between Dartmouth Park Hill to the west, Highgate Hill to the east, a primary school to the north and Magdala Avenue to the south. It occupies a single site of 4.5744 hectares between the urban centres of Archway to the south (1/4 km) and Highgate Village to the north (1/2 km). The closest underground station is Archway on the Northern Line and numerous bus routes pass or terminate close to the hospital.
The postal address is:
The Whittington Hospital

Magdala Avenue, London, N19 5NF

In addition to the main site, WH has rights of occupancy over two further buildings:

1) Highgate Wing (HGW) leased from a private landlord. This building is directly adjacent to the Western boundary of the main site, lies in the Borough of Camden and is also located within a conservation area. The current rent is £244k p.a. and the lease is due to expire on 25th March 2017.

2) Under a partnership agreement WH has rights to nominate residents to off-site residential accommodation at 220 Sussex Way, London, N19 4GH

Figure 1.1: Aerial view of the Whittington Site (2007) (from South looking North)

The site is densely developed with a mix of Victorian and contemporary hospital buildings. It provides a range of in-patient wards, ambulatory services, the emergency department, residential accommodation, administration and other support departments. There is one Grade II listed building (The Jenner building – block F).

The buildings on the acute site have a total floor area of circa 71,593m² (Inc. Highgate Wing and Waterlow buildings) (HGW and Block J) with an overall value of operational assets of £118m, including an operational land value of 27m. (Source: DV valuation report March 2012.

Of the total floor areas:

- Highgate Wing (HGW)(leased from a private landlord): GIA = 2,364m^2
- A Block (PFI funded and operated): GIA = 13,300m^2
- L Block (Great Northern Building) (PFI funded and operated): GIA = 12,255m^2

Figure1.2: Floor area deployment

Main Floor Areas	m^2	m^2
Total Gross internal floor area	**71,592.9**	
Leased out	2,098	
Unoccupied	5,318	
Total deployed (occupied)		**64,177.0**
Comprising:		
Patient areas		33,502
Non-patient		27,240
Circulation		3,434

The most significant development over recent years has been a large PFI project (circa £40m built in two main phases). Phase 1 consisted of a new building (Block A) completed in October 2006 providing 13,300m^2 floor area accommodating:

- New main entrance
- Undergraduate centre
- Retail spaces
- Staff and visitor dining
- Critical care Inc. 15 beds
- Imaging centre
- Thalassaemia unit

- Oncology day care
- 4 ward areas

Phase 2, Stage 1 was completed in April 2008. This development in the Great Northern Building (Block L) entailed the construction of the Day Treatment Centre in level three of the building. Further sub phases are ongoing and will be completed in 2013 when the remaining floors (4, 5 and 6) of this legacy building are upgraded. The work is focussed upon upgrading rather than functional changes. Over time this will upgrade the overall condition of the building to condition B from condition B/C at 2008. The total unitary charge is currently £4.8m p.a.

3. Service Profile

The Whittington Hospital NHS Trust is a medium sized acute general teaching hospital, with a core of 269 beds (including labour ward/recovery and NICU/SCBU cots), and an additional 69 beds/cots which provide additional capacity or a decant facility as required. The Whittington Hospital provides a wide range of services including:

- Accident and emergency care
- Critical care
- Emergency surgery and trauma services
- Orthopaedics and surgery
- Acute inpatient medical care
- Care of the elderly services
- Day surgery and medical day case procedures
- Obstetrics and neonatal services
- Paediatrics
- Direct access imaging and pathology services
- Outpatient services and the management of chronic diseases
- Medical Education and Undergraduate Training
- Paediatric therapies
- School Nursing
- Family Nurse Partnership
- Child & Adolescent Mental Health Services (CAMHS)
- Community paediatrics

Figure 1.3: Patient Activity Levels

	2008/9	2011/12
Inpatient and Daycase (FCEs):	48,273 (of which 16,952 were day cases)	53,221 (of which 18,373 were day cases)
Outpatients (attendance):	324,382	384,717
A&E Department (attendance):	77,386	86,418

Figure 1.3 shows that activity levels have risen across the reference period. It is forecast that bed numbers are sufficient as further initiatives will be put in place under our 'care closer to home' strategy to reduce in-patient activity. Pressure on A&E and Outpatients is becoming significant; this trend will be monitored carefully. It could be possible to expand these departments into the vacant K-Wing Old Imaging area and this vacant space will be reserved for this eventuality.

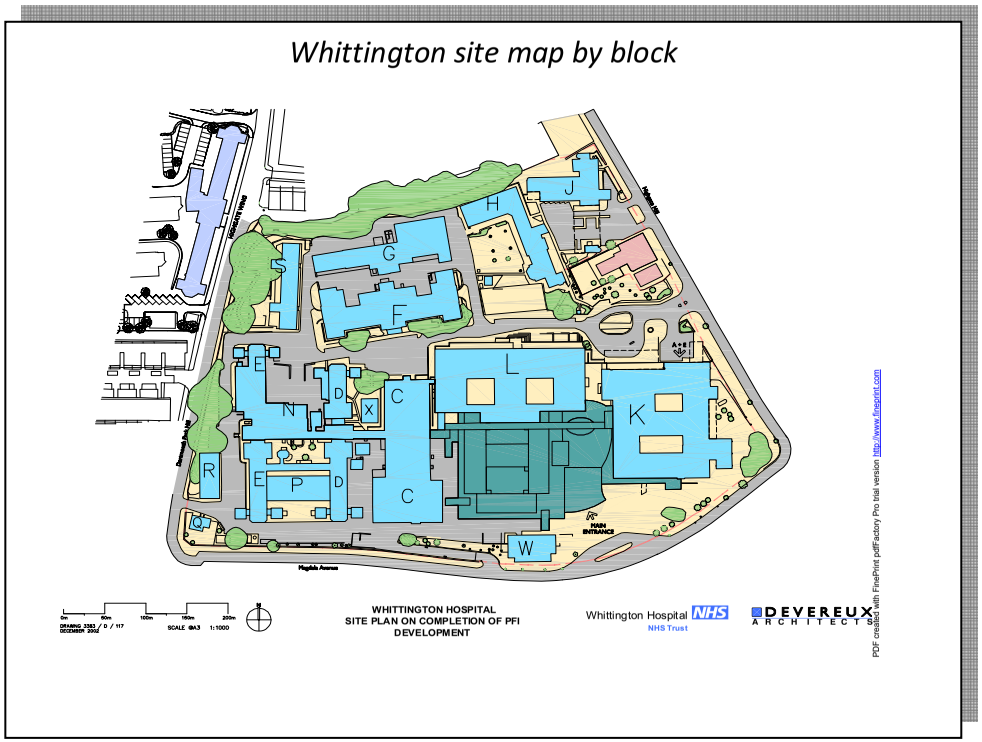
4. Site Usages and Block Coding

The estate consists of:

	Internal Gross (m^2)
▪ HGW - Highgate Wing, Dartmouth Park Hill (leased from a private Landlord)	2,364
▪ Block A – In-patient, diagnostic and critical care (PFI)	13,300
▪ Block C – Temporary records storage (Old Boiler house)/Goods In/CSSD	3,582
▪ Block D & E– Maternity Wards and some Bulk Storage Areas	9,144
▪ Block F – Administration	4,237
▪ Block G – Teaching	1,169
▪ Block H – Nursing Acc/Social Services/Physiotherapy/Occupational Therapy	3,143
▪ Block J – Waterlow Unit	4,483
▪ Block K – ED/Diagnostics/Pathology/Medical Records	13,674
▪ Block L – Ward Areas and Day Treatment Centre (PFI)	12,259
▪ Block M – In-Patient Therapy Unit	109
▪ Block N – Chapel and Clinical Offices	254
▪ Block P – Ward Areas	838

▪ Block Q – Occupational Health		108
▪ Block R – Oil Storage		213
▪ Block S – Doctors Accommodation		991
▪ Block U – Energy Centre		118
▪ Block W – Mortuary		625
▪ Block X - Medical Records Store		108
▪ Balance figure		874
	TOTAL=	**71,593m²**

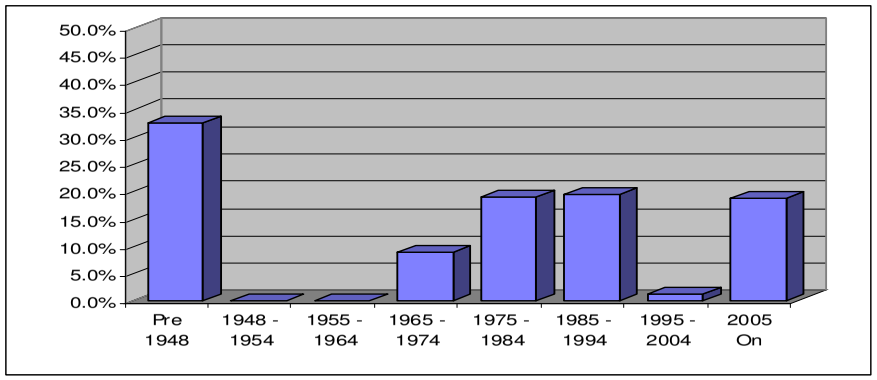
Fig 1.4: Block Codes



Circa 98% of patient contact services are located in the Southern part of the site (to the South of the central service road).

Highgate wing is located top left. The new PFI building is shown in blue below Block L.

Figure 1.5: Age profile of estate by percentage as at March 2012



After completion of stage 1 of the PFI development in 2006 there has been little material change in the age profile of the estate over recent years.

5. Planning Context

Highgate Wing falls within a conservation area. The Jenner building (Block F) on the main acute site is listed Grade II. London Borough of Islington is currently consulting on "Proposed Submission" drafts of Development Plan Documents including Site Allocations and Development Management policies. The consultation process is ongoing; however WH has made submissions that are intended to create a flexible planning environment in order to:

- Maximise development options for Hospital use
- Maximise development options and POTENTIAL site values for alternative use, should disposal of part of the site be contemplated.

The consultation round has not as yet concluded and London Borough of Islington has not as yet published their final submission documents. Initial indications are encouraging, as it appears the Local Authority may:

- Zone part of the site as suitable for development under its site allocation categorisation
- Recommend that this part of the site be included in the Mayor's "site match" initiative.

6. Six-Facet Survey

In 2007 the Trust commissioned a six-facet survey. This survey was updated in 2008/9 and was further updated via a desktop review in 2012. Key data remains to be finalised but can be summarised bellow. Although the results of this desk top survey is helpful, in November 2012 a further 6 facet survey was commissioned "from the ground up" this will more accurately reflect more the actual property condition that currently exists. The output from the survey will be used to update this strategy. Estimated figures (or outputs from older surveys) are therefore used in this strategy. The new survey will not change the strategic direction or conclusion of this strategy.
Figure: 1.1 in Appendix 1 shows Main Whittington Hospital site 2008/2009 6-facet survey output.

Figure 1.6: 6 facet survey data

Measure	% at 2012*	Cost 2012* (2011 in brackets)
1. Physical condition	A=16.8% B=58.1% B=2.8% C=22.0% D=0.2%	**£9.1m (£12.67m)**
2. Functional suitability	A=0.4% B=78.3% C=20.4% D=1.0%	**£3.9m (£4.2m)**
3. Space Utilisation	Empty=1.3% Underused=2.3% Fully Used=95.9% Overcrowded=0.5%	**£4.4m** ** **(£4.4m)**
4. Quality of the Environment	A=0% B=87.1% C=12.9% D=0%	**£0.07m (£0.2m)**
5. Statutory Requirements	A=0% B=84.8% C=15.2% D=0%	**£0.42m (£0.8m)**
6. Environmental performance	A=1.3% B=47.6% C=51.0% D=0.2%	**£0.67m (£0.4m)**
	Totals	**£18.65m (£22.67m)**

NB
** figures for 2012 are indicative only and are in draft as the final report has not as yet been validated and accepted.*
*** at time of writing 2012 space utilisation costs not received so 2011 figures used.*
The data above is to be treated with caution. The data is the output from successive desktop surveys and will be updated after the full survey is completed require a full resurvey. In any event the figures should be uplifted by circa 36% to allow for overheads, decanting, fees, preliminaries and contingency. VAT where applicable, should be added at 20%. An uplift of **60%** to the figures quoted above would be likely in practice.

6.1 Data Summary

- The majority of the backlog lies in blocks, D, E and K – our key patient areas.
- That functional suitability is an issue in D and E
- The site is shown as well utilised however some areas which are used for inappropriate functions (acute areas used as storage)
- Almost 50% of the estate has an energy performance of B or better
- J block is impaired
- Total site backlog estimated to be circa £18.65m 2012 a reduction from previous years totals of £22.67m

6.2 Physical Condition

- In the past 5 years the WH has invested £13.079 million on backlog / legal and statutory improvements and £9.7 million on improvements associated with the delivery of the WH's business objectives.
- The current estimate of condition backlog is £9.1m and legal and statutory is £0.42m.
- The Waterlow Building (J block) was transferred to the ownership of the trust in 1999. It is currently empty. No backlog costs are included in the 6-facet survey for J block. However, separate indications are that the cost to bring the building back into use would be in the region of £7m at 2009 prices.
- The most significant backlog in patient areas are Blocks, C, D and E (circa 2.0m net of on-costs) and K Block £1.4m net of on-costs.
- Non-patient backlog in Jenner (F Block) is the highest of all non-patient buildings at circa £1m net of on-costs.

6.3 Functional Suitability

- Although not specifically mentioned in the 6-facet survey it is increasingly apparent that some of the main administrative buildings are becoming unsuitable for modern methods of working. Increasingly large open plan office spaces are required to improve ease

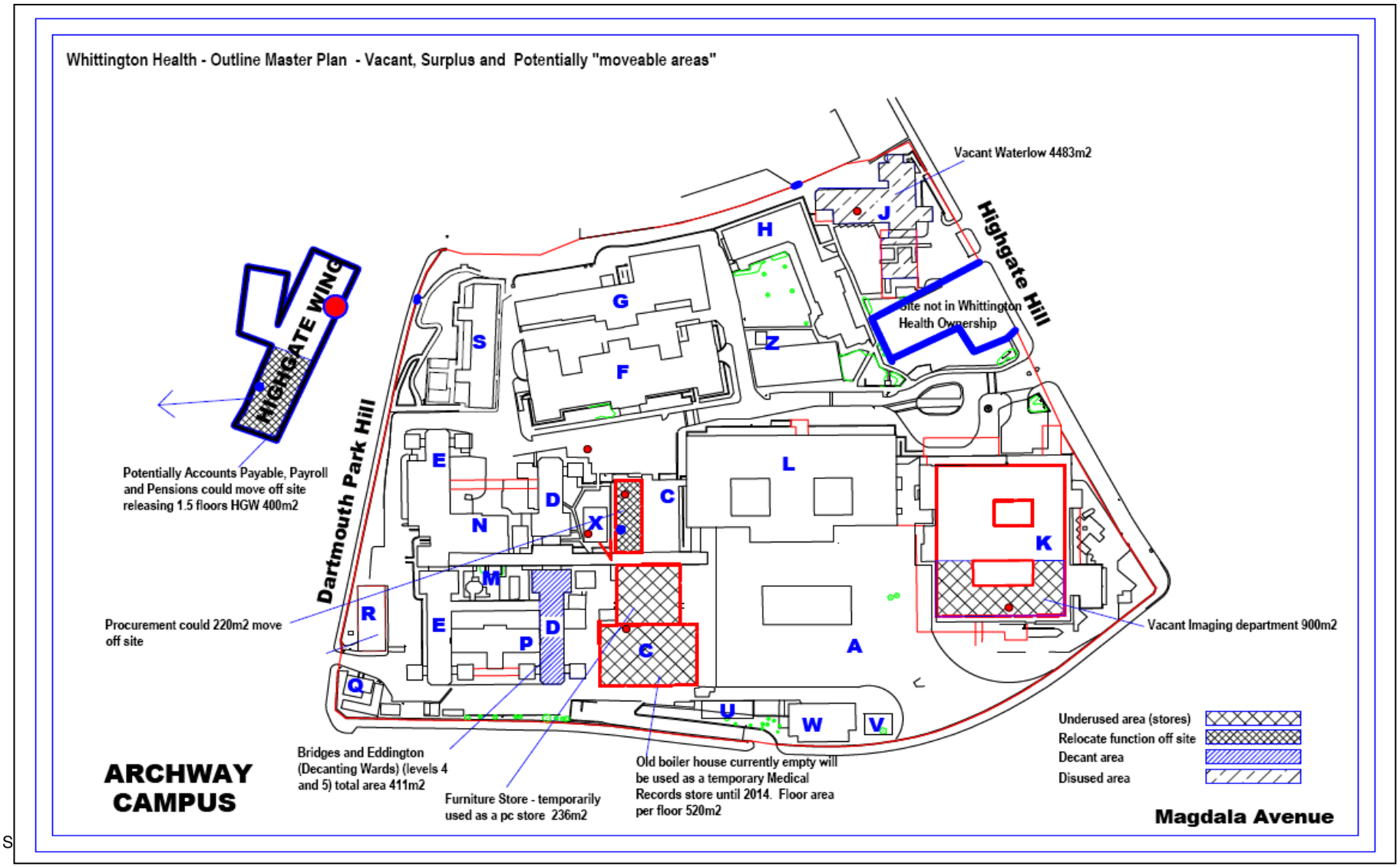
of communication but also for flexibility and economy of space reasons. Both HGW and Jenner (F Block) contain cellular office layouts. Jenner in particular is listed and it would be difficult to remove the load bearing masonry internal walls.

- In 'D' and 'E' block the issues are different. These blocks are what remain of the Victorian Hospital and consequently the wards are open plan 'Nightingale' type. Although single sex is not an issue here, the predominance of open wards means that the accommodation falls short of the standards expected in a modern health care facility. There are few side rooms, no rooms with en suite facilities and achieving acceptable levels of privacy and dignity is challenging

6.4 Space Utilisation

- Significant progress has been made with addressing mixed-sex wards. All wards can be managed in such a way so as to meet the criteria set out in the DoH guidance for single sex accommodation.
- In general, space is used well. However, some areas are empty such as: Waterlow (Block J). Other areas are not appropriately used, such as the Old Boiler House (Block C), furniture store (level 3 block C) and the old Imaging area (K Block level 2) whilst not empty, are being used for temporary storage, which should be reviewed in any long term plan. Two wards are empty in Block D (Bridges and Eddington) however these are used as decanting when upgrading other wards or as a spare ward used as a winter pressure ward. This usage is under review and is therefore shown as potentially vacant space in figure 1.7.

Figure 1.7: Vacant, Surplus and Potentially Moveable areas



6.5 Quality of the Environment

Generally good and significant improvements have been made. The PFI building in particular has contributed to improved overall standards.

6.6 Statutory Requirements

Investment in new facilities has significantly improved accessibility of services for both patients and staff. The Trust commits an annual sum from its Capital Resource Limit to legal and statutory compliance schemes in terms of both Fire and Health & Safety. Statutory backlog is predominately located in blocks C, D and E and with site externals.

7. Estate Key Performance Indicators

Figure 1.8: 2010/2011 key performance indicators (11/12 not yet available).

			Grouping PI (Percentile Bands)		
PI SUMMARY	**Trust PI**		**33%**	**34%**	**33%**
Space Efficiency					
Income £10/m²	292		190	191 and 265	266
Activity/100m²	90		6	7 and 87	88
Asset Value £10/m²	206		128	129 and 170	171
Occupancy Cost £/m²	240		161	162 and 203	204
Asset Productivity					
Asset Value £10/m²	206		128	129 and 170	171
Capital Charges £/m²	159		83	84 and 119	120
Total Backlog £/m²	129		42	43 and 119	120
Rent & Rates £/10m²	262		0	1 and 447	448
Asset Deployment					
Land £/m²	384		195	196 and 351	352
Building £10/m²	146		93	94 and 119	120
Equipment £/m²	214		101	102 and 173	174
Capital Charges £/m²	159		83	84 and 119	120
Estate Quality					
Asset Value £10/m²	206		128	129 and 170	171
Depreciation £/m²	117		64	65 and 88	89
Critical Backlog £/m²	38		7	8 and 35	36
Risk Adjusted Backlog £/m²	40		8	9 and 40	41
Cost of Occupancy					
Rent & Rates £/10m²	262		0	1 and 447	448
Energy/Utility £/10m²	235		186	187 and 235	236
Maintenance Costs £/10m²	310		224	225 and 309	310
Capital Charges £/m²	159		83	84 and 119	120

The Whittington Hospital performance indicators are generated through the ERIC system. (Figure: 1.2 in Appendix 1 contains historic trends).

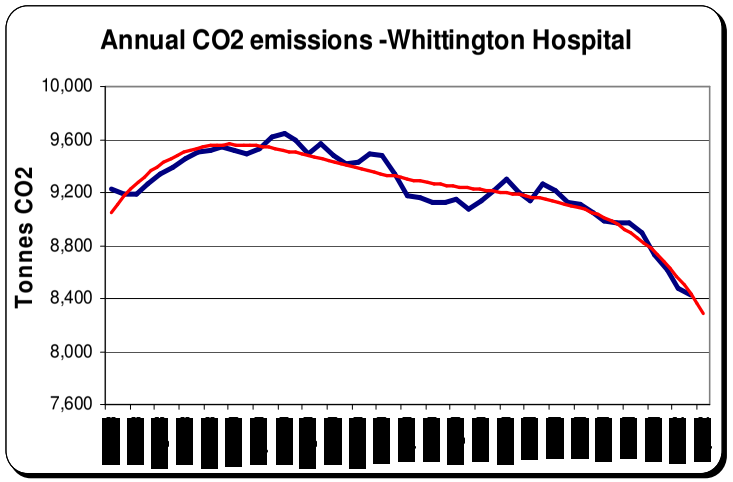
8. Environmental Impact

The total heated volume of the estate is 164,262m^{3,} distributed across a number of multi-level buildings all of varying ages and construction. WH has developed and adopted a Carbon Reduction Strategy intended to meet the government targets for carbon reduction. The strategy sets out a plan that will deliver a reduction in carbon emissions of 900 tonnes over five years from 2009/10 to 2014/15. A case for investment in measures to reduce direct emission of carbon into the atmosphere is made over the 5-year period.

A key recent initiative has been the decentralisation of the main Boiler House. This project has run over several years and installed a series of decentralised LPHW boiler systems for those blocks still supplied by steam. The work was practically completed June 2011.

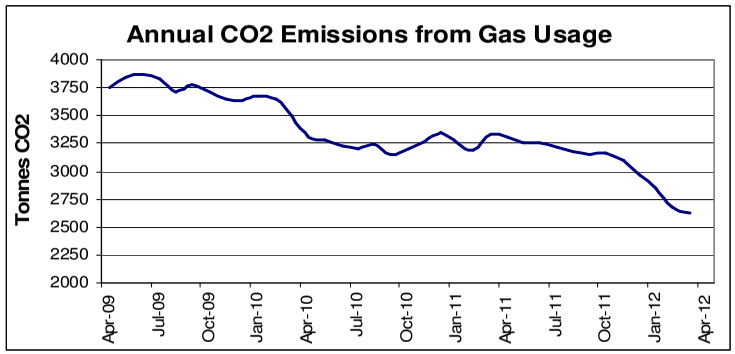
The hospital uses a building management system to monitor electricity use, heating temperature regulation and environmental control. The system is used to set targets to reduce consumption and the impact upon the wider environment.

Figure 1.9: Overall CO_2 emissions



The mild winter together with the ongoing programme of energy conservation initiatives have driven down energy consumption. The effect of the decentralisation of the Boiler House (completed summer 2011) can clearly be seen from the overall reduction of CO_2 emissions.

Figure 1.10: CO_2 emissions arising from gas consumption



The reduction of CO_2 emissions arising from gas consumption is as a proportion even greater than the overall emissions reduction. This is unsurprising as the gains made by decentralising the inefficient gas fired Boiler House were always most likely to impact mainly upon gas consumption.

9. Historical Investment

The table below shows the capital investment made over the past 5 years. Data collection criteria have varied over recent years. Figure 1.3 in Appendix 1 shows the estates maintenance capital plan for 11/12.

Figure 1.11: Capital Investments

	2007/8	2008/9	2009/10	2010/11	2011/12	Total by type
Medical Devices	2,070	600	1250	967	1,511	**6,398**
IM&T	1,340	742	977	1,180	7,000	**11,239**
Non-estates total	**3410**	**1342**	**2227**	**2147**	**8511**	**17,637**
Backlog/Legal	2,147	1,972	1280	3,580	4,100*	**13,079**
Improvement	2,959	1,570	2,160	2,020	1,000*	**9,709**
Estates Total by year	**5106**	**3,542**	**3,440**	**5,600**	**5,100**	**22,788**
Total CRL	**8,516**	**4,884**	**5,667**	**7,747**	**13,611**	**24,231**

*figures Estimated

10. Estate Occupancy Costs

Base occupancy costs are supplied via the ERIC returns as follows:

Figure 1.12: Estate Occupancy costs

	2008/9	2009/10	2010/11	2011/12
Occupation costs m^2 (from ERIC returns) (£/m^2)	232	253	240	287*est.
Capital charge (dep and int) and PFI charges (£/m^2)	141	169	159	159 est
Total (£/m^2)	373	422	399	446

** figures estimated.*

The increase in property occupation costs is due to reclassification of some costs, increases in rent at Highgate Wing (effective from March 2011- 30k), inclusion of non-emergency patient transport (806k), and Telecoms (295k). Total estimated impact is circa £17/m^2 additional cost.

The overall occupancy cost at £446/m^2 is reported in the ERIC returns. This figure is an increase over previous years as for the first time the effect of PFI, loans, and capital charges has been included. This brings WH to near the top of the upper quartile of the ERIC data when compared to other organisations.

11. Estate Value

The District Valuer (DV) has assessed the value of the operational assets of WH. The overall value of operational assets was estimated to be £118m in March 2012 including a land value of £27m.

12. Occupational Rights of Third Party Education Providers

12.1 Education & Training

WH is one of the largest centres for training and accreditation of health professionals of varied disciplines, in addition to its more widely recognised role in undergraduate education. WH works closely with Middlesex University and UCL. Both organisations occupy space within the Whittington acute site to deliver education and training, as follows:

Middlesex University gave up rights held under an existing lease and in return will be granted a licence to occupy (currently under negotiation) of parts of Block G (WEC) (Whittington Education Centre). Their key focus is training and education for Nursing and Medical staff. The licence will have a term certain of 15 years (from date of signature). A licence fee charge of £111,461p.a. plus VAT will be payable. The licence details termination rights – whilst these are yet to be finally agreed, there will be provisions permitting the Licensor to terminate upon 12 months' notice and (depending upon the period the Licence has run) compensation (or relocation to alternative suitable premises) will be payable on a stipulated formula.

UCL has allocated space within Block A (PFI Building) that is used for education and training. The space includes a lecture theatre, 2 seminar rooms, offices and associated support spaces comprising total floor area circa 666m2. No documented occupation agreement is currently in place. UCL originally obtained occupation rights by contributing capital funding to the Great Northern Building in 1992. The agreement at the time granted UCL ongoing rights of occupation. This right of occupation was then transferred into the PFI building when the Great Northern site area was redeveloped under the PFI contract in 2006. The un-codified nature of this agreement and the resultant ongoing rights creating embedded space will need to be formalised.

UCL also provides space in its adjacent Archway campus for the following functions:

- Clinical Skills Centre (Department of Medical Education) c400m2. Includes parts of the Undergraduate Assessment Centre
- Library and associated functions c280m2

The Clinical Skills Centre and the Library and Associated functions are provide Teaching and Learning for Doctors. These spaces are funded from the SIFT allocation, in usual circumstances it would be the responsibility for the service provider to allocate and fund spaces for this purpose. By historical accident of adjacently UCL provided space for these functions at no cost to WH.

UCL have decided to dispose of the Archway Campus (circa August 2013). If WH wish to retain the SIFT grant and access to these teaching and learning it will need to re-provide these facilities on the WH acute site. This is a key challenge for WH.

12.2 Residential Accommodation

WH provides residential accommodation for medical staff, key workers and others in three locations:

1) Nurses' Home – Block H. Acute Hospital site. Comprises:
- single residential rooms (34 rooms level 4, 34 rooms level 3 and 10 rooms level 2) 1 double room

- 18 on call rooms (level 2)

These rooms are typical traditional cellular nurses' home accommodation, comprising single rooms with shared kitchen and bathrooms. WH holds the freehold of this building.

2) Doctors' Accommodation – Block S. Acute Hospital site. Comprises:

- 1 on call flat (flat 6)
- 11 residential 2 bed flats

Despite the historic block name these flats are now no longer provided for occupation solely for doctors (save for flat 6 on-call). They are now used for general accommodation for hospital staff and some visitors.

This building is of particularly poor quality: it is a prefabricated concrete construction with a limited potential life. WH holds the freehold of this building.

3) Sussex Way Accommodation - 220 Sussex Way, London N19 4HG. Comprises:

- 124 units in 6 bedroom cluster flats

This building was completed in 2002 under a PFI arrangement. The nomination agreement between WH and Network Housing Association dated 26th March 2001operates for a period of 35 years. The operating risk at various occupancy percentages is carried as follows:

- 90 – 100% - operator carries the risk (loss of revenue)
- 80 – 90% - WH carries the risk and is charged by the operator for loss of revenue (rent and council tax) according to an agreed formula set out in the nomination agreement
- 0 - 80% - operator carries the risk

Over 2 years subsequent to the opening of the property, WH was penalised under the nomination agreement for failing to achieve 80 – 90% occupation. Management and booking prioritisation changes were implemented and since that time WH has not been penalised under the nomination agreement.

The property is in good condition and is functionally a vast improvement on the dated single cell shared bathroom and kitchen layout in the Nurses' Home. However, the rent levels and short distance for the acute site sometimes drive residents to request the Nurses' Home accommodation as their first preference. The rental charges for 2011/12 (due to rise 3% in August 2012) are shown in Appendix 1 Figure 1.4 and range from £305 per month for a decorated room in the Nurses Home to £577 per month for a room in Sussex Place.

13. Estate CRL Expenditure Objectives

WH's current CRL is circa £7m p.a. A capital programme is presented and approved to the Trust board annually. In broad terms 25% is invested in L&S, backlog, and plant replacement; 25% in Medical Equipment; 10% in IT infrastructure and 25% in improvement, adaptation and alterations and 16% in MES/PFI

Figure 1.13: Estate CRL Expenditure Objectives

Aim	Outcome
Legal and Statutory Compliance	To address known non compliance and to ensure that site infrastructure is maintained ahead of the compliance curve
Plant replacement and Backlog	To reduce the historical backlog, improving site efficiency, carbon reduction, maintenance costs and time lost through defects
Improvements, adaptations and alterations	Through a business case process invest in new or improved facilities to ensure the estate is capable of delivering cost effective services that meet the commissioned intent
Medical Devices	To maintain a programme of regular equipment replacement, reducing the risk of failure , improving patient care and patient outcomes
IT infrastructure	To ensure that the IT infrastructure is maintained to modern standards, reducing the risk of system obsolescence and creation of legacy services

14. Key Site Issues

Estate planning across the ICO is the responsibility of the Estates Transformation Board (ETB). This group is responsible for co-ordinating Estates planning across the main Whittington acute site and the community properties. As part of its planning process this group has identified several key issues on the acute site that will need to be addressed in the estates strategy. These are particular issues over and above estate related maintenance and cyclical renewals. Key issues include:

- Insufficient and/or functionally unsuitable office space for existing and forecasted numbers of staff
- Short term remaining lease period for HGW makes long term planning for this building difficult
- Deteriorating condition of the externals envelope of Jenner (Block F) causing dampness internally and a danger to passers-by from falling masonry
- Overcrowding in Jenner and formation of Support Services directorate
- Inadequate, inappropriate Medical records storage, cataloguing and retrieval issues. Records are currently poorly indexed, located in various unsuitable areas in functionally inappropriate buildings
- X Block is not watertight and could be in danger of collapse – currently used to store medical records – requires decanting and demolition
- Inefficient printing and copying strategy. Too many printers of inappropriate types, sizes and numbers. In many cases poorly located
- Identify use for vacant spaces within the acute centre including old Boiler House (C Block), Old furniture store (level 3 C Wing) and Old Imaging area level 2 K wing
- Resolve long-term strategy for Waterlow building – sell or reoccupy
- Agree functions that will relocate from Archway campus. Identify potential locations on the acute site for these functions
- Relocate Inpatient Physiotherapy from basement of main building (continuation of long term strategy of relocating patients from functionally unsuitable Basement area)
- Backlog maintenance generally – increase resources to minimise backlog maintenance
- General functional suitability, access and condition of maternity buildings
- In line with emerging clinical strategy support additional provision of Ambulatory Emergency Care Facilities
- Support and implement (estate-related) requirements developed from the emerging Unipart study (forming part of Clinical Strategy)
- Lack of sufficient meeting, seminar and training rooms to meet forecasted requirements. Existing facilities are often poorly located and functionally unsuitable.
- Formalise terms of occupation of third party organisations with embedded/shared space on main site (UCL and Middlesex University)
- Should WH agree to replace the Clinical Skills Centre, Library and associated functions on the Whittington site once Archway campus closes (August 2013) it will need to identify suitable space

Part 1 b): The Community Estate

1. Background

WH became an Integrated Care Organisation (ICO) under the terms of a Business Transfer Agreement (BTA) dated 4th April 2011. Under the terms of the BTA, WH assumed responsibility for providing the community services previously managed by both Haringey and Islington PCTs. The BTA described a process whereby Whittington Health would then lease some 35 community properties from the PCTs (either wholly or in part) in order that it could carry out its obligations under the Community Services Contract (CSC) agreement. These leases would be operating leases, for no more than a 3 year period, and thus would be coterminous with the CSC which runs for the 3 years to 31 March 2014.

On 4th August 2011, the Department of Health (DoH) issued guidance entitled PCT Estate Future Ownership and Management of Estate in the Ownership of Primary Care Trusts in England. This set out the process whereby the PCT's estate would be transferred to the healthcare body who have the majority use of each individual property, and if a property had no single body who occupied more than 50% of the space, then they would be transferred to a further body called NHS Properties Ltd.

The advent of this transfer process has overtaken the main provisions of the BTA and WH now anticipate taking operational control of some 16 properties and to lease space inside a further 16 properties (NB actual numbers not finally agreed as at end October 2012). Legal transfer will take place on 31st March 2013 and the equipment relating to that particular property will also transfer alongside the property.

In addition to those properties where WH will have a legal interest in the property (freehold or leasehold) WH also occupy a number of properties where their occupancy is based on a Service Level Agreement (SLA). Principal of these is the St Ann's Hospital site where WH occupies a number of buildings and is provided with a range of services to manage those buildings. It is anticipated that WH will take over responsibility for the SLA with effect from 31st March 2013.

It should be noted that due diligence investigations are still ongoing. Until such time as this process is completed, WH is not able to formally confirm whether it is willing for certain properties to be transferred to them – and plan accordingly. Therefore whilst this strategy ***assumes*** that the due diligence process will be completed to the satisfaction of WH this ultimately is a matter for further investigation.

2. Locations of Community Properties

Appendix 1 Figure 1.5 shows the location of main community properties WH operates services from. Property ownership can only be confirmed at the end of the due diligence process. Significant Community properties only are identified. Minor or un-codified occupations are not identified.

3. Services Operating from Community Properties

Figure 1.14: Indication of Key Services Provided from Managed Properties

	GP Surgery	IAPT	District Nursing	Podiatry	Physiotherapy	Dietetics	Health Visiting	Speech and Language	Mental Health	Dental	Sexual Health	Admin
Holloway Community H C	✓		✓	✓	✓	✓				✓		✓
164 Holloway Rd (Pulse)											✓	
Lansdowne Clinic		✓										
Stroud Green Clinic											✓	
Highbury Grange H Centre	✓		✓	✓			✓					
Hornsey Rise H Centre	✓		✓	✓			✓	✓				
Stuart Crescent H Centre	✓		✓	✓			✓					
Bounds Green H Centre	✓	✓		✓	✓							
Crouch End H Centre		✓								✓		✓
1-3 Edwards Drive									✓			
Northern Health Centre	✓											
Tynemouth Road H Centre	✓						✓					
Goodinge Health Centre	✓											
Goswell Road												✓
Simmons House									✓			
13-15 Pine Street								✓				

In addition to those properties that Whittington Health will take responsibility for, they will also be providing services from the following properties, which are occupied either on a sub-lease or under the terms of a Service Level Agreement.

Figure 1.15: Indication of Key Services Provided From Non-Managed Properties

	GP Surgery	IAPT	District Nursing	Podiatry	Physio/ Rehab	Dietetics	Health Visiting	Speech and Language	Mental Health	Dental	Sexual Health	Admin	Other
Sub Leased properties													
Hunter St Health Centre	✓									✓			
Laurels Healthy Living Centre	✓			✓			✓						
Bloomsbury Day Hospital					✓								
Finsbury Health Centre	✓			✓	✓		✓						
New Park Day Centre					✓								
133 St John's Way					✓								
Lordship Lane H Centre	✓		✓	✓				✓			✓		
Hornsey Central H Centre	✓	✓			✓	✓	✓	✓					
Bingfield Health Centre	✓						✓						
Partnership P Care Centre	✓											✓	✓
SLA properties													
Belsize Priory H Centre	✓									✓			
Crowndale Health Centre	✓									✓			
Kings Cross PCC										✓			
Kentish Town H Centre	✓									✓			
Hanley Road H Centre	✓						✓						
St Ann's Hospital		✓		✓	✓	✓		✓		✓	✓	✓	

4. Baseline

The PCT estate transfer process will identify the space that is legally attributable to WH, and this will then be supported by either a freehold/leasehold transfer or a sub-lease. In accordance with the BTA process these properties will be fully funded and form the baseline property envelope within which the Trust is initially expected to operate.

5. Property Responsibilities

WH expect the following property and occupational arrangements to be agreed with NCL.

5.1 Leasehold and Freehold Transfers

For the financial years 2011/12 and 2012/13, responsibility for managing all of the properties has remained with the respective PCT via the North Central London (NCL) cluster.

From 31st March 2013 management responsibility for the following properties is expected to be transferred to WH:

Figure 1.16: Freehold and Leasehold Community Properties Expected to be transferred to Whittington Health

Freehold responsibility (9)	Leasehold responsibility (8)	Leasehold details
Bounds Green Health Centre	Crouch End Health Centre	99 year lease from London Borough of Haringey expiring in 2084 with the annual rent set at a Peppercorn
1-3 Edwards Drive	Goswell Road	9 year lease from a commercial provider expiring 2015 with annual rent of £ 220,000
Goodinge Health Centre	Highbury Grange Health Centre	20 year lease with London Borough of Islington expiring 2030 at an annual rent of £ 99,500
Stuart Crescent Health Centre	Lansdowne Clinic	20 year lease from a commercial provider expiring 2017 at an annual rent of £ 18,000
164 Holloway Rd (Pulse)	Simmons House	Anticipated 17 year lease from Camden & Islington Mental Health NHS Trust expiring 2029 at an annual rent yet to be determined.
Hornsey Rise Health Centre	Stroud Green Clinic	125 year lease from London Borough of Haringey expiring 2118 at an annual rent of £ 6,500
Northern Health Centre	13-15 Pine Street	20 year lease from the charity "Action for Stammering" expiring 2031 at an annual rent of a peppercorn
River Place Health Centre	Holloway Community Health Centre	10 year lease from a commercial provider expiring 2019 at an annual rent of £ 470, 000
Tynemouth Road Health Centre		

Although overall responsibility for the property will be transferred to WH, based on the fact that they occupy more than 50% of the leasable area, there may also be other tenants who occupy a smaller proportion of the property under the terms of a sub-lease. This will generally be a GP practice.

Additionally, at the end of the existing 3 year CSC, the services will be open to tender again and, should WH not be successful in retaining the provider services, then responsibility for the property will be transferred back to the Secretary of State.

In addition to the properties where WH has responsibility, they will occupy a further 16 properties under the terms of a sub-lease.

5.2 Sub Lease Over Part of Buildings

Where WH have a sub-lease over part of a building (10)

- Bloomsbury Day Hospital
- Hunter Street Health Centre
- Laurels Healthy Living Centre
- Finsbury Health Centre
- New Park Day Centre
- 133 St John's Way (Outlook) - Lease with LB Islington expired August 2012 (new lease under Negotiation)

- Lordship Lane Health Centre - LIFT
- Hornsey Central Health Centre - LIFT
- Bingfield Health Centre - LIFT
- Partnership Primary Care Centre- LIFT

With effect from 1 April 2013 the Trust will be granted a sublease and provided with a service charge contract setting out the cost of occupation and operation of the property. These figures are still to be computed by NCL but, when known, will be fully funded.

5.3 WH Occupy Premises as Part of an SLA

Where Whittington Health occupy the premises as part of an SLA (6)

- Belsize Priory Health Centre
- Crowndale Health Centre
- Kings Cross Primary Care Centre
- Kentish Town Health Centre
- Hanley Road Health Centre

- Various buildings at St Ann's Hospital (generally on a yearly SLA)

With effect from 1 April 2013 the Trust should be granted a formal sublease and provided with a service charge contract setting out the cost of occupation and operation of the property. These figures are still to be computed by NCL but, when known, will be fully funded.

6. Property Condition

Having taken responsibility for the property, WH will take responsibility for the condition of the property both in terms of its own use but also in terms of the element occupied by any sub-tenants.

In March 2012 Whittington Health and NCL jointly commissioned a six-facet survey from NIFES Consulting Group, which identified both the Backlog and Impending Backlog for all of the properties in which WH will have an interest. The results are shown in Figure 1.17

Figure 1.17: Backlog Maintenance

	Condition					Statutory				
	High Risk	Significant Risk	Moderate Risk	Low Risk	**Total**	High Risk	Significant Risk	Moderate Risk	Low Risk	**Total**
Bounds Green Health Centre		5,508	1,807		**7,315**			5,000	1,200	**6,200**
1-3 Edwards Drive				9,000	**9,000**			4,600	1,050	**5,650**
Goodinge Health Centre				2,000	**2,000**			10,000		**10,000**
Holloway Community H C				2,319	**2,319**		1,200	12,200	6,250	**19,650**
164 Holloway Rd (Pulse)				31,658	**31,658**			11,200	5,600	**16,800**
Hornsey Rise Health Centre				22,350	**22,350**			15,445	5,100	**20,545**
Northern Health Centre				2,956	**2,956**			10,000	15,750	**25,750**
River Place Health Centre				17,000	**17,000**			24,000	16,650	**40,650**
Stuart Crescent Health Centre			12,000		**12,000**			8,400	7,900	**16,300**
Tynemouth Road Health Centre				800	**800**		1,500	15,300	5,400	**22,200**
Crouch End Health Centre			1,500	4,000	**5,500**			6,700	3,800	**10,500**
Goswell Road					**0**					**0**
Highbury Grange Health Centre			5,000	9,923	**14,923**		2,800	16,200	37,950	**56,950**
Lansdowne Clinic			3,664	18,617	**22,281**			14,400	3,250	**17,650**
Simmons House					**0**					**0**
Stroud Green Clinic				4,300	**4,300**			8,500	3,350	**11,850**
13-15 Pine Street**(NEED DATA FOR THIS)**										
		5,508	23,971	124,923	**154,402**	0	5,500	161,945	113,250	**280,695**

7. Backlog Figures

The backlog figures shown relate to "works" only and extra costs would need to be added to arrive at a project cost. The NIFES figures therefore need to be uplifted by circa 63% to take account of fees, decanting, VAT contingency and the like.

WH regard the backlog issues as manageable as the total spend required to bring the buildings up to Estate Code category B in terms of both condition and statutory compliance is not financially significant and there is very little that falls into the "High" or "Significant" risk categories.

Figure 1.18: Summary of Backlog

	High Risk	Significant Risk	Moderate Risk	Low Risk	Total
Condition		5,508	23,971	124,923	**154,402**
Statutory		5,500	161,945	113,250	**280,695**
Sub Totals		11,008	185,916	238,173	**435,097**
Potential capital spend + 63.2 %		17,965	303,415	388,698	**710,078**

During 2011/12 Haringey and Islington PCT made a depreciation provision of £ 700k for the above properties and, as a consequence, could possibly remove the backlog within one year. Figure 1.17 shows the backlog in each property. This is not regarded as significant.

Figure 1.19: Combined Backlog per Property (Ranked)

	High Risk	Significant Risk	Moderate Risk	Low Risk	Total	Including on costs £'000
Highbury Grange Health Centre		2,800	21,200	47,873	**71,873**	**117**
River Place Health Centre			24,000	33,650	**57,650**	**94**
164 Holloway Rd (Pulse)			11,200	37,258	**48,458**	**79**
Hornsey Rise Health Centre			15,445	27,450	**42,895**	**70**
Lansdowne Clinic			18,064	21,867	**39,931**	**65**
Northern Health Centre			10,000	18,706	**28,706**	**47**
Stuart Crescent Health Centre			20,400	7,900	**28,300**	**46**
Tynemouth Road Health Centre		1,500	15,300	6,200	**23,000**	**39**
Holloway Community H C		1,200	12,200	8,569	**21,969**	**36**
Stroud Green Clinic			8,500	7,650	**16,150**	**26**
Crouch End Health Centre			8,200	7,800	**16,000**	**26**
1-3 Edwards Drive			4,600	10,050	**14,650**	**24**
Bounds Green Health Centre		5,508	6,807	1,200	**13,515**	**22**
Goodinge Health Centre			10,000	2,000	**12,000**	**19**
Goswell Road					**0**	
Simmons House					**0**	
13-15 Pine Street					**0**	
		11,008	185,916	238,173	**435,097**	**710**

By comparing the full backlog with the Risk-Adjusted backlog there is a 74% drop in the backlog value.

Figure 1.20: Backlog Maintenance

	Full Backlog			Risk-Adjusted Backlog			Cost per m²	
	Condition	Statutory	**Total**	Condition	Statutory	**Total**	**Full Backlog**	**Risk Adjusted**
Holloway Community H C	2,319	19,650	**21,969**	116	2,123	**2,238**	138	14
164 Holloway Rd (Pulse)	31,658	16,800	**48,458**	1,583	840	**2,423**	113	6
Lansdowne Clinic	22,282	17,650	**39,932**	1,114	883	**1,997**	112	6
Stroud Green Clinic	4,300	11,850	**16,150**	215	593	**808**	85	4
Highbury Grange Health Centre	14,923	56,950	**71,873**	746	5,508	**6,254**	84	7
Hornsey Rise Health Centre	22,350	20,545	**42,895**	1,118	1,027	**2,145**	34	2
Stuart Crescent Health Centre	12,000	16,300	**28,300**	600	815	**1,415**	26	1
Bounds Green Health Centre	7,314	6,200	**13,514**	5,598	310	**5,908**	15	6
Crouch End Health Centre	5,500	10,500	**16,000**	275	525	**800**	12	1
1-3 Edwards Drive	9,000	5,650	**14,650**	450	283	**733**	9	0
Northern Health Centre	2,956	25,750	**28,706**	148	1,288	**1,435**	9	0
Tynemouth Road Health Centre	800	22,200	**23,000**	40	2,535	**2,575**	9	1
Goodinge Health Centre	2,000	10,000	**12,000**	100	500	**600**	8	
Goswell Road	0	0	**0**	0	0	**0**	0	0
Simmons House	0	0	**0**	0	0	**0**	0	0
13-15 Pine Street	0	0	**0**	0	0	**0**	0	0
	154,402	280,695	**435,097**	12,953	19,263	**32,216**		

8. Backlog Responsibility

WH is wholly responsible for the backlog maintenance and future condition of the transferred properties. Where the property has a long term sub-tenant (e.g. GP practice) it is expected that maintenance costs will be recovered from the sub-tenant, thereby reducing the net cost to WH for managing the backlog. The lease with sub tenants is currently being dealt with by NCL and it is expected that formal occupation arrangements will be in place ***before*** any handover to WH. Similarly WH may become responsible for contributing towards the maintenance costs of other sites over which it has a sub-lease interest.

9. Impending Backlog

In the short term, the remaining period of the Clinical Services Contract mitigates against significant expenditure for improvement of significant functional changes. Impending backlog could however be a risk to WH. An assessment of impending backlog has been made as part of the NIFES survey. As part of the due diligence process WH is also requesting a clear oversight of general compliance issues from NCL, the output from these investigations will also help inform WH of the potential impending backlog risks within the community properties.

10. NBV of Transferring Properties

Figure 1.21: NBV Freehold Properties Expected to Transfer on 31st March 2013

	Land NBV £'000	Buildings NBV £'000	Equipment NBV £'000	**Transfer NBV £'000**
River Place Health Centre	900	1,523		**2,423**
164 Holloway Rd (Pulse)	144	334		**478**
Hornsey Rise Health Centre	800	1,554		**2,354**
Northern Health Centre	1,200	5,599		**6,799**
Stuart Crescent Health Centre	945	901		**1,846**
Tynemouth Road Health Centre	1,890	3,069		**4,959**
1-3 Edwards Drive	1,350	975		**2,325**
Bounds Green Health Centre	1,260	780		**2,040**
Goodinge Health Centre	1,200	1,743		**2,943**
	9,689	16,478		**26,167**

NB: Figures are indicative and based on entries in the ledgers of the respective PCT as at 31 March 2012

In addition, the lease on the Stroud Green Clinic is for 125 years and has therefore to be treated as a finance lease where the capital value of TBA will appear on the Balance Sheet of Whittington Health after 2012/13. Similarly leasehold improvements valued at £ 2,139,377 are expected to transfer to the Trust.

11. The St Ann's Site

St Ann's forms part of the Community Estate but due to its size and impending site rationalisation it is described separately in this document.

11.1 Terms of WH Occupation

WH has services located on the St Ann's site. Occupation of the properties is under an SLA currently held between Haringey PCT and Barnet Enfield and Haringey Mental Health Trust BEHMHT. The SLA is renewable running from 1st April on a yearly basis.

The terms of the SLA requires BEHMHT to provide all general services relating to the external building maintenance and repair together with general management and facilities services. The SLA charge levied by BETMHT for 10/11 was circa £2m p.a. equating to a unit rate of £262m^2.

The estate obligations under the SLA for Haringey PCT now effectively fall under NCL. The SLA required NCL to be directly responsible for internal renewals and renovations such as flooring and redecorations together with all furniture and loose items. The costs expended on this area by NCL have not as yet been ascertained.

11.2 Services Located on the St Ann's Site

Appendix 1 Figure 1.6 is the St Ann's site plan and shows the location of Whittington Health Services. Since September 2010 there has been a considerable change in the location and types of services located on the St Ann's site. The total area occupied as at September 15th 2010 was 7,723m^2. Since then we estimate circa 592m^2 of WH service departments have been relocated into community properties or the main Whittington site. In addition, Greentrees patients have now moved from St Ann's to a ward in the WH acute site. In effect services have been compressed into existing properties increasing space utilisation and reducing the area occupied at St Ann's.

11.3 The Development of the St Ann's Site

Barnet Enfield and Haringey Mental Health Trust (BEHMHT) are seeking to rationalise the St Ann's Hospital site and expect to sell a significant proportion in the future. Whittington Health provides services from the site under the terms of an operating SLA, which is under review. Whittington Health is working very closely with BEHMHT to help them achieve their plans resulting in:

- Movement of Whittington Health's St Ann's non clinical services off site into existing community properties thus facilitating consolidation of remaining services into a smaller footprint
- The rationalisation of St Ann's is being used as an opportunity to look at the configuration of two services – Sexual Health (possibly increased capacity and /or relocated offsite) and Child Development Centre (possibly form a co-located integrated Children's service – on or off site).
- The consultation period is currently in progress. Appendix 1 Figure 1.6 also shows one possible divide between land retained and land disposed of.
- WH have been working closely with BEHMHT to facilitate the relocation and removal of WH departments where required as part of the BEHMHT site rationalisation programme. Over time WH non-patient departments have been removed off site and compressed in other WH properties including: IT, Finance, APTs (West), Smoking Cessation, Temporary Staffing & Human Resources and Learning & Development. Total savings under the SLA resulting from these relocations are estimated to be circa £144k p.a.
- In-patient services have also transferred to the main WH acute site Greentrees Ward.

12. Significant Community Estate Issues

At the time of producing this strategy paper there were several key issues outstanding. It is expected that before the handover date these issues will be satisfactorily resolved. These issues are noted below:

12.1 Estate Management related Issues

- Resolution of outstanding sub leases to GP's and tenants for properties that are envisaged to transfer to WH
- Completion of compliance information together with details of existing contracts and TUPE issues
- Finalisation and agreement upon financial data including pass through costs – all properties
- SLA's for all relevant properties have as yet to be received
- Liability for significant existing backlog maintenance where WH holds a lease of part of the building
- Finalisation of BTA leases

12.2 Property Specific Issues

- Goswell Road – WH has taken a direct lease of this o/s issues in relation to NCL funding and payment mechanism.
- Holloway Health Centre – Landlord remedial works after serious black water flooding. Property as at November vacated – awaiting programme of remedial works.
- Simmonds House – awaiting agreed sub lease from NCL and resolution of financial amortisation issues (property has been leased and needs to be written off over proposed lease period (17 years) as against current write down period (over 40 years)
- St Ann's - resolution of financial treatment of NCL's (tenant's) improvements – amortisation period and funding for internal tenant's works

- St Ann's – resolution of SLA/lease issues – including financial breakdown
- St Ann's – liability for costs driven by BEH MHT site rationalisation – relocation and operational
- 133 St John's Way – NCL negotiating new lease with the Landlord (Local Authority) lease expired 17th August 2012
- New Park Day centre – NCL have been served notice by the Landlord (Local Authority) that the lease will not be renewed upon expiry 5th June 2013.

PART 2: Developing a Strategic Estate Policy Framework

Part 2 (a): Propositions

1. Introduction

WH has agreed a series of "propositions" which represent our view of the current environment. The propositions enable a corporate consensus to be established. This worldview set an overall framework that enabled more detailed strategies and polices to be developed.

2. Key Propositions

2.1 Environmental and Market Uncertainty

Proposition 1:	*The external environment is (and is expected to remain) in a state of flux – there will not be a point where we possess "perfect knowledge". Our planning is based around establishing a strategic direction rather than a very detailed set of initiatives.* *Environmental uncertainties will continue to challenge the status quo and any plans that are developed will need to be flexible and kept under regular review.*

2.2 The External Environment

2.2.1 Policy and structural changes

Proposition 2:	*National policy developments such as "any qualified provider" and the redistribution of commissioning functions will have significant impact upon Whittington Health which will need to be kept under review and factored into longer term planning considerations. Planning will need to be flexible to adapt to changing*

	circumstances

Proposition 3:	*WH wishes to remain a provider of world class education. The Archway campus closure compromises this objective. WH will take necessary steps to ensure that it can continue to offer world class education post closure of Archway campus.*

2.3 The Internal Environment

2.3.1 Overall Strategy Direction

Proposition 4:	*Estate plans should support the "*Whittington Health Strategy 2011 -2016"*.* *Detailed tactical plans will be developed and they will support the Trust's strategic direction. However environmental uncertainties mean that tactical plans are likely to be less useful as the planning time horizon increases.*

Proposition 5:	***Subject to satisfactory completion*** *of the due diligence process, WH will take lead ownership of qualifying Community properties to maximise the ability of the ICO to improve the quality of care provided to our patients.*

2.3.2 Foundation Trust Status

Proposition 6:	*Whittington Health will become a Foundation Trust on 31st March 2013 – Estate Strategies shall be developed that support, enable and thereafter further the implications of this major organisational change.*

2.3.3 Planning Cycle and planning phases

Proposition 7:	*The Estates planning reference period will not be constrained by the three year term of the Clinical Services Contract. A 5 year reference period shall be adopted to allow a more effective long-term planning horizon.* *Key issues will change over the short and longer-term. Initial planning is likely to focus upon management challenges arising from FT status and integrating the Community Estate. Large or capital-intensive*

	projects will be planned for the medium/longer-term to minimise short-term risks to the organisation.

2.4 Developments on the main Whittington Hospital

Proposition 8:	*The development of the Whittington site and in particular the need to upgrade the maternity block is an important long-term vision. WH's clinical strategy for maternity caps births at 4000 per annum. The facilities will require updating and reconfiguration but this is intended to be funded by consistent focusing of Capital funding.*

2.5 Sale of parts of the St Ann's site

Proposition 9:	*The closure of parts of the St Ann's site and the enforced decanting and relocation of affected departments will be used by WH as an opportunity to reconsider the shape, location and disposition of its services affected by these plans – key considerations include: The formation of a multi-agency co-located Children's centre*

2.6 Financial considerations

Proposition 10:	*The financial pressures upon Whittington Health are likely, over time, to increase. The Estate will also need to contribute cost efficiencies. A reduction of property overhead costs on an ongoing basis will be a significant contributor to the financial health of the organisation*

2.7 Management of Space

Whittington Health Strategy 2011 – 2016 states that we will:

"*Change the way that we work to build a culture of innovation and continuous improvement, working flexibly and in new ways to achieve efficiency and effectiveness…"* page 3. And,

"…we intend to…ensure that the hospital provides services that only the hospital can provide. In turn we will transfer a significant part of the demand for hospital services to more appropriate community care settings…." – page 9.

Proposition 10:	*Space is a finite resource and should be considered similarly to finance and manpower resources. Any particular occupier does not own space - it is owned and managed corporately. Effective management of space will reduce and change the type of physical space required. Space will be given currency by the introduction of space charging. This will enable those who do more with less to offer up space as part of cost improvement programmes* *The geographical spread of the estate will drive changes to working practices. We will support the introduction of modern flexible working practices, as we believe they will deliver:* ▪ *Cultural change - improved team working* ▪ *More effective use of resources* ▪ *Space efficiencies leading to property overhead cost reductions*

2.7.1 Space and the management of the location of services

Proposition 11:	*The creation of the ICO and the enlarged estate provides opportunities to review the range and location of services. Service locations shall be based upon providing the most effective service delivery to our patients.* ▪ *Services / functions on the main Whittington site that could deliver services from a community base (or elsewhere) shall be considered for relocation* ▪ *Services / functions on the main site (or elsewhere) that do not directly contribute to the corporate objectives shall be considered and, where agreed, discontinued* ▪ *Reducing the intensity of non-essential functions located on the main site will provide opportunities to accommodate additional acute clinical activities or potentially, sale of parts of the site* ▪ *Critically examine the opportunities to rationalise services from leasehold properties into community properties where the trust is the Freeholder and surrendering of leases where possible.*

2.8 Potential Hosts of Community Services

Proposition 12:	*Services need not necessarily be located within Whittington Health services buildings. Service efficiencies could be achieved by locating services within other public buildings. Whittington Health will work with public sector organisations to maximise the sharing of public sector buildings and to consider*

	the sharing of appropriate services

Part 2(b): Estates Policies

1 The Estate: Key Strategy Drivers

The 12 high level propositions provide a framework for the more detailed estate policies and strategies. This section develops the propositions into estate strategies. Six key strategic drivers have been identified:

1) Integration of Clinical services
2) Rationalisation of the St Ann's Hospital site
3) Support the Trust's Education Strategy
4) Development of the Whittington site
5) Clinical services Initiatives
6) Space location and management initiatives

1.1 Integration of Clinical services

The Estates Strategy is an integral part of the Trust's plans to deliver on its vision: "*To be an outstanding provider of high quality joined up healthcare to local people in partnership with GPs, councils and local providers*". (Whittington Health Strategy 2011–2016)

This is expected to influence the estate in the following ways:

- Community and acute services will harmonise through pathway re-design which will potentially change the type and amount of physical estate needed to be able to provide that service.
- Services will migrate from high-value acute sites towards more community provision, leaving the acute site free to concentrate on services that can only be provided from that environment.
- Services will migrate from leasehold premises to community freehold premises where this is deemed clinically appropriate allowing the trust to reduce its property overhead by surrendering or not renewing leases.

The Trust will adopt Smart working principles with the expectation that, overall, there will be less space required in the future. This initiative will "*Change the way we work to build a culture of innovation...*" (Whittington Health Strategy 2011 – 2016) and facilitate a flexible, dynamic working culture delivering real operating efficiencies.

1.2 Rationalisation of the St Ann's Hospital site

Barnet Enfield and Haringey Mental Health Trust (BEHMHT) are rationalising the St Ann's Hospital site and expect to sell a significant proportion in the future. Consultation has commenced. WH provides services from the site under the terms of an operating SLA, which is reviewed every 12 months. WH are working closely with BEHMHT to help them achieve their goals. Work areas include:

- Further movement of WH's St Ann's non-clinical services off-site into WH community properties facilitating consolidation of remaining services into a smaller footprint. The space savings will reduce the total charges under the BEHMHT SLA.
- Using the rationalisation of St Ann's as an opportunity to review the configuration of the Child Development Centre by possibly forming a co-located integrated Children's service

Further negotiations will be required with our commissioners as it is for them to decide the quantum and location of services before any final decision can be made.

The substantial threat remains; the relocation of WH services on the St Ann's site is driven by BEH MHT's rationalisation plans. A decision need to be made as to who funds the relocation of services

1.3 Sale of the Archway campus

The sale of the Archway campus by UCL/Middlesex University (August 2013) will be used by WH to strengthen their reputation as a provider of world class education. In accordance with the emerging education strategy WH will re-provide key education facilities that are supported by SIFT that will close as part of the sale of the Archway Campus. It is recognised that finding space to accommodate these functions on the Whittington acute campus closes opportunities for expansion of other departments however WH regard the maintenance of world class education as core to its overall positioning. Our planning needs to allow for the following departments to relocate onto the Whittington Acute site:

- Clinical Skills Centre (Department of Medical Education) c400m2. (includes Undergraduate Assessment Centre)
- Library and associated functions c280m2

.

Other services currently located on the Archway Campus, which work with WH; however, as space is limited and these services *could* be located elsewhere it is unlikely that they will be offered accommodation on the acute site. Services include:

UCL Archway Campus - 2nd floor – Holborn Union Building:

Assessment Skills Centre (Primary Care & Population Science) inc:

- Post-grad assessments

UCL Archway Campus - Urology & Urodynamics – (Clinical Physiology) inc:

- Lab space
- Examination rooms
- Offices

1.4 Development of the Whittington Site

Over the short / medium-term it is Capital funding will be focused upon the buildings to the South of the service road bisecting the site. These buildings are generally in poor condition and contain nearly all of our patient services. The maternity buildings (Blocks D and E) in particular require upgrading.

The buildings to the North of the service road accommodate predominantly administrative and support functions. Some of these are in poor condition however over the year 11/12 some limited external repairs have been undertaken to minimise ongoing water penetration and further deterioration of the building envelope. Future expenditure to these buildings North of the service road, (pending space and departmental relocation changes - discussed later in the document) will be restricted.

The short-term investment focus on this site will therefore be investment to buildings South of the service road, in particular maintaining and upgrading Maternity blocks D and E. Detailed development plans are provided later.

1.5 Maternity Buildings / Strategy

Restricting investment to buildings North of the service road will free additional investment for the buildings South of the service road. However, even allowing for this policy, it is difficult within the CRL constraints to undertake more substantive investment and upgrading to the maternity buildings. Any longer term site-development plan should releasing parts of the site for potential sale that allows reductions in the ongoing expenditure required into buildings.

The emerging clinical strategy for maternity caps births at marginally above current levels at 4000 per annum. The existing facilities are adequate at this level of activity however the poor quality environment and disrepair of the building stock requires ongoing investment. At this capped birth level additional facilities are not envisaged. However the existing facilities will need functionality, environmental and backlog investment.

It will not be possible to undertake the required works over a single year, however consistent ongoing investment form within the CRL will over time bring about the required improvement.

1.6 Clinical Service Strategy Initiatives

There are several emerging clinical service initiatives that will need to be taken account of in the estate plan.

1.6.1 Unipart recommendations – this project will change the way patients are managed through the administrative pathways of Whittington Health. Space and manpower reductions will be achieved together with an improved service to patients. There will be a central patient reception and waiting area, together with a centralised point for standard health checks. The remaining clinic reception functions based within individual clinics in Whittington Hospital (+/- 12) will also be centralised. The space allocated to these functions will be used to base staff relocated from Jenner and elsewhere on a rotating basis. There will be a number of staff relocations, including medical secretaries, appointments and admissions staff (access centre), and clinic notes preparation staff. Estate implications are – formation of central reception desk in the main entrance, formation of central health check area, relocation of circa 20 persons from Jenner into vacated clinical areas, and the reallocation of office space for medical secretaries, access centre and clinic notes preparation staff. This project will be implemented in phases running over several years.

1.6.2 Increased provision of Ambulatory Emergency Care – WH has agreed a general strategy to reduce the ward bed base. As an ICO we are committed to delivering care closer to home. To further this strategy there is a proposal to develop an enlarged Ambulatory Emergency Care facility.

This facility allows patients being treated at home to attend the Hospital for urgent treatment on a walk-in basis. This facility acts as a check on patents who might normally be admitted to a ward. The existing service has proved to be successful and is currently at near-to-full capacity. Growth trends show increasing demand – March 2012 – 163 patient episodes and June 2012 – 320 patient episodes. Key elements of this system are:

- Consultant led service.
- Timely access to advanced diagnostics.
- Aim to reduce unnecessary inpatient admissions.

- Co-located with the urgent care centre and links to a community virtual ward.

The preferred area for this additional service is the currently vacant space in K Wing, level 2, which adjoins the existing emergency department. The ease of access to diagnostics services and the infrastructure support of ED makes this the ideal area. The exact area required is not as yet known however it is unlikely to be over 600m^2.

1.6.3 Outpatient departments level 2 K wing - Studies are on-going to forecast the likely demand for Outpatient facilities. A combination of demand, system changes and efficiency factors are likely to lead to a diminution of space requirements in this area. The strategy of "care closer to home" will lead to WH caring for more patients in their homes rather than relying upon them visiting the acute site. The quantum of space that is likely to be released has not as yet been fully determined however it is likely that space will become available in the short / medium term and the estate plan should take account of this.

1.6.4 In-Patient Bed Reductions - clinical in-patient bed planning is ongoing but as part of a plan of efficiency and cost improvements it has agreed to implement a planned programme of bed in-patient bed reductions. Beds in various areas will be closed; the remaining beds will be consolidated into "whole" wards. Following the process of reduction, relocation and consolidation the following wards are ***likely*** to become vacant and available for alternative use:

Murray Ward – now vacant –	short term use an training suite available for alternative use end 2014		area **405m^2**
Betty Mansell Ward -	currently in use as ward likely to become available 2013- 2014		area **271m^2**
Cloudsley and Meyrick -	currently in use as ward likely to become available 2013- 2014	allow	area **1200m^2**

The Estates plan will make allowance for the re-use of these areas.

1.6.5 Medical Records Management Handling and Storage – WH has agreed to review general medical records management. This entails reviewing current arrangements that consist of dispersed storage in many (occasionally inappropriate) locations and over time implement a paperless electronic medical records (EPR) system. Estates related work is likely to be identifying an onsite area for collation, culling and scanning and then identifying an off-site storage and retrieval centre for those files that will not be converted to an electronic medium. This project will be completed during 2016. The recently vacated boiler house has been identified for this purpose. General works to the envelope will take place to make the building secure and compliant together with a limited internal fit out. The area will be used as central facility for sorting, culling and scanning files prior to relocating into the central records store in the basement of K Wing or relocation off site.

When the Medical records project is complete the boiler house will be returned for alternative development (part of the long term strategy) and the current medical records store in the basement in K wing will be reduced from circa 580m^2 to circa 300m^2 freeing a total area of space of circa **280m^2**.

1.6.6 Patent (PAS) and Electronic Medical Records (EPR) - these IT led initiatives also impact upon the physical estate. Ultimately the total quantum of space given over to these functions will diminish due to electronic record storage and improved manpower efficiencies. In the short term however there is a significant need to provide additional IT training facilities. The initial lead in training period will be the peak space demand and this will run for a period of approximately one year. There will then be a further ongoing period of lower level training and "programme roll out" demand where the space requirements diminish somewhat and tail down over a period of a further 18 months to two years.

The areas required for training, project roll out teams and administrative staff are likely to be quite significant in the short term. An allowance in the project plan has been made for:

- One floor of HGW to be uses for training and the project team
- One ward space (Murray Ward – currently vacant) to be used as larger training spaces. This location is ideal as it is closest to the main clinical activities.

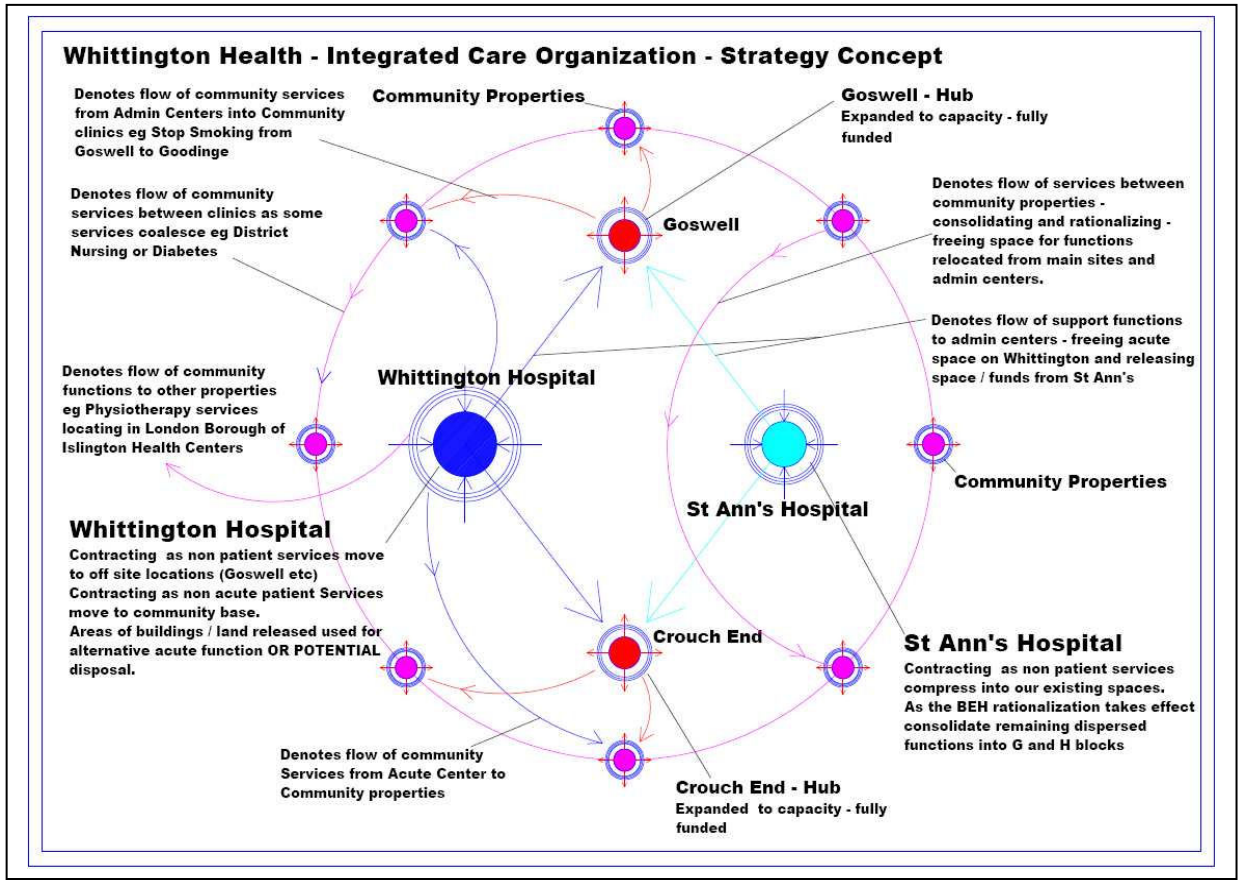
1.7 Space, location and management initiatives

This is regarded as a key area of short / medium-term focus if the advantages of an Integrated Care Organisation are to be fully realised. This includes a series of related threads:

- A general presumption in favour of moving non-acute services from acute centres into the local community
- Moving administrative functions from the St Ann's site into existing Community properties to achieve a reduction in occupation costs at St Ann's
- Building partnerships with other key agencies such as Local Authorities and, where possible, sharing capital assets
- Maximising the use of space in office based functions by applying SMART working principles - target space saving 20%
- Reducing the use of paper – target reduction 90% over 5 years
- Maximising organisational effectiveness by implementing flexible, peripatetic working methods with supporting technological, cultural and environmental changes

The effect of these movements are expressed diagrammatically **see figure 2.1**

Figure 2.1: Strategy Concept Diagram - Flow of Departments and Services Between Estate Properties



2. Whole Estate Policies

2.1 Allocation of Space – an Indicative Cascade of Location Priorities

The effective use of space and the necessary managerial, behavioural and technological changes is one of the key priorities of the Estate strategy.

Estates Policy Statement 1:
1) The location of departments / services shall be based upon a "cascade of location determination". Individual preferences or personal circumstances shall generally not be material factors when deciding locations of departments.

1a) Communication barriers will not block locating departments off-site, as IT strategies will mitigate this problem.

1b) Business efficiency and clinical factors are priority factors in determining location.

1c) Managerial and administrative functions cannot presume a base in the main Whittington site. WH shall have regard to a reasonable balance between basing these functions throughout its estate and ensuring that financial and organisational conditions are met.

A basic set of space location categorisations will be used to help WH consistently decide where a particular function / department is to be located. This could be viewed as a cascade of location determination.

Figure 2.2: Departmental Location Criteria

	Functions/Departments	Description	Examples
Type 1	Location non-specific	Those functions or departments that could reasonably undertake their work from any location	Help desk, some finance and payroll services, consultancy projects
Type 2	Whittington Health Area non-specific	Those functions or departments that need to be based within the WH boundaries but can be flexible within those boundaries	Some administrative departments, whole area community functions
Type 3	Whittington Health Area-specific	Those functions or departments that need, due to administrative or clinical need, to be located at particular points within the community	Some administrative departments and community based clinical departments
Type 4	Whittington Health Acute adjacent-specific	Those functions or departments that need, due to administrative or clinical need, to be located adjacent to the acute site –including Highgate and Jenner	Chief Executive Offices
Type 5	Whittington Health Acute critical-specific	Those functions or departments that must be located within the acute site.	Acute patient-facing functions

In general, WH shall be "blind" to matters such as personal convenience and seniority. Ease of communication will not (except in exceptional circumstances) be a determining factor. Technology and Smart working mean that this consideration over time will lose strength.

2.2 Determining the Basis of Allocating Space Between Acute and Community Sites

Estates Policy Statement 2:

2a) Space on the main acute site is unique and therefore of high worth. First priority shall always be given to service-critical functions that cannot be located elsewhere.

2b) Functions that are not frontline, acute service-related will, where possible, be relocated off the main acute site into Community properties, partnering organisations or elsewhere

2c) Clinical services operating from community leasehold premises will, where possible be aligned with services provided from community freehold premises and leases either surrendered or not renewed

Whittington Health is no longer centred on a single acute site. Similarly, the community services previously operated by PCTs are no longer a stand-alone, community-based service. The new organisation - Whittington Health - is an Integrated Care Organisation and to be fully effective it needs to exploit the synergies between the acute and community aspects of its work.

2.3 Changing the way we work

Estates Policy Statement 3:

Whittington Health will

3a) Introduce SMART Working – It will aim to reduce space occupied by administrative and support functions by 20% over a five year period.

3b) introduce paperless (lite) working – we aim to reduce total paper consumed by the Trust by 90% over a three year period

3c) introduce mobile methods of working with supporting technologies.

3d) support IT strategies to improve cross-boundary communication, mobile and paperless working

"***Change the way that we work*** *to build a culture of innovation and continuous improvement, working flexibly and in new ways to achieve efficiency and effectiveness……"* (Goal 5 Page 3 Whittington Health Strategy 2011-2016)

WH will implement modern methods of working consistent with our goals and aspirations. We will introduce SMART working and this will require engagement from all organisational levels to deliver significant changes to:

- Work spaces
- Supporting Technology

- Organisational culture and working practices

Some general principles outlining the potential operation of this initiative are contained at Appendix 2. In estate terms we expect the more effective use of space driven by these changes will enable space to be minimised and used more productively.

There are considerable challenges in "joining" together the differing IT systems used in acute site and two PCT areas. Estates will support IT strategies in order to facilitate improved communication and mobile working.

2.4 The Costs and Management of Space

Estates Policy Statement 4:

4a) All space is held corporately and is not the property of any individual or department. The CEO is ultimately responsible for all space; however, this responsibility is delegated to the Director of Estates who shall develop policies and procedures for the management of space,

4b) Space-charging mechanisms will be investigated to test their efficacy and applicability to Whittington Health. In principle any policy should encourage effective space-management by charging for space in proportion to the quantum consumed. The charging mechanism may include positive incentives allowing the participants to share in any savings made by relinquishing space.

4c) Whittington Health shall work with other public sector bodies and seek to actively co-locate services into other public buildings where benefits (financial or service) can be demonstrated.

Over time, space tends to become the property of the user department. This policy establishes clear lines of responsibility for space ownership and management.

Space is supplied as a free good to the user service. There is little incentive to relinquish space. It is intended to conduct a review of the costs and benefits of implementing a space-charging scheme.

Under a Government sponsored asset optimisation initiative under the leadership of the London Borough of Islington, WH and other public agencies have been working together under an "Asset Optimisation Scheme" to explore opportunities for sharing public sector capital assets – this policy supports this initiative.

2.5 Estate Management Related Policies and Standards

Estates Policy Statement 5:
Our first priority is to provide an estate that:
5a) is safe and compliant with all national legislation and relevant standards – current non-compliances are identified remedied or risk managed.
*5b) is maintained so that over time, overall backlog maintenance is reduced at a rate of 2% p.a.**
*5c) is functionally suitable and fit for purpose.**
5d) is sustainable and meets Government targets for sustainability and reducing emissions

**At the time of transfer of the Community properties the Clinical Services Contract shall only have one year to run. In this case the short-term contractual uncertainty means that significant investment into the community estate shall be limited. In general the community properties shall be maintained to the condition that existed at handover and measured by the six-facet survey undertaken by NIFES in 2011/2012.*

In general, existing standards and policies in force at WH will be extended to apply to the Community Properties. This includes, but is not necessarily limited to:

- Health and Safety Policies and Procedures
- Fire Policies and Procedures
- Policies for Maintenance and Repair (including reporting of defects)
- Sustainability and Energy Conservation

2.6 Management of the Enlarged Estate

Estates Policy Statement 6:
6a) The WH Estates and Facilities team will be responsible for the core strategic management of the enlarged estate
6b) For an initial period of one year (1/4/13 – 31/3/14) existing outsourced estate management arrangements will be extended to manage the additional community properties on a management fee basis.
6c) Using information gathered over the preceding year, full tenders for the maintenance and management of the community estate shall be sought from third party facilities management organisations. The new contract will run from 1/1/14 for a period of three years. The scope of services offered for tender shall be wide in order that full facilities services are obtained, enabling the existing Estates and Facilities management to assume the role of an "intelligent client" and focus its resources on the significant strategic challenges highlighted elsewhere in the estates strategy.

The ICO estate presents very different challenges to those that existed when the estate was focused upon a single acute site. The challenges are both managerial (an increased focus upon estate management matters – leases, licences etc.) and logistical – the WH maintenance organisation is designed to service a high-intensity acute hospital.

Maintenance and Management services for the acute site are delivered via a "mixed economy" including outsourced contractors, PFI organisations and a small direct labour force.

Maintenance and management of the Community properties is currently delivered via a small professional team at NCL through a variety of outsourced contacts and a small direct labour force. It is not clear how these resources will be redistributed when the properties are distributed across various receiving bodies

At the point of transfer the CSC will only have a year to run and it is likely that insufficient knowledge will exist of the transferring properties to enable full commercial tenders. In order to minimize risk and ensure a managed transfer, WH will extend the existing outsources arrangements at WH to cover the community estate on a management fee basis for one year. Over the initial year information shall be gathered to enable a three-year contract to be tendered if WH retain the CSC.

PART 3: Site Specific Development Plans

This section looks at the development of the Estate's two main sections:

The Whittington Hospital site,

- Short term*
- Long term*

The Community Estates – subdivided into,

- Community properties
- The St Ann's site (due to impending potential site rationalisation by BEH)

*For the Whittington Hospital site two time horizons are taken:

1) A short-term time horizon over say, 1-4 years where many of the changes (both managerial and physical) are implemented to ensure the benefits of an ICO are fully realised, whilst at the same time minimising risk to the new organisation.

2) Longer-term plans detailing more significant projects to address key development requirements. These projects will set a long-term direction of travel and provide a framework for short-term decision-making.

PART 3(a): Whittington Hospital Estate

1. Introduction

This section details the main projects or "work strands" that are based upon the policies and strategies developed earlier and also focuses on addressing those "Key site issues" Part 1(a) item 14. The work strands represent a chain of works (projects) that naturally link together.

2. Short-Term Development Plan – Work Strands

This section details the "work strands" over the next 4 years. Only significant project/work strands are detailed here i.e. those that have a significant effect upon the configuration or content of the estate

2.1 Relocation of non-acute functions from the main site.

This work strand relocates departments from the main acute site into community premises by increasing occupancy levels and implementing SMART working. These moves off-site form part of the general strategy of "freeing" space on the main site for essential acute functions, and to accommodate additional functions see figure 3.1.

Figure 3.1: Additional functions to be accommodated under the short term plan

Function	Relocated from	To Location (Short term plan) (area m^2)
Clinical Skills area	UCL Archway Campus (currently 400m^2)	Current UCL area in PFI block Whittington Acute site
IT cluster room – 27 pc's **Seminar rooms** **Offices for 10 persons**	UCL embedded space. Main PFI block Whittington Acute site (displaced by Clinical Skills above)	Highgate Wing Levels 1 and 3 gross area circa 380m^2 per floor Total 720m^2
Library and Associated Functions	UCL Archway Campus (currently 281m^2)	

WORK STRAND 1

Project	Details	Stages	Outcomes	Compliance with Strategy
1) Convert Goswell Road to SMART working and relocate departments from main site **2012/2013 costs circa £120k**	Undertake minor works to level 1 Goswell Road. To convert to accommodate to SMART working. Increase in total occupants from circa 70 to 110	1a) Relocate Pensions department from level 1 HGW 1b) Relocate Payroll department from level 2 Highgate wing 1c) Relocate Procurement department from basement level main acute block (NB should Procurement be successful in bidding for further contracts and staff increases are such that Goswell no longer offers sufficient accommodation alternative rented accommodation will be sourced).	After completion of these moves Goswell Road is fully occupied. Creates space in HGW (1.5 floors) and creates space in the heart of the acute site by relocating procurement.	Increases space efficiency by SMART working Relocate non acute departments from Acute Hospital site
		See Appendix 3 Figure 3.1 for draft plan of "SMART worked" Goswell Road layout		
2) Relocate Muscular Skeletal Physiotherapy MSK from Nurses' Home (H Block) to Finsbury HC **2012/2013 Cost circa 50k**	Undertake minor works to create new Physiotherapy department Finsbury Health Centre level 1.	2a) Relocate MSK services from functionally poor location in basement of Finsbury Health Centre 2b) Relocate MSK services from part of main outpatient Physiotherapy department in the H Block Nurses' Ground floor 2c) Relinquish lease for basement area – overall space saving and rent reduction	MSC services located in the Basement are functionally unsuitable and not DDA compliant. Relocation to the ground floor addresses these defects, increases Physiotherapy capacity in the community and relocates non-acute services from the acute site (H Block Nurses' home). Overall service provision at Finsbury Health Centre will increase from two staff over two days to three staff over 5 days.	Relocate non-acute departments from Acute Hospital site Improve delivery of community services Provide compliant department Increase Physiotherapy services in the community. Reduction in overall rental costs at Finsbury

2.2 Highgate Wing – alterations and occupations

This work strand describes the works necessary to remodel Highgate Wing to implement SMART working, increase overall density of use freeing space to accommodate functions relocated from UCL. Before investment can be made into this building the lease will be renegotiated on agreed terms so that if possible this property will be secured for the long term (beyond the term of the current lease). In this way WH seeks to minimise risk. If lease extension negotiations are unsuccessful alternative office space will be sourced at an early stage.

WORK STRAND 2

Project	Details	Stages	Outcomes	Compliance with Strategy
3) Negotiations with Landlord to agree lease extension **2012/2013 (cost not known)**	The lease is due to expire in March 2017. WH would wish to retain this property long term. Before further investment it is intended to agree terms for a lease extension	3a) Draw up plans for works and receive tenders 3b) Agree terms of new lease extension with Landlords 3c) Agree POTENTIAL occupation terms with tenants (see later)	Agreed terms for extended lease Agreed terms for POTENTIAL occupants relocated from Archway (see later)	Increases space efficiency by SMART Working Provides space for departments relocating From Archway campus Lease certainty for the long term for future planning
4) Works to Highgate Wing to increase occupancy, create SMART working office spaces and create space for education departments decanted from UCL **2012/2013 Minor works 30k** **2014/2015 level 6 £130k** **2012/2013 level 5 £80k to convert to EPR suite.** **2015-2016 level 5 80k to convert to Smart working** **2015/2016 level 4 130k Smart Working** **2012 -2013 Level 2 Minor works to accommodate additional persons 20k** **2014/2015 level 2 to Smart working £110k**	Works to create open plan layout to floors allowing improved space utilisation and to free floors 1 and 3 to accommodate UCL decanted education functions and level 5 to EPR training and Project suite (level 5) this function will convert to offices when this function diminishes	4a) Relocate Estates department from level 5 to C Block Estates area (work in progress) 4b) Minor initial works then convert level 6 to open plan SMART Worked Area allowing planning and performance to relocate from level 1 to level 6 4c) Convert level 5 to EPR project floor as short term use. Longer term Smart worked 4d) Convert level 4 to open plan SMART worked area 4e) Convert level 2 in stages to SMART worked area to accommodate relocated finance staff (accounts Payable from level 3 and 4No finance staff from level 6) 4g) Spare desks over each floor used as “hot desks”	Increase in total occupancy over 2 floors of circa 30 persons Creation of vacant areas on levels 1 and 3 to accommodate educational functions from UCL and PFI building Creation of flexible open plan SMART working paperless offices	Improved space utilisation Support EPR training requirements SMART working Creation of empty floors level 1 and level 3 to accommodate additional functions from Archway Campus (see later)

5) Relocation of functions from Archway Campus (due to sale) onto Whittington Acute Campus **2012 – 2013 Works to convert PFI Building to accommodate Clinical Skills area £300k** **2012/2013** **Works HGW levels 1, 3 £1900k tbc** **Spend Profile** **£300k 2012-2013** **£1900k 2013-2014**	UCL intends to dispose of the Archway Campus by June 2013. WH regards it essential to retain access to education and training facilities. Some functions move directly into the PFI building and displaced functions from the PFI building together with remaining functions from Archway campus move to levels 1 and 3 of HGW	5a) Clinical Skills area relocates from Archway Campus to embedded space (UCL area) in the PFI building on the main Whittington Acute site 5b) Displaced educational functions from 5a) relocate to HGW including IT cluster room, offices and seminar rooms. Library and associated functions move directly from Archway campus to converted level 1 and 3 HGW target completion date August 2013	Additional Functions accommodated NB this location is driven by the August 2013 Archway Closure.	Retention of access to Education and Training facilities. World leading education centre status maintained SIFT grant secured Compliance with Training and Education strategies
		See Appendix 3 Figure 3.2 for draft "SMART Worked" floor plan of Highgate Wing		

2.3 Main site – Jenner - Minor Works and Reorganisations into vacated spaces

This work strand moves further departments out of Jenner into vacated spaces in the main acute buildings. Occupancy in Jenner is then rationalised by introducing SMART working and reorganised to create a Support Services Directorate.

WORK STRAND 3

Project	Details	Stages	Outcomes	Compliance with Strategy
6) Occupation of Vacated Procurement department **2013/2014 Cost £20k**	Open plan office area vacated by Procurement department (moved to Goswell) 200m^2 reoccupied by functions from Jenner e.g. medical secretaries	6a) Minor works only and change desks to agreed SMART work sizes 6c) Reoccupy space	Fully occupied SMART worked space. Reduction in overcrowding in Jenner	Increases space efficiency by SMART working Relocation of staff from Jenner
7) Minor reorganisation of Jenner **2012/2013 costs circa 35k (minor Works)** **2013/2014 Cost circa 50k (move into Procurement offices)**	Remove minor internal studwork walls an ongoing plan of minor works to create Smart works offices. Utilising vacant spaces by relocating to Old Procurement offices. Minor works and re-planning to create Support Services directorate.	7a) General removal and relocations Inc. change furniture to SMART working. 7b) Create Support services department to re-planned g/f	Increased SMART working Improved efficiencies by centralising Support services functions Reduction in overcrowding	SMART Working Improvement in functional suitability Support Potential Unipart recommendations

2.4 Reorganisation of Medical Records and off-site storage

The following estate related works are planned to support the management of medical records; this supports two key WH objectives:

- The implementation of Electronic Document Management (EDM) and Patient Administration System (PAS) strategies led by the IT department
- Rationalizing and reorganisation of the medical records. Strategy currently being reviewed by a separate task force

WORK STRAND 4

Project	Details	Stages	Outcomes	Compliance with Strategy
8) Prepare vacated Old Boiler house to store Medical records **2012/2013 – 100k (Boiler House works)** **2013/2014 - 30k X Block demolition** **Costs for off-site accommodation under investigation** *NB Costs relate to building works only Not works related to records project itself.*	To make old boiler house secure, wind and watertight. Install security cameras and system, small office, racking and shredding facilities.	8a) Undertake works to secure boiler house and provide limited racking 8b) Relocate medical records into old boiler house into stages (over time for sorting, categorisation, disposal, scanning) 8c) Immediately empty X Block medical records store and demolish building 8c) Identify and source external off-site storage for long term holding of medical records 8d) By end 2015 medical records located off-site and any residual on site hard copy records returned to K Wing Basement (space released in K Wing circa 180m2) and old boiler house returned for alternative uses	Old boiler house used in short term for sorting of medical records X Block demolished (reduced backlog 120k) Redundant medical records destroyed Space "freed" on site where previously used for medical records storage Medical records coded categorised and kept in compliance with protocols Safe off-site storage identified and in use by 2015	Building condition improved – X Block removed Space freed on main site for acute functions Furtherance of EDM and EPS (clinical strategy) At end of project space releases – in K Wing – various points in medical records stores and in K wing basement.

2.5 Clinical Initiatives

WORK STRAND 5

Project	Details	Stages	Outcomes	Compliance with Strategy
9) General works to Facilitate Unipart patient flow initiative **Estimates only – allow:** **2012/2013 - 100k** **2013/2014 - 100k** **2014/2015 - 100k** **2015/2016 - 100k** *NB this project is still under investigation details and costs here are Provisional*	Alterations to create main reception area, central health check area, removal of individual clinic waiting and reception areas, and relocation of staff from Jenner, clinics and the access centre.	9a) Alterations to main desk A wing to become central reception desk 9b) Alterations to main entrance lobby to form open plan waiting areas 9c) Alterations to admissions dept and creation of health check area. 9d) Centralisation of individual clinical receptions and waiting functions from +/- 12 clinics. 9e) Minor conversions to accommodate relocation of +/- 20 staff from Jenner, clinics and access centre.	Improved patient service Reduction in space and revenue costs	SMART Working Support Clinical strategy Support Medical records management project Reduction in space – relocation of staff from Jenner
10) Formation of Ambulatory Emergency care department **PROVISIONAL Estimate 2013/2014 – £2.9m**	The provision of additional Ambulatory Emergency care provision in the currently vacated space in the Level 2 K wing area	10a) This project is currently under investigation. If accepted it will be formed adjacent to the ED department on level 2 K wing. The exact functional content and size of the department is being forecast. However the space available within K wing at circa 900m2 is unlikely to be totally used. A space allowance of 600m2 is taken.		Support Clinical strategy Support in patient bed reductions

2.6 Upgrading of Main Buildings (South of Service road)

Over the short / medium-term investment will be focused upon the buildings south of the bisecting service road. This will further the long-term strategic direction detailed later.

Clinical strategy development is ongoing; however, key focus areas are emerging:

- Increased provision of Ambulatory care capacity – and in-patient bed reductions
- Improvement of patient experience and facilities - with a focus upon improving the current Maternity facilities. It is recognised that this significant and leading service does not offer standard of accommodation that should be expected.
- Several large redevelopment schemes have been considered in the past however but these have proved financially unworkable. . Recent more detailed projections of the potential growth in maternity services have been undertaken, however, and current estimates do not currently foresee significant growth in overall services with births remaining at circa 4000 per annum. At this level no significant expansion of facilities is required. Functional changes will be necessary; however investment will therefore be targeted upon reducing backlog and, improving functionality and quality for patients by a series of planned interventions. These interventions will be planned as a series of self contained projects running over several years. Individually these projects are assess at a maximum capital cost of circa £2m. This sequential project approach avoids substantial early investment, which complies with plans to minimise risk in the early years after becoming a Foundation Trust as described by Proposition 6. .

WORK STRAND 6

Project	Details	Stages	Outcomes	Compliance with Strategy
11) Upgrading to Buildings South of service Road. **year 13/14 £2.0m (provisional)** **year 14/15 £2.0m** **year 15/16 £2.0m** **year 16/17 £2.0m**	Forms part of a long-term plan to focus investment into the buildings South of the service road. Main focus is upon maternity facilities	11b) Form additional new lifts to access into existing maternity areas. 2013/2014 £2.0m 11c) On-going investments circa £2.0m per financial year	Access and way finding improved. Additional lifts 2 No will improve access and way finding and permit the existing lifts to be closed down for upgrading.	Backlog maintenance and functional suitability improved. On-going investment into Acute buildings to improve quality of environment for patient care.

2.7 Training and Meeting Spaces

Training and meeting rooms are mainly located in the WEC. There are also some meeting rooms dispersed around the site. Rooms in the WEC are at full capacity. Training rooms embedded within departments tend to become "owned by that department" and could be more effectively used. Over time individual offices will be reduced under the SMART working initiative and therefore the ability to hold small meetings is diminished. This combined with intensive training requirements as part of the IT RIO, Patient Administration Systems (PAS) and Electronic Document Management (EDM) projects mean that additional training and meeting rooms are required. Part of this demand is met in the short term by creating a Project and training base in HGW (see work strand 2 item 4c) however envisaged demand is such that further short term teaching and training facilities are required for the roll out of the PAS system this is likely to create a short term demand "spike" requiring easily accessible facilities for clinical, nursing and administrative staff. This requirement is addressed in work strand 7.

WORK STRAND 7

Project	Details	Stages	Outcomes
12) Convert vacant Murray ward to short term training base for PAS system **To be funded 12/13 allocation 200k**	Works to be minimised due to short term use. Conversion is straightforward. Location of ward to staff to be training is a significant advantage Any spare capacity will be used to add to the existing meeting and training room stock.	13a) Undertake works (area currently vacant)	Increased provision of meeting and training rooms to meet projected demand Existing underused space is converted in a manner to allow easy conversion to open plan offices under long-term development plan (discussed later)

WORK STRAND 8

Project	Details	Stages	Outcomes
13) Convert Old Furniture store to Smart worked area **2014/15 allocation 200k**	Upgrading with installation of kitchen and WC facilities into a flexible open plan smart worked area. This will pull staff from the overcrowded cellular Jenner Building the total area is circa 235m2.	13a) Clear existing function (Old furniture store, PC store and workshop) 13b) Undertake works in open plan style	Increased provision Smart Worked office spaced Improved utilisation of underused space located in the centre of the acute site. Existing underused space is converted in a manner to allow easy conversion to other uses if required offices under long-term development plan (discussed later)

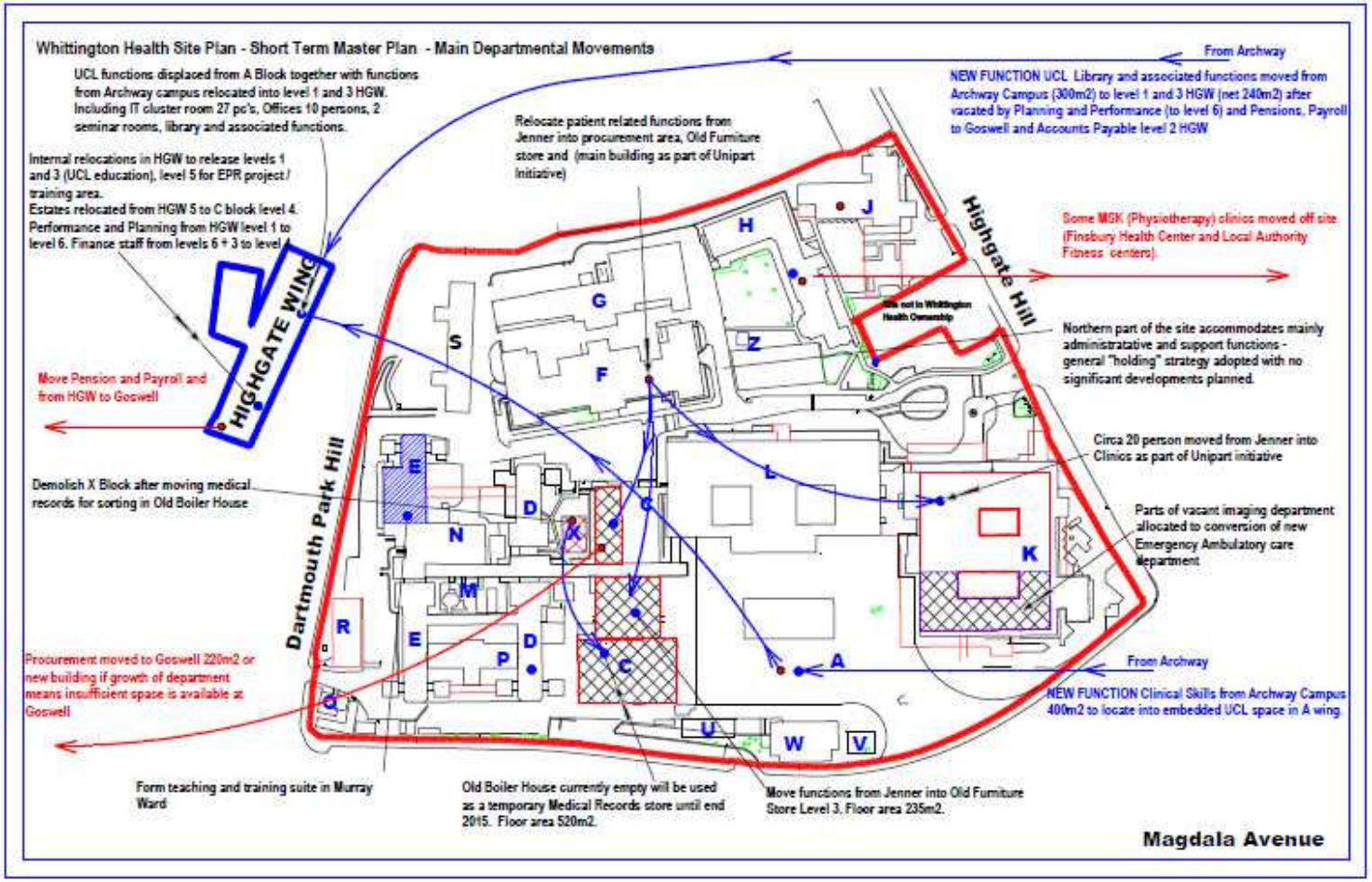
WORK STRAND 9

Project	Details	Stages	Outcomes
14) General Sum to facilitate estate related organisational changes, such as SMART working, paperless environment and rollout of multifunction devices. **2012/2013 – Taken elsewhere** **2013/2014 – Taken elsewhere** **2014/2015 – 200k** **2015/2016 – 200k**	These works are designed to improve organisational efficiency and space utilisation.	Allow a general sum for rollout after initial works in Highgate and Jenner are completed.	Improved space utilisation. Reduction in space consumed by administrative functions circa 25%. Improved efficiency. Reduction in paper consumed from 2012/2013 baseline 50% over 2 years and 90% over 3 years.

3. Site Development Plans

These "work strands" and relocations are shown in the short-term site development plan below.

Figure 3.2: Whittington Hospital site - Short Term Site Development Plan



3.1 Main projects

The development plan is focused upon delivering several short-term key projects that are driven by external forces, whilst also progressing organisational and efficiency projects. In particular:

- Relocating Archway functions into the Acute site
- The new functions are accommodated by relocating functions to the Community Estate i.e. moving Pensions, Payroll and Procurement to Goswell, MSK to Finsbury Health Centre

- Underused space on the main campus and HGW is productively used to accommodate:
    - Clinical strategies are furthered by relocating staff from Jenner into clinics within the main Acute Hospital (Unipart).
    - Medical records are collated into the Old Boiler House for sorting and categorization, allowing functionally unsuitable X-Block to be demolished.
    - A teaching and learning suite is formed in the Murray Ward to progress the Patient Administration System.
    - An EPR project suite and training facility is formed in level 5 HGW to progress the EPR project
    - An Emergency Care department is formed in unused space in K wing level 2
- Administrative functions are generally flowing from Jenner to vacated area in HGW and the main acute site, and as part of the Unipart Initiative. This allows reorganisation of departments in Jenner to reduce overcrowding and improve functionality.
- Projects described above progress the space and SMART working initiatives allowing increased density of use, better communication and flexible working.
- Although not shown directly on the plan, general upgrading and maintenance expenditure is focused to the buildings south of the service road, i.e. those buildings accommodating patient activities.

4. Short Term Investment Programme

The projects shown above are drawn together into the following investment programme.

Figure 3.3: High Level Investment programme – short term plan

Work Strand	Project	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	Comments
Work Strand 1	1) Convert Goswell Road to SMART working and relocate departments from main site	120,000	0	0	0	0	
	2) Relocate Muscular Skeletal Physiotherapy MSK from Nurses' Home (H Block) to Finsbury HC	50,000	0	0	0	0	
Work Strand 2	3) Negotiations with Landlord to agree lease extension	0	0	0	0		Costs not known (revenue).
	4) Works to Highgate Wing to increase occupancy and improve functionality					-	

	and create SMART working office spaces						
	Minor Works level 6 Open plan level 6 EPR suite level 5 Open Plan level 5 Open Plan level 4 Minor works Level 2 Open Plan Level 2	30 0 80,000 0 0 30,000 0	0 0 0 0 0 0 0	0 130,000 0 0 0 0 110,000	0 0 80,000 0 130,000 0 0		
	5) Relocation of UCL functions from Archway Campus (due to sale) onto Whittington Acute Campus	300,000	1,900,000	0	0	0	
Work Strand 3	6) Occupation of vacated Procurement department	0	20,000	0	0	0	
	7) Minor reorganisation of Jenner	35,000	0	50,000	0	0	
Work Strand 4	8) Prepare vacated Old Boiler house to store Medical records	100,000	30,000	0	0	0	Costs for off site accommodation are under investigation.
Work Strand 5	9) General works to Facilitate Unipart patient flow initiative	100,000	100,000	100,000	100,000	100,000	
Work Strand 5	10) Ambulatory Emergency care Provision	£2.9m Cost Allowance £2.9m Spend profile PROVISIONAL 2013/2014 NB may be funded form additional Capital Allocation 2012/2013					
Work Strand 6	11) Upgrading to Buildings South of service Road	0	2,000,000 (provisional)	2,000,000	2,000,000	2,000,000	
Work Strand 7	12) Convert Murray ward to Short term training facility	200,000	0	0	0	0	
Work Strand 8	13) Convert Old Furniture store to Smart worked Office Accommodation	0	0	200,000	0	0	

	(relocate from Jenner)					
Work Strand 9	14) General sum to facilitate estate related organisational changes, such as SMART working, paperless environment and rollout of multifunction devices	Taken elsewhere	Taken elsewhere	200,000	200,000	200,000

5. The Whittington Hospital Acute Site - Long Term Development Plan

This section looks beyond the immediate period after Whittington Health becomes a Foundation Trust. These plans can be of a more "transformational" nature and include more strategic projects that would need to be carefully reviewed nearer the time but are included here to give a long term vision for the site which in turn guide short term planning decisions.

It is envisaged that this stage of work will not commence until 3 or 4 years after the formation of the Foundation Trust, however, this will be kept under review and will be implemented as circumstances dictate.

Some transformational projects have thus far been "blocked" as insufficient funding has been identified. Our Estate objective would be to support these projects by:

1) Creating funding to contribute towards the capital costs of developments and upgrading of existing sub-standard facilities
2) Reducing operational costs – by reducing the overall occupied area, or,
3) Creating surplus space on site which could be used to accommodate additional clinical activities to generate additional on-going revenue streams.

Achieving these objectives will require balancing the various calls upon space and identifying any further functions on the acute site that:

- Could be discontinued,

- Could be moved off site,
- Could be reduced in size.

This section is based upon the assumption that the short term plan has been completed and in particular the departments relocated from the closed Archway campus have been successfully accommodated.

5.1 Potential Site Areas for Disposal or Alternative Use

Several high level studies have been undertaken. The area to the North of the main bisecting service road is the area easiest to release for disposal or to vacate to create space for other revenue generating departments, because:

- There is no in-patient activity (out-patient Physiotherapy – is the only patient facing function currently located North of the service road).
- Other functions could be most easily relocated or discontinued
- The buildings on this portion of the site are (save for WEC - G Block) in poor condition, functionally poor and/or not directly supporting WH's goals as below;
  - The cellular nature of the Jenner offices is unsuitable for modern working methods
  - The institutional nature of the Nurses Home (H Block) is not appropriate for modern residential provision
  - The Doctors Building – (s Block) – contains predominately private lettings within a pre-cast concrete building
- The site area has been zoned by the London Borough of Islington as a site for Potential Future Developments as part of their current consultation on "Site Allocations Development plan"
- The site is likely to be included in the Mayor's "Sitematch" initiative that aims to provide information to developers and link them to key site opportunities.
- The Waterlow Building (J Block) is currently vacant and could be targeted for early sale. This is not planned as the valuations below are based upon achieving "marriage values": Waterlow with its street frontage effectively unlocks the remainder of the site. Selling Waterlow in isolation will "land lock" the rest of the site devaluing its potential sale value. Our strategy is therefore (at least for the medium term) to retain Waterlow to allow time to examine and plan a more significant site disposal (or reuse) plan.

Site valuations should only be used as a guide. Site planning and valuation advice was originally obtained from Montagu Evans 24th September 2007 and updated June 2012. Appendix 3 Figure 3.3 – plots these valuations onto a site plan.

Figure 3.4: Outline site valuations

Block	Occupants	Site Value	Comments
J Block (Waterlow)	Empty	£4.8m	If sold in isolation will devalue remaining parts of the site
H Block	Nurses residential accommodation, On Call rooms, Social workers offices, Physiotherapy	£4.4m	Value based upon sale with J Block
G/F Blocks	G – Education and training F - Office accommodation	£4.5m	Values dependent upon selling with rest of site – key issue affecting value will be the listed building status of F Block and the extent of alterations permitted by the Local Authority
S Block	General accommodation	£3.3m	Values dependent upon selling with rest of the site. Access unlikely onto Dartmouth Park Road.

This gives a total *POTENTIAL* disposal value of **£17m**

5.2 Town Planning Environment

- Development options are dependent upon the Town Planning environment. The Local Authority is currently undertaking a planning consultation round. WH has submitted representations intended to create a flexible planning background for the main acute site. This is important in two main ways: a flexible site planning regime will assist WH to undertake its own on site redevelopments (WH may seek to reoccupy and remodel vacated buildings)
- A beneficial site-planning regime will maximise development potential and sale values.

London Borough of Islington has included the Whittington Hospital acute site in its list of "Potential Future Developments" as part of their current consultation on "Site Allocations Development Plan". The site is also likely to be included in the Mayor's "Sitematch" initiative that aims to provide information to developers and link them to key site opportunities.

The constraints placed upon Jenner Wing will greatly affect the potential site values. This listed building is in the middle of the area of the site that could potentially be for sale. Its close location to the main hospital buildings and layout may not make it suitable for residential development. Similarly its small cellular layout may not make it suitable for modern office use. Although listed, alterations behind the main facade would increase alternative use values. If some scope for alterations could be negotiated with the Planners this could increase the potential sale value of the sites. This will form a major element in any sale strategy.

The overall planning environment will impact development options, potential uses and sale values. Work to date has been in outline only and this area will be subject to further investigation and testing as part of the development of any business case. Appendix 3 Figure 3.3 shows the planning restrictions and potential sale area on a site plan.

5.3 Existing Departmental Space Reductions (floor space required)

Figure 3.5 shows functions on the Northern part of the site that could be discontinued, moved off site or reduced. This is a challenging target and will bring into play space location strategies together with SMART working initiatives described earlier.

Figure 3.5: Base data – Schedule of Areas and Potential floor area reductions - Functions located on Northern Strip

Building / Bock	**Current use**	**Current Area (m^2)**	**Area used for Planning m^2 purposes**	**Assumptions - Area Reductions**	**Proposed new location**
Jenner F Block	Predominately Office use	3140	1800	Original area less 25% but **see Appendix 3 Figure 3.4** for details of reductions under short term plan	Essential site based services relocated main site (or building near main site)
WEC - G Block	Teaching and Learning	1171	1040	Original area less 15% due to layout efficiencies in new location	Essential Site based services to serve Clinical and Nursing staff
Doctors Accommodation - S Block	Residential accommodation	1011	Nil	**Assume function Not re provided**	Currently not supporting core Hospital objectives
Nurses Home H Block	**Mixed use comprising**				
	Nurses rms floor 4	606	Nil	**Assume function not re- provided**	There is residential accommodation at Sussex Way
	Nurses rms floor 3	626	Nil	**Assume function not re- provided**	
	Nurses rms 50% floor 2	313	Nil	**Assume function not re- provided**	
	On Call rms 50% floor 2	313	300	Function required	To be provided on site
	Social workers 50% floor 1	313	235	Anecdotally limited use made of this area for direct acute care related functions. No charges currently being made. Move off site if	Provided within office accommodation

				possible but assume 25% space reductions if retained on site	
	Physiotherapy 0ffices 50% level 1	313	200	Assume 30% reduction in overall space required. Some parts of Physiotherapy will move to the community as part of a wider reorganisation	Provided on site location tba
	Physiotherapy 100% g/f	569	300	Assume efficiency space reduction and some parts move to community (Finsbury Park HC)	Not allowed at present but the outpatient service *COULD* be located to an offsite location
Total		**8375**	**3875**		

From an existing occupied floor area of circa 8,375m^2 a residual floor area of circa 3,875m^2 will form our planning assumption.

5.4 Further Space Available (Planned to be released as part of ongoing strategies)

As part of the Clinical strategy of reducing in-patient bed numbers further space will become vacant as follows.

Figure 3.6: Schedule of released spaces areas as part of ongoing strategies

As part of a Strategy of bed reductions		**m^2**
	Murray ward - short term use a training suite finishes available for reuse from end 2014	405
	Betty Mansell ward (released as part of bed reduction strategy)	271
	Cloudsley and Meyrick wards (released as part of bed reduction strategy)	1200
As part of the Medical records project		
	Part of K wing basement area (not before 2015/16)	180

Space released in HGW as part of the Smart Working Project		
	Level 5 upon completion of EPR project 2016 (available for SMART working conversion)	380
Other spaces *Potentially* available as part of redesign of level 2 K Wing (see below)		
	Surplus area from formation of Ambulatory care 900m^2 available 600m^2 planning area *(see note below)*	300
	"Freed" area as part of diminution of Outpatients Department (area not determined however assume 100m^2 *(see note below)*	100
	Total Space available or created	**2836**

It can be seen from the above that one of the key projects is the development of K Wing level 2 floor. There is currently circa 900m^2 of unused space in this area it is planned under the short term strategy to locate a new Ambulatory care department into this area. The current space allowance for this department is estimated at 600m^2. In addition it is forecast that there will be a planned reduction in activity within the Outpatients department – for planning purposes it is assumed that this will free up a further 100m^2 of space within this area.

By reviewing these projects as a cohesive whole and combining the planning for Ambulatory Care department with the diminished size of the outpatients department it should be possible re-plan the floor and block the space savings together and create a 400m^2 (300m^2 plus 100m^2) block of usable space. It can be seen from **table 3.5** that the only clinical activity that requires to be relocated from the North of the site is Physiotherapy at a area of circa 300m^2. This could be an ideal target location for this function with the supporting infrastructure in place.

5.5 Forecast Space Requires Verses Available

Total floor area required (see **Figure 3.5**) 3875m^2

Total spaces available / created (see **Figure 3.6**) 2836m^2

Therefore shortfall (additional floor space required) **1039m^2**

Any long term development plan will need to identify a further **1039m^2** of floor space. This is an optimistic scenario as inevitably additional spaces will be required that are not currently foreseen.

5.6 Potential Long Term Development Option – (Sale and Compression)

The plan is the most optimistic and seeks to release the maximum land and buildings for sale of reuse. It relies upon optimistic scenarios for space planning – due allowance must be made for further space requirements.

The plan seeks to relocate all functions from the Northern strip allowing sale (or for use as additional clinical activities). Key features:

1) ***A new building on the redundant Old boiler House Site***. It is envisaged that the new building footprint would be the same as the Boiler House (circa 520m^2). It would replace this old building once the temporary use as a medical records store had finished. It is envisaged that the new development would be over four floors and due to lower ceiling heights it will be lower than the surrounding buildings.

   There is an opportunity to make a significant statement building – it is in a prominent position on the "front" of the Whittington acute site. The old boiler chimney – which is regarded as a local landmark could be retained and enveloped on the lower floors in a new modernistic building picking up references from the adjoining PFI building.

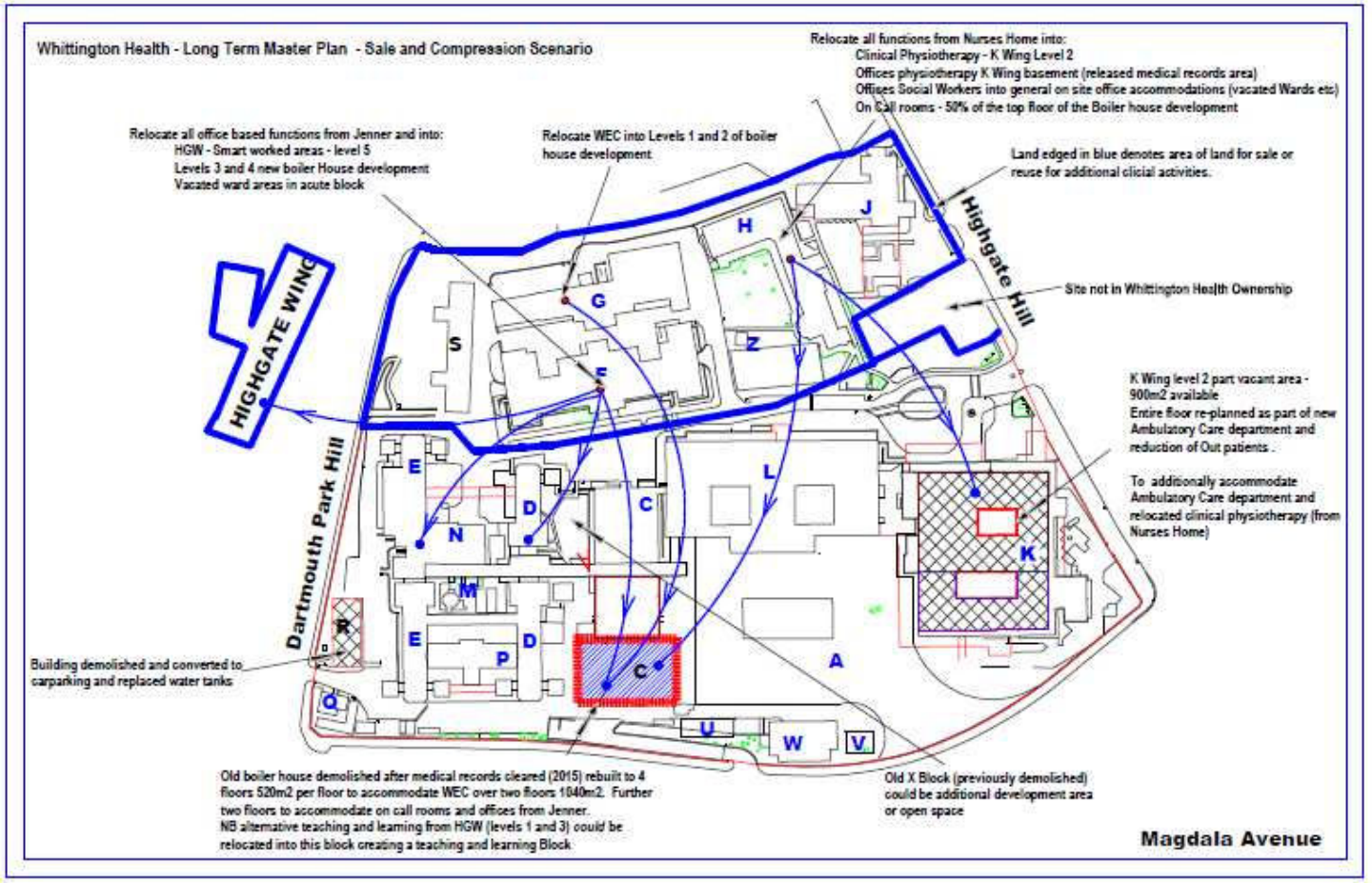
   It will be used on the lowest two floor to directly relocate the Teaching and learning functions from WEC – (block G) with the upper floors providing large open plan office spaces with a allocation of On call rooms on part of the top (4th floor).

   A total floor area of 2080m2 will be developed.

2) ***All relocated Clinical functions located into K Wing 2nd Floor***. The opportunity created by the ambulatory care centre and the forecast reduction is Out patients means that with careful planning it will be possible to locate the Physiotherapy department form the Nurses home into this floor. This is easily accessible area for patients, contains supporting infrastructure and is an ideal location for this function.

3) ***Relocated Offices viewed as a single entity.*** Existing offices are allocated along lines of specialism. Social workers, physiotherapy (both in H block – nurses home), clinicians, medical secretary's and managerial, administrative and secretarial staff(in F Block – Jenner) are all in separate office areas. These will be relocated into new and existing areas in the main acute site general in Smart worked open plan areas. This will improve space usage, communication and remove some traditional demarcation lines.

Figure 3.7: Example Site Development Option – Long Term Master Development Plan – Sale and Compression



Redevelop floor area calculation

Total floor area required (see **Figure 3.5**)	3875m^2	
Total spaces available / created (see **Figure 3.6**)		2836m^2
Area of New Boiler House Development		2080m^2
Total area available /created as part of long term plan		**4916m^2**
Additional space provided under this option circa		**1040m^2**

At this planning stage that space estimates are subject to change therefore although this overprovision appears substantial this area should at this early stage us reserved as a contingency as it is likely that further space bids will be identified. In any event the move to Smart working will require additional seminar / meeting rooms that have not been allowed for at this stage this are Provisionally allowed below as part of the outline space allocation plan.

Figure 3.8: Planned Floor Areas – Stack allocation

Building/Block	Total Floor Area available (m2)	Proposed Use	Relocated from
New Boiler House Development- level 1	**520**	Teaching and Learning	WEC levels 1 and 2
New Boiler House Development- level 2	**520**	Teaching and Learning	
New Boiler House Development- level 3	**520**	Offices	Jenner
New Boiler House Development- level 4	**520**	On call rooms seminar / meeting rooms	Nurses Home Various
Wards - Murray, Betty Mansell Cloudsley and Meyrick	**1876**	Offices Offices	Jenner, Social workers G/F nurses home
Level 2 K Wing	**300**	Clinical Physiotherapy	Nurses Home Ground floor
Level 1 K Wing	**180**	Offices Physiotherapy	Nurses Home First floor
Highgate wing level 5	**380**	Offices	Jenner
indicative totals	**4816***		

*NB excludes small areas created as part of Ambulatory care

This option has the following features:

- Releases the majority of the Northern part of the site for sale (or reoccupation by additional clinical activities)
- Releases Capital, reduces operating costs and backlog maintenance
- Maximises the use of vacant or underused space in the main hospital
- Relocates and reorganises administrative functions into SMART worked functionally suitable areas

5.7 Financial Outcomes

Appendix 3 figures 3.5 – 3.6 gives the financial model for the "sale and compress" option, summarised as follows:

Figure 3.9: High Level financial outcomes – Sale and Compression scenario

Variation Pre and Post Sale of Northern Strip	Cost pre development	Cost post Development	Variance
Operating Costs inc capital charges	1643	1033	-610
Net Capital Receipts	0	7413	7413
Backlog maintenance	2450	0	-2450

All figures should at this stage be treated with great care however initial forecasts indicate that should the "sale and compress" followed there is likely to be:

- Residual Capital receipt upon completion of the programme of works: £7,000k
- Reduction in operating costs: £600k
- Reduction in backlog maintenance (from disposal of buildings only): £2,000k

All figures are estimates and will need to be investigated further as part of any business case. In particular the valuations for capital disposals are very sensitive to planning and market conditions. Any easement of the envisaged planning restrictions will directly affect the values realised for the site.

5.8 Other Significant Potential Options

5.8.1 A Combined Teaching and Learning Block

The Teaching and Learning functions that were relocated from UCL's Archway campus into HGW levels 1 and 3 as part of the short term plan naturally fit with the teaching and learning functions transferred from WEC (block G) into the proposed Boiler House development under the long term plan. It may be consider a desirable option to move all Teaching and Learning from HGW to the new boiler house development forming one combined Teaching and Learning Hub. The displaced functions could move into HGW – centralising offices into this building. The option would incur greater costs and is not therefore examined further here.

5.8.2 A "Developers" Option

Any redevelopment of the northern strip will need to comply with the overall planning environment. The development could be "mixed use" or residential. In any event the developer will need comply with planning policies. WH could consider working with the developer to locate some of its own requirements onto the developed land. This could help the developer meet some of his "social" obligations that may be imposed upon him by the Local Authority. In particular asking the developer to include On Call rooms could benefit WH (high quality on call rooms provided – releasing space on the acute site) and the developer as it may help meet his own obligations. Various other options exist and these would need to be fully examined.

5.9 Risks

A detailed risk assessment is not included here as the circumstances, when these development *may* be considered, could be very different to those presumed today. High level key risks that will remain pertinent include:

- Insufficient appetite to close, compress or relocate some of the departments listed
- Failure to adopt SMART working and consequently not achieve some of the forecast space gains
- Failure to achieve beneficial planning consents, including overall zoning aspects of the site for disposal
- Highgate is retained leaving Whittington Health at the mercy of a private Landlord. Failure to agree a new lease at the expiration of the current term 28th March 2017 or failure to agree financial terms could be a major issue for Whittington Health.

6 The Community Estate Development Plan

6.1 Introduction

The strategy envisages accommodating services relocated away from the Whittington Hospital site and the St Ann's site, using space within the community based estate buildings.

After the transfer of the properties on 1 April 2013 WH will be able to easily move services between the buildings over which it has control (freehold or head lease), subject to agreement with the commissioners about the location of services. Moving services to the other properties over which Whittington Health has only a lease interest may be more problematic as it will require reference to the change mechanism within the Business Transfer Agreement that governs the operation of the ICO.

The state and condition of the properties is good and is not judged to require any significant capital spend within the next 5 years other than that required to re-site the services as they migrate away from the acute unit. Additionally the short-term nature of the clinical service contract does not provide an incentive for capital to be spent on buildings that could simply be transferred to the Secretary of State at a later point. Similarly tenure restrictions and limited timescale also mean that it is unlikely that any properties could be vacated for sale within the initial 5-year time horizon.

6.2 Future of the Community Estate

The principal strategy is for the community estate to be integrated with the acute estate in pursuit of the ICO's operational strategy. In general, appropriate services will flow from the Whittington Hospital and St Ann's to community properties. Effective space utilisation and SMART methods of working will enable occupancy rates to be increased.

6.3 Development Projects

We have no significant plans to develop any of the community properties beyond making the premises fit for purpose or making better use of the existing space (however see Simmonds House – see later).

We have no material plans to sell or acquire further community properties.

We intend to release the leasehold interest in one property (19 Highbury new Park) **Provided** that a new leas can be agreed on 133 St Johns Way. See later.

We will maintain properties to the general condition at date of transfer; however, we will focus funding upon addressing any outstanding health and safety issues identified by the 6 – facet survey not addressed at the point of handover.

In pursuance of our strategies of moving Clinical services into the Community, removing non acute services from Whittington Hospital and St Ann's and maximising space utilisation, the following projects are planned:

- Conversions to Goswell Road to increase occupancy to accommodate departments from Whittington Acute site and St Ann's
- Undertake a LEAN review/consultation of patient journey within Health centres
- Align reception areas across community based sites and acute to represent the 'Whittington Health' values and standards
- Space management and Smart working initiatives across all sites to improve space utilization
- Consolidation of community departments where operating efficiencies or demonstrable service gains can be achieved e.g. community hubs for Specialist Nursing and reorganisation of District Nursing teams
- Conversions to Finsbury Health Centre to allow Physiotherapy functions to relocate from Whittington Hospital site
- Closure of Ridge House (dental unit) due to significant Health and Safety Issues. Now agreed relocations underway to new compliant premises. (Forest Road Health Centre).
- Roll out of the Managed Print project to community sites
- Integrate systems and infrastructure within community-based properties to align with acute sites and general best practice.

6.4 Service Reconfiguration Projects – Simmonds House

WH is considering increasing the provision of in-patient bed provision at Simmonds House from 12 to 13 beds. Initial studies have revealed that there is significant demand for additional in-patient beds at Simmonds and the project could be self funded over 2 years. It is proposed that an existing day bed room be converted into an full overnight room with the provision with en-suite bathroom facilities. Costs have to be fully determined however **allow £250k.**

6.5 Lease Related Projects

Some leases are due to expire over the life of the Clinical Services Contract. In general WH position is that it would, in most cases, seek to retain the property and agree an extended lease. In the case of third party owned properties the Landlord for his own reasons may not wish to extend the lease. There are two current third party leases currently under negotiation.

- 133 St John's Way – expiry date 17th August 2012 – Landlord - London Borough of Islington to Islington Primary Care Trust. WH has asked for this lease to be renewed. NCL are currently in negotiation
- 19 Highbury New Park – expiry date - 5th June 2013- Landlord - London Borough of Islington to Islington Primary Care Trust. London Borough of Islington has advised that they will not be renewing this lease. WH and NCL are considering alternative locations for the services operating from this property.

6.6 Community Estate Management

As described, market testing the estates and facilities services to a third party provider will be undertaken after a "shadow year" when full details of the TUPE and existing contracts will be discovered. In the interim, it is envisaged that a Third party facilities management company manages the community properties under a management fee basis.

7. The St Ann's Site Development Plan

7.1 Introduction

The St Ann's site strategy is largely driven by the impending site rationalisation by BEHMHT that is currently being consulted upon. WH has been working closely with BEHMHT and the Commissioners to agree a master plan that identifies the services that should ultimately be provided on this site. In the final event however, it is for the **commissioners** to determine the scale, configuration and location of services. The most up to date version of the intended site plan shows the retained site to the right of the red line.

7.2 General Strategy

In accordance with our general propositions and estate strategies determined earlier, our strategy will:

- Move non-clinical functions from the site and place them in existing community properties – thus releasing floor area at St Ann's and reducing occupation charges under the SLA.
- Compress remaining functions where possible into G and H Blocks which are plan to remain in the long term
- Relocate remaining services into a planned BEH development.

Specifically WH have identified the following developments that should take place:

- Relocate to various Community properties - Occupational Health, Foot Heath (administration) Child Health Information Unit (currently located in G and H Blocks)
- BEH MHT to remove their services from G and H Block.
- Relocate Whittington Health functions into G and H Blocks as far as possible – IAPS, PIP's.
- Plan all remaining functions either into G and H Block or to alternative spaces in the new development.

7.3 Significant Departmental Proposals

In accordance with **Proposition 8** WH have sought to engage with BEH MHT and NCL and regard the development of St Ann's as an opportunity to review its service location and disposition. In general, apart from some minor relocations off site (non clinical departments), the majority of all other departments are envisaged to remain on site. A paper has been sent to the commissioners setting out the case for:

- Review the potential of forming a co-located multi agency children's hub. This envisages drawing together several children related services provided at different sites by different agencies and co-locating them onto one site. This meets with National policy objectives of providing integrated children's care services. Several locations have been examined however location on the St Ann's site appears the most viable option. There is some element of "betterment" in this proposal for which Commissioners support will be required. If this proposal is not accepted this service will relocate at current levels on the St Ann's site.

The commissioners have advised although they support the proposals in principle they will not agree funding over and above the current contract. In order to progress their redevelopment plans BEHMHT have agreed to fund the relocation of, Sexual Health and Clinical Audiology, to new locations on the St Ann's site. To date no agreement has been reached upon the relocation of further WH departments on the St Ann's site.

The relocation of remaining WH departments on the St Ann's site is a significant risk and will need to be addressed with BEHMHT and the new CCG's as they become established.

7.4 Development Plan

Appendix 3 figure 3.9 shows an outline development plan - the key elements of this plan as envisaged by WH.

7.5 Proposals, Programme and Costs

Timing is largely driven by BEHMHT's site development proposals.

Funding for the capital works require urgent consideration if the BEHMHT development proposals are not to be delayed. NCL are currently conducting negotiations with BEHMHT in respect of the SLA and site developments. We await the outcome of these discussions.

In any event WH does not expect to contribute to the costs of relocation of services when driven by BEH MHT site developments.

Appendix 1: The Existing Estate base Information (Where Are We Now?)

Appendix 1 Figure: 1.1Main Whittington Hospital site 2008/2009 6 facet survey output

Measure	Condition	Backlog by value		
1. Physical condition	A=18.6% B=56.8% B=2.8% C=21.6% D=0.2%	**Whole site backlog** H backlog C, D, and E backlog K backlog L backlog Site backlog	 £0.68m £4.92m £3.5m £0.75m 	**£12.67m** £0.75m
2. Functional suitability	A=0.4% B=73.4% C=25.2% D=1.0%	**Whole site backlog** C, D and E backlog L backlog	 £2.53m £2.47m	**£4.27m**
3. Space Utilisation	Empty=12.4% Underused=3.2% Fully Used=79.2% Overcrowded=5.2%	**Whole site backlog** D and E backlog L backlog	 £1 m £2.8m	**£4.4m**
4. Quality of the Environment	A=0% B=87.4% C=12.6% D=0%	**Whole site backlog** C, D, and E backlog L backlog	 £75,000 £82,000	**£220,000.**
5. Statutory Requirements	A=0% B=85.1% C=14.9% D=0%	**Whole site backlog** D Backlog F Backlog U backlog Site backlog	 £125,000 £115,000 	**£800,000** £125,000 £383,000
6. Environmental performance	A=1.2% B=46.5% C=52.1% D=0.2%	**Whole site backlog** K backlog L backlog	 £184,000 £265,000	**£400,000**

Appendix 1 Figure: 1.2Main Whittington Hospital site historic performance Indicators (2011/12 not as yet available)

Performance indicator	2006-07	2007-08	2008-09	2009-10	20010-11
Income £10/m²	262	261	275	277	292
Activity/100m²	85	87	91	88	90
Asset Value £10/m²	141	140	127	207	206
Occupancy Cost £/m²	210	213	232	253	240
Capital Charges £/m²	146	134	141	169	159
Rent & Rates £/10m²	203	291	261	261	262
Land £/m²	427	415	282	383	384
Building £10/m²	79	82	82	143	146
Equipment £/m²	189	168	173	251	214
Depreciation £/m²	86	73	77	116	117
Critical Backlog £/m²	50	37	36	37	38
Risk Adjusted Backlog £/m²	53	47	39	40	40
Total Backlog £/m²	247	194	171	161	129
Energy/Utility £/10m²	191	183	331	258	235
Maintenance Costs £/10m²	247	314	323	328	310

Appendix 1 Figure 1.3: Capital Schemes for 2011/12

Block	Level	Capital Scheme	Scope of Works
E	2	Obstetrics theatre ventilation plant	The included installation of a new AHU to HTM04-01, refurbishment of labour ward operating theatre. This included installation of white rock, redecoration, removal of redundant plant and additional MGPS outlets to improve functionality of theatre.
E	5	Semple ward conversion to extend Ante-natal and relocate Midwifery	Major refurbishment of the North of E Block. This included flooring, redecoration, new heating emitter, sanitary fittings, false ceiling, lighting, fire alarm system to L1, doors and door ironmongery.
K	2	Urgent Care Centre	Major refurbishment of 40% of ED. This included floor finishes, improvements to ventilation, redecoration, sanitary fittings, false ceilings, CCTV, fire alarms to L1 and access control
H	Roof	Nurses Home Roof replacement + Dorma windows	Replacement of remaining 40% of roof. This included insulation to loft space
H	All	Flooring to central staircase	Renewal of flooring using vinyl floor covering
C	2	Replacement of pipe work to Endoscopy Processing Unit	Replacement of existing pipe work with stainless steel pipe work. This includes new filters and installation of return
C	4	Window replacement	Installation of 5 x double glazed upvc windows to Medical Physics
C	2	Completion of steam decentralisation works	Installation of new dual fired boiler plant and associated systems to provide heating and hot water to C, D and E Blocks. This includes, Trend BMS controls, renewal of dhws to C Block, stripping out of redundant pipe work and boilers, asbestos removal
Site	Site	External Road works	Various repairs to defective road and path finishes. This included site re-lining. Patch repairs amounted to approx 400m^2
Z	Sub Station B	Replacement of Sub-station "B"	This included replacement of transformer, ring main unit, local distribution board and new sub main distribution board serving H Block
Block	Level	Capital Scheme	Scope of Works
K	4	Redecoration and flooring in Clinic 4D	New vinyl flooring and redecoration of main corridor
C	Ext	New fire escape	Replacement of fire escape for C block roof
C	Roof	New Roof	Removal of redundant AHU, plant room, insulation of roof and re-roof. This also included fall from height protection.
C	3	Replacement of 7 x distribution boards and SWA feed from C Block Switchboard	Installation of 3 x new DB's and new SWA. This included redecoration
D	1	Replacement of vacuum plant and medical air plant	This plant serves C, D, P and E blocks
Site	All	New medical plant alarms	New medical plant alarms site wide
R	1	Removal of 2 x oil tanks	Removal of 2 of 4 oil tanks and disposal of contaminated oil which was replenished.
E	1	Labour Ward	Replacement of Nurse call unit

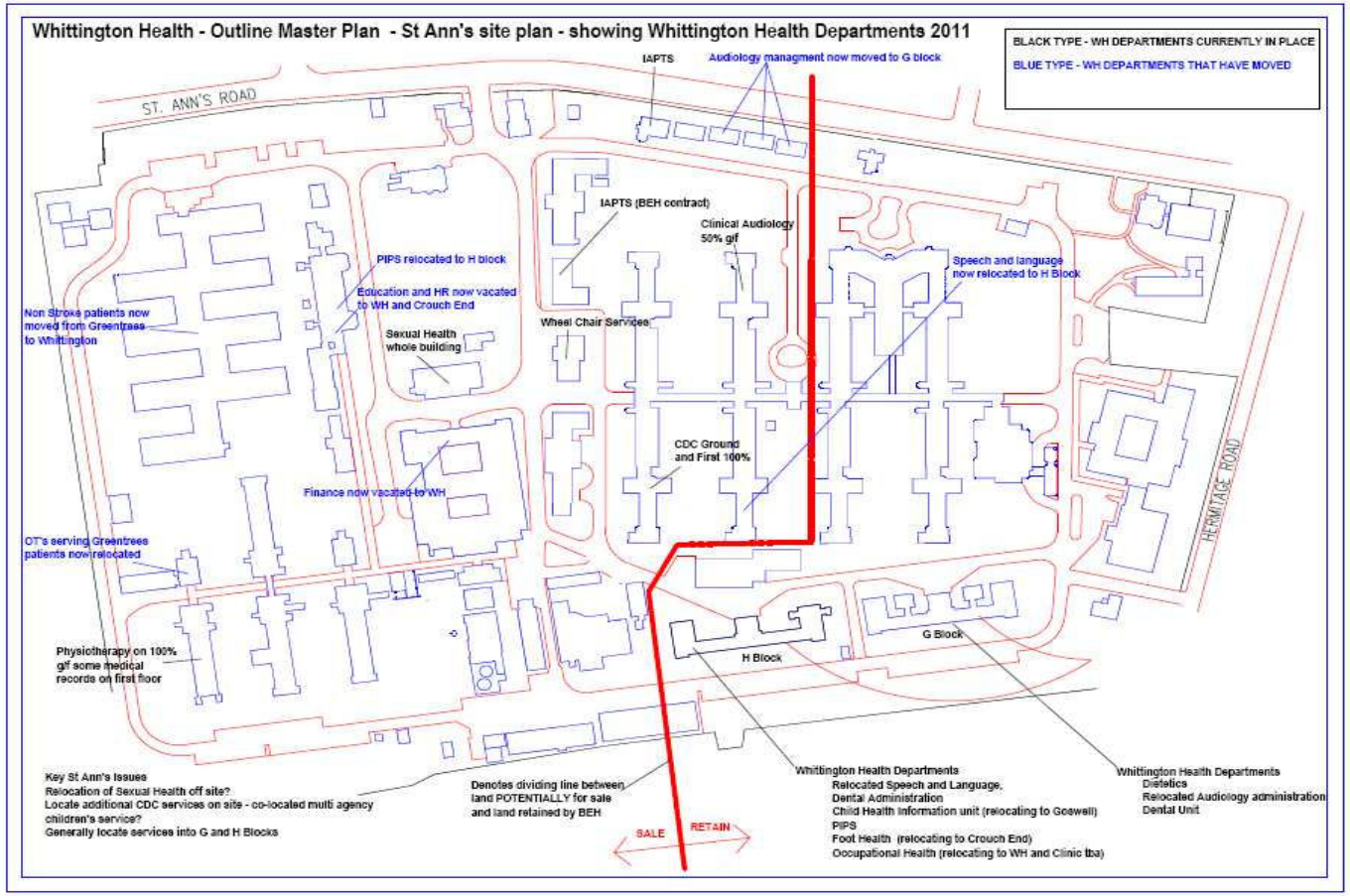
Appendix 1 Figure 1.4: Typical accommodation charges

Location	Cost per Month (£)
Sussex Way	577
Nurses Home (undecorated – qualified staff)	261
Nurses Home (decorated - qualified)	305
Nurses Home (undecorated – students)	261
Nurses Home (decorated – students)	305
Nurses Home double	468
Drs Residence (Flats 1,2,3 7, and 8) (6 is on call)	1,306
Drs Residence (Flats 4, 5, 9, 10 and 12)	1160
Guest day rate	20

Appendix 1 Figure 1.5: Community Properties Location Plan

To Be Inserted

Appendix 1 Figure 1.6: Site Plan St Ann's Hospital Showing Whittington Health Service Locations



Appendix 2: Draft Smart Working Operational Principles

Draft Smart Working Operational Principles

Version 3 (amended 2nd April)

1) These are indicative principles – a full policy and implementation plan is required.

2) A Working Party has been established to lead the development and implementation of Smart Working – these are initial principles to aid policy development.

3) This paper has been approved in Principle by the Executive Committee

Statement of Intent
Whittington Health has agreed to introduce Smart working. and over time shall implement paperless working. It aims to:

- Improve space utilisation and/or reduce the floor area occupied by administrative functions by up to 20%
- Reduce the use of paper and associated consumables by 50% over two years and 90% over 3 years (measured from current financial baselines)

Statement of General Principles
The sections below describe broad operational principles.

1) General Office Environment and Planning

- Open plan office layouts will be adopted wherever possible
- Meeting rooms, touch down areas and quiet rooms will be provided to match the operational requirements
- Office layouts will, where possible, include a soft seating area and access to tea and coffee making facilities. Consumption of food in the office is not permitted.
- Desk provision shall be provided on a **4 for 5 basis i.e. for every 5 persons 4 desks will be provided** – it is highly unlikely that (certainly for larger departments) 100% of staff will be present at any one time.

2) General Working Principles

- No paperwork or personal effects shall be left on a desk at the end of a working period. A small secure cabinet will be provided for the storage of personal effects, office stationery, equipment or files.
- You will not have a permanent fixed desk. Desks with be arranged in team "clusters" You will use any desk available in your cluster (all desks are of a similar design and layout): this system is termed "flexible self addressing desking".
- At the beginning of the working period you will select a desk and "log in" to the PC. You will also log in to the telephone so that your calls and messages are diverted to you.

3) Paperless Working

Whittington Health has resolved to move towards paperless working. This will need to be brought in over time and will be supported by the IT department. In the interim, wherever possible, paper will be reduced – "paper lite". To this end:

- Printers and copiers shall be minimised – centrally located multi function devices shall be implemented.
- **Printing will be discouraged – only central waste and recycling bins shall be provided**
- Storage facilities for printed medium will be minimised – electronic storage of data and records shall, where practical, be the default position.

4) Technology (this section will need to be completed by the IT dept)

This initiative shall be supported by the IT department.

- For those staff that are required to work in various locations appropriate devices will be provided – subject to manager's agreement.
- Protocols will be established covering the electronic storage of records and data – minimising paper and printed medium.
- Telephone systems will be reviewed to assess potential for harmonisation
- Data bases will be reviewed to assess potential for harmonisation to facilitate flexible community based working
- Electronic systems of data storage will be reviewed and rolled out to encourage paperless working.

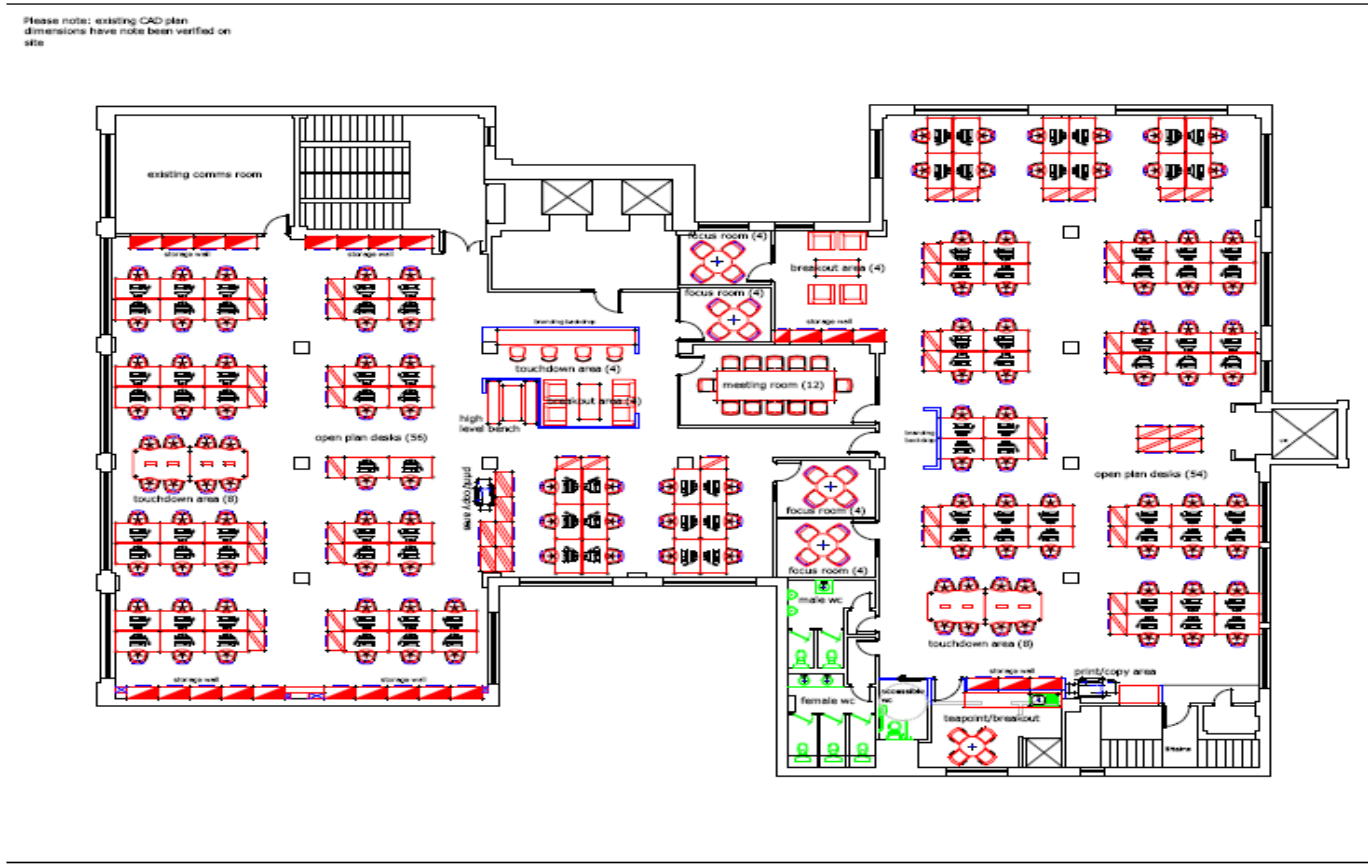
5) Mobile Working including from Home (this section will need to be completed by the HR and IT departments)

This initiative is supported by the Human Resources dept

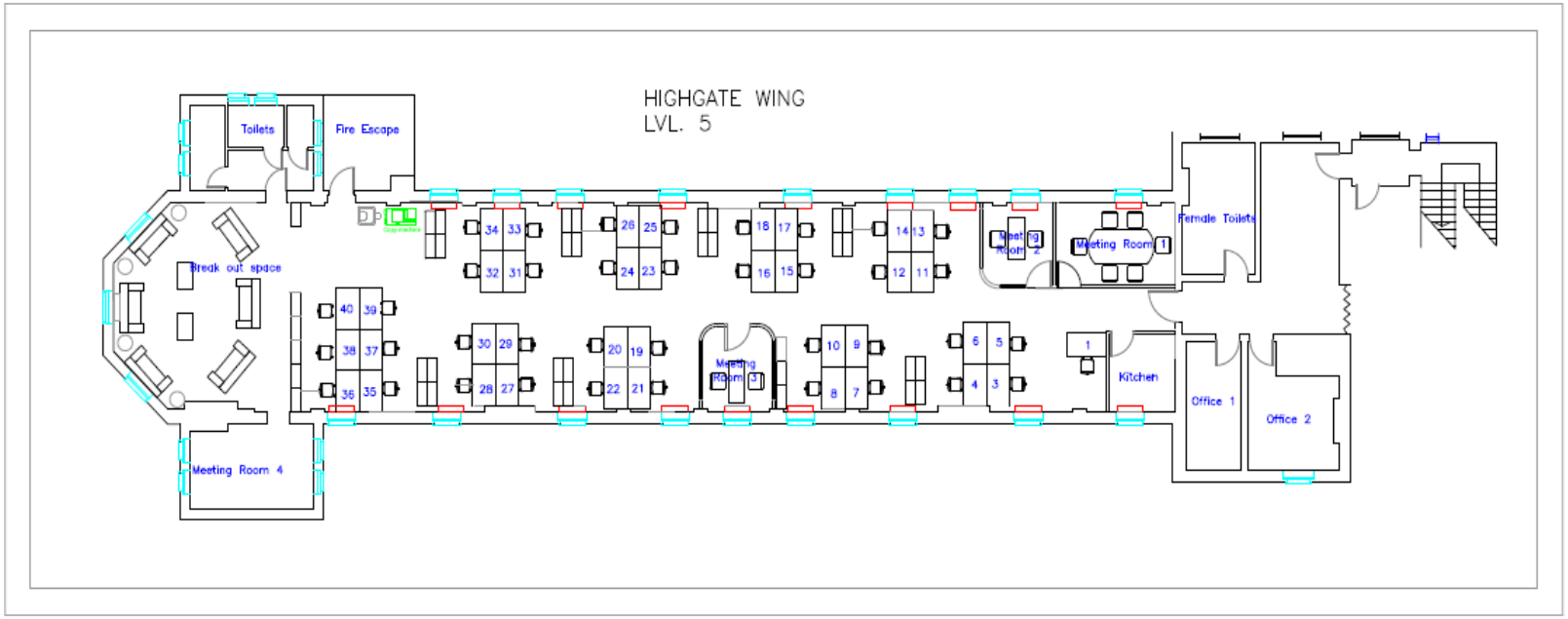
- Where practical and congruent with business needs staff will generally be permitted to work from home one day per week. This would not be a right and would be subject to the manager's discretion.
- Appropriate devices will be provided where necessary to facilitate mobile working or working from home if the staff member has not or does not wish to use his/her own equipment.
- Technological solutions to facilitate mobile and home working will be provided by the IT dept
- The home worker themselves will be responsible for assessing their home workplace for compliance with relevant Health and Safety legislation. Appropriate training will be given.

Appendix 3: Site Specific Development Plan Information

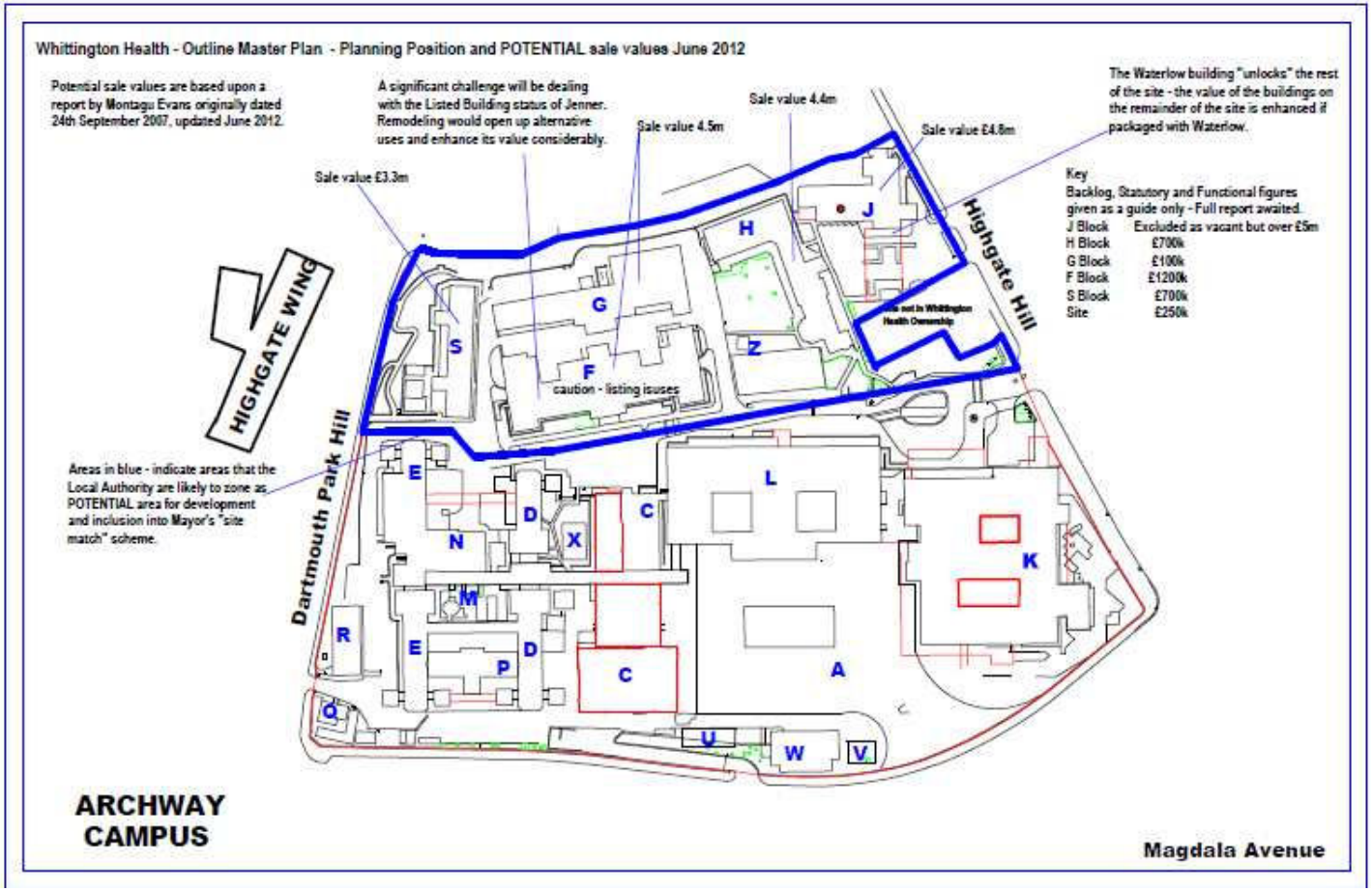
Appendix 3 Figure 3.1: SMART Worked layout of Goswell Road



Appendix 3 Figure 3.2: Draft "Smart Worked" floor plan of Highgate Wing



Appendix 3 Figure 3.3 – Planning and Potential Site Valuations – Whittington Hospital



Appendix 3 Figure 3.4: Calculation of Floor Areas Required Jenner

Jenner Planning Area	m2	Space relocations	Area m^2	Comments
Commencing area	3140	25% for SMART working	2355	General Allowance
		Unipart Initiative	100	Short term plan (estimate)
		Relocations to vacated Procurement	220	Short term plan
		Relocations to furniture store	235	Short term Plan
	Total end short term plan		**1800**	

Appendix 3 Figure 3.5: Base Financial Data as Existing (February 2012)

Cost Analysis (Base Data Existing)	Building/site area m2	Capital Charge (k) Depreciation	Interest	Total	Running Costs (k) at £160/m2	Income (k)	Net running cost p.a. (k)	Operating Cost p.a. (k)	Backlog maintenance (3)	
Jenner	3140	78	40	118	502	0	502	620	1200	estimate
WEC	1171	38	50	88	187	see note (1)	187	275	100	estimate
Doctors accommodation	1011	42	25	67	162	see note (2)	162	229	200	estimate
Nurses Home	2671	89	81	170	427	-340	87	257	700	
Waterlow	4483	0	0	0	0	0	0	0	0	Impaired
Site backlog									250	estimate
Sub Total				**443**			**939**	**1382**	**2450**	
										estimate
Total				**443**			**939**	**1382**	**2450**	
Land										
Northern Strip Including Waterlow	13446	0	262	262				262		
						Totals	**939**	**1643**	**2450**	

(1) Income discounted as will be constant for all before and after option scenario's

(2) Income for Doctors Accommodation included in Nurses Home
(3) Backlog maintenance currently being resurveyed therefore estimates are inserted. Waterlow is impaired and no allowance made for backlog - however "real" costs are inserted here.

Appendix 3 Figure 3.6: Base Financial Data as Proposed

Cost Analysis (Base Data Proposed)	Building/site area m2	Capital Charge (1) (k) Interest	Total	Depreciation	Running Costs (k)	Net running cost p.a.(2)	Operating Cost p.a. (k)	Estimated capital Costs (k)	Capital cost m2 (£'s)
Build Boiler House development 4 floors	2080	121	255	376	270	at £270/m2	647	7280	3500
re plan Outpatients to create space for physiotherapy (4)	300	10	21	31	0	zero as no marginal increase	31	600	2000
Convert space K Wing Basement for physiotherapy	180	2	4	7	23	£120/m2 (marginal increase)	30	126	700
Convert wards to Offices	1876	25	53	78	244	£120/m2 (marginal increase)	321	1501	800
Convert level 5 HGW offices (4)	380	1	3	4	0	zero as no marginal increase	4	80	210
		158	**333**	**491**			**1033**	**9587**	**7210**
								Capital Receipts	
Northern Strip Capital receipt								17000	see note (3)
						Totals	1033	7413	

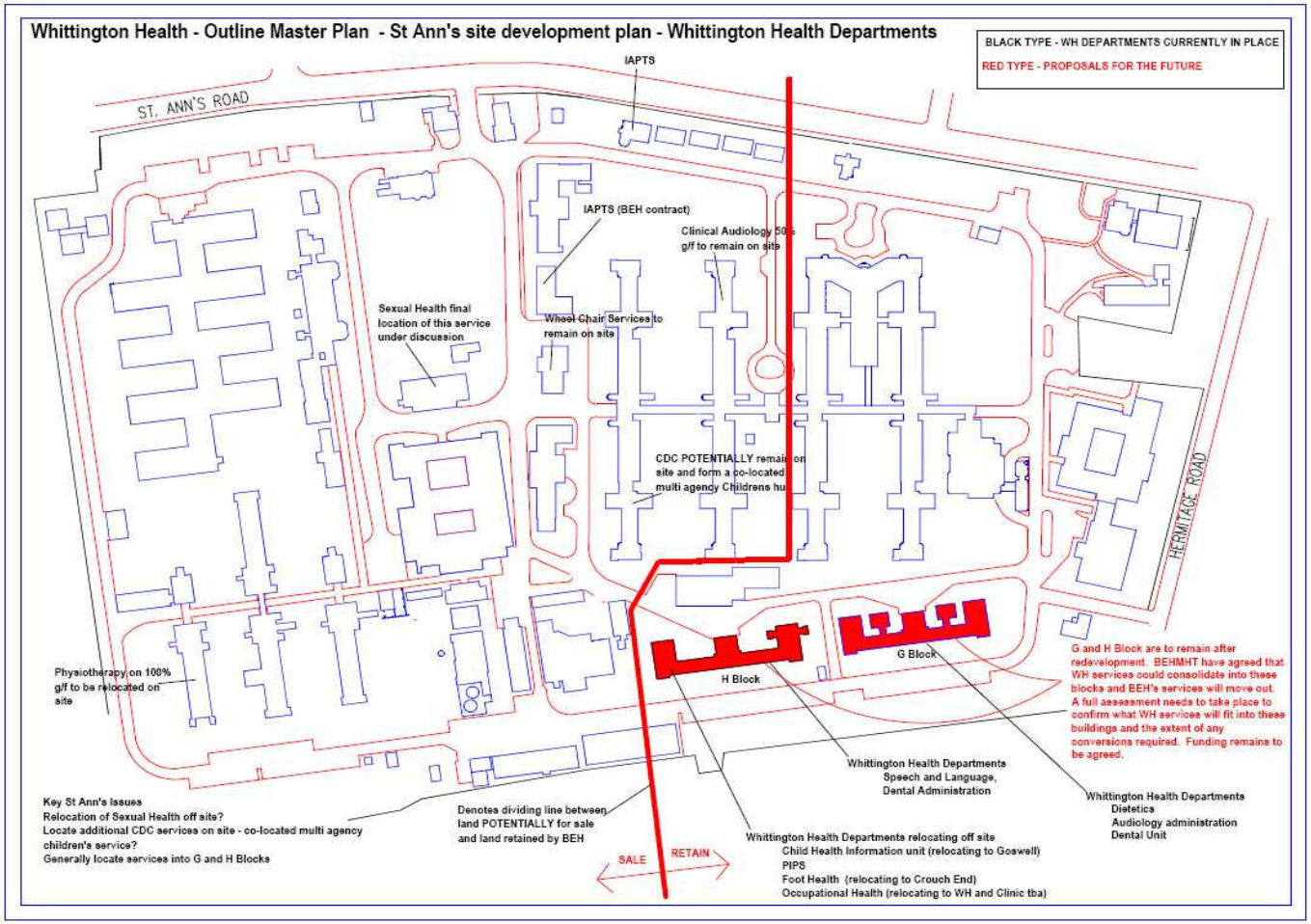
(1) Capital charges assessed on additional marginal cost basis generally 3.5% of new capital investment and buildings depreciated over 60 years

(2) Running costs are assessed as marginal over the existing costs where occupying existing buildings. Assume new builds have slightly lower running costs

(3) Source Montagu Evans 24th September 2007 updated June 2012. values the northern strip at £17m

(4) general costs of creating Ambulatory care taken under short term plan

Appendix 3 Figure 3.10: St Ann's Site Outline Development Plan



POLICY BRIEFING

The Francis Inquiry into Mid Staffordshire NHS Foundation Trust – messages and implications

Author: Christine Heron, LGiU Associate

Date: 8 February 2013

Summary

The Francis Inquiry report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations to respond to concerns. The report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

Repeated NHS restructuring was identified as an important element in the background to the failures, and with the most substantial changes to the NHS since its inception now taking place there is clearly potential for further major failings in NHS providers. This policy briefing summarises the report and identifies some significant messages for local authorities in their health responsibilities.

Briefing in full

Background

In June 2010 the then Secretary of State for Health Andrew Lansley charged Robert Francis QC with undertaking a public inquiry into the failures of Mid Staffordshire NHS Foundation Trust. The terms of reference were to:

- examine the operation of commissioning, supervisory, regulatory and other agencies in their monitoring role of Mid Staffordshire NHS Foundation Trust (Stafford Hospital) between January 2005 and March 2009 to identify why problems were not identified and addressed sooner
- identify relevant lessons for how any future failing regimes can be identified as soon as practicable within the context of NHS reforms.

The Francis Inquiry followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis.

The failings at Stafford Hospital have been well reported in the media and will not be repeated in detail here. The number of excess deaths between 2005 and 2008 is

estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

The Inquiry looked at the hospital itself and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement, and health scrutiny. It made 290 detailed recommendations.

What organisations knew or should have known

Many respondents to the Inquiry indicated that they were not aware of the extent of problems at the hospital and that failings had not been drawn to their attention. The report disagrees with this stance, indicating that clear warning signs were available. These include:

- star ratings reduced from three-star to zero by the Commission for Health Improvement in 2004
- poor peer reviews, auditor reports, and Healthcare Commission reports including staff and patient surveys
- staff concerns reported to management and instances of whistleblowing ignored
- financial recovery plan not consistent with maintaining quality and safety.

The overall picture was that the Trust Board operated with a 'culture of self promotion rather than critical analysis and openness' and that organisations with a role in assessing performance at the hospital all too often accepted the hospital's version of events at face value.

Stafford Hospital

Hospital leaders failed to appreciate the enormity of failings, downplayed their significance, and sought to explain away problems. There was a culture of accepting poor standards and isolation from good practice elsewhere. The leadership prioritised financial issues, meeting targets and achieving foundation trust status rather than quality of care. There was no culture of listening to patients or acting on complaints or poor surveys; information from patients was probably seen as of low importance. Some clinicians raised concerns but did not pursue these 'with vigour' and are described as 'passive'. Evidence to the Inquiry described an environment in which professional staff were in conflict with each other. Clinical governance was not introduced effectively. Due to poor leadership and staffing levels the standard of nursing on some wards was 'completely inadequate'.

LGiU LOCAL GOVERNMENT INFORMATION UNIT

POLICY BRIEFING

The PCT, GPs and the strategic health authority

The report indicates that at the time PCTs were subject to constant reorganisation and followed national guidance that focused on financial control and access targets. However, PCTs were also under a duty to monitor and improve the quality of services they commissioned and had significant resources. The report indicates that the local PCT experienced a dilemma about potentially destabilising a provider when no alterative provider was available. It criticises the PCT for the time taken to address issues, insufficient focus on developing systems to monitor performance and a willingness to accept that clinical safety was not compromised. Local GPs only expressed 'substantive concern about quality of care' after the announcement of the Healthcare Commission investigation.

The Strategic Health Authority was also operating under extensive financial challenges, organisational restructuring and lack of role clarity. While it did not actively seek out concerns it was willing to intervene if necessary. However all too often it judged concerns as not warranting exceptional action. Overall, it was too ready to trust providers and too remote from patients. The SHA failed to provide information to the DH on the application for foundation trust status and did not consult with the Healthcare Commission.

The report points to the new commissioning systems of NHS Commissioning Board and clinical commissioning groups (CCGs). It indicates that there is an 'urgent need to rebalance and refocus commissioning' on standards of services for patients.

The regulators

Monitor and failure of the foundation trust authorisation process

Monitor is the NHS financial regulator and responsible for foundation trust authorisation. Stafford Hospital was granted foundation trust status in 2008 and the report is swingeing in its criticism of this decision. 'An elaborate, resource-consuming process failed to achieve what should have been its primary objective; ensuring that the only organisations authorised were those with the ability and capacity to deliver services compliant with minimum standards on a consistent and sustainable basis' (Executive Summary 1.51). The report also indicates that there was an 'undue delay' in Monitor intervening when problems were identified. The major factor in the 'erroneous authorisation' was the dissonance between regulation of finance and quality – Monitor and the Healthcare Commission did not co-ordinate their regulatory roles.

The Healthcare Commission

The report points out that the HC was the regulator at the time of the failings, but it was the first organisation to identify serious concern and take action. It suggests that the top-down design and confusion of the NHS Annual Healthcheck – the process of self-assessment on compliance against standards – contributed to failure to detect problems sooner.

The Care Quality Commission

The report supports the new regulatory model which collects a wide range of information to identify risk of non-compliance. It points to the multitude of organisational challenges the CQC has had to face in a short period of time (merging three organisations, new system of regulation and standards, new registrations). However, it indicates that while the CQC aspires to be an open organisation it has exhibited defensiveness and 'instinct to attack' in the face of criticism. While it is improving and becoming more responsive, it still needs to focus on information from patients.

Professional bodies/regulation

The report describes an inadequate response from organisations including the General Medical Council, the Nursing and Midwifery Council, university/deaneries, the Health Protection Agency, and the Health and Safety Executive. It describes the Royal College of Nursing as 'ineffective both as a professional organisation and a trade union' with failure to uphold professional standards or address problems identified by members. It suggests a potential conflict between its professional and trade union roles.

Department of Health

The report indicates that the DH was genuinely concerned about the failings at Stafford Hospital and has a sincere aim to improve quality for patients. However, over successive governments there have been struggles between rhetoric and implementation. Reforms aimed at improving quality for patients have been imposed too quickly and followed by further reform without being given time to succeed. Clinical leaders were not always at the heart of decision making and officials were sometimes too remote from patients and front-line staff. While it is not fair to say that there is a culture of bullying, action has been interpreted as bullying and instructions may have been applied locally 'in an oppressive manner'.

Voice of the local community

Patient and public involvement

The report identifies that failure to engage with patients and the public is a major factor in the problems at Stafford Hospital. It also indicates that formal patient and

public involvement mechanisms were not operating well, leaving the campaigning patients' group Cure the NHS as the only effective local voice.

Patient Opinion (a not for profit social enterprise that allows patients and carers to anonymously share their health service experiences in order to receive feedback and improve services) commented on the Francis report that patients themselves need to speak up about their care or nothing will change as a result of the inquiry and that patient stories can make a difference - being an early warning of systemic failings that needs to be urgently redressed. Councils will be interested that a similar scheme will be launched soon for adult social care users and their families.

Most of the respondents to the Inquiry suggested that the organisational model of Community Health Councils, with their mix of officers and board would have been a more effective structure than the models that replaced it.

On Staffordshire Patient and Public Involvement Forum, the report describes 'mutual acrimony' between members and between members and the host, a preoccupation with constitutional and procedural matters and a 'degree of diffidence towards the Trust' as leading to a failure to be effective. Local Involvement Networks (LINks) were described as an 'even greater failure'. 'The albeit unrealised potential for consistency represented by the Commission for Patient and Public Involvement in Health was removed, leaving each local authority to devise its own working arrangements. Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all' (Executive Summary 1.22).

On Local Healthwatch (LHW), the report says that without a national framework to provide consistency there is a 'danger of repetition of the arguments that so debilitated Staffordshire LINks'.

Health overview and scrutiny committees (HOSCs)

On health overview and scrutiny, the report says the following. 'The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be.' (Executive Summary1.25)

Recommendations

The Inquiry makes 290 recommendations of which many are detailed proposals for changes to aspects of policy or process. The overall recommendation is that all organisations involved in NHS commissioning, provision and regulation and 'ancillary organisations' should consider the findings and recommendations of the report. The DH should publish regular reports on how they have responded, and the Commons

LGiU LOCAL GOVERNMENT INFORMATION UNIT

POLICY BRIEFING

Health Select Committee should consider including this issue in their work programme.

This section presents some of the high profile recommendations and those that relate to the work of local authorities.

- Prioritising the needs of patients in the NHS, with caring, compassionate and committed staff working within a common culture; for example:
  - developing the NHS Constitution so there is greater commitment to staff putting patients before themselves.

- Clear responsibility for, and effectiveness of, healthcare standards and governance, for example:
  - there should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patients' safety and quality standards
  - a merger between Monitor and the CQC should be undertaken incrementally and after thorough planning. CQC would take on responsibility for foundation trust authorisation, incorporating relevant departments from Monitor
  - zero tolerance for failure to meet fundamental standards – organisations who fail should not allow to continue. Criminal liability should follow where serious harm or death results from a breach of fundamental standards
  - any 'wilfully or recklessly false' statement about compliance with safety or essential standards in provider quality accounts should be made a criminal offence.

- Complaints handling should be improved with sensitive, responsive and accurate communication and learning, for example:
  - a facility should be available to Independent Complaints Advocacy advocates and their clients to access expert advice in complicated cases
  - overview and scrutiny committees and LHW should have access to information about complaints (confidentiality maintained).

- Commissioners should incorporate standards and monitor compliance, for example:
  - GPs need to take a monitoring role on behalf of their patients who receive acute hospital or other specialist services
  - commissioners need wherever possible to make available alternative sources of provision
  - greater involvement of patients and the public in commissioning.

- Patient, public and local scrutiny should be improved, for example:

- there should be a consistent national structure for LHW
- local authorities should be required to pass over their funding allocation for LHW
- respect for the independence of Local Healthwatch should not be allowed to inhibit a local authority – or Healthwatch England as appropriate – intervening
- guidance should be given to promote coordination and cooperation between LHW, health and wellbeing boards and scrutiny committees
- proper training and, where necessary, expert advice should be available to the leadership of LHW
- scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role including easily accessible guidance and benchmarks
- scrutiny committees should have powers to inspect providers rather than relying on patient involvement structures, or should actively work with those structures to trigger and follow up inspections rather than receiving reports without comment or suggestions for action
- MPs are advised to adopt a simple system for identifying trends from individual complaints.

- Greater openness, transparency and candour, for example:
  - a statutory obligation for healthcare providers and professionals to observe a duty of candour
  - criminal liability relating to dishonesty about incidents when informing a regulator or commissioner.

- Nursing – a number of recommendations relating to culture of care and practice, training, national standards and leadership.

- NHS leadership – a number of recommendations relating to training, code of ethics and standards. Serious breaches of the code could result in managers being disqualified from senior positions in future. However, the report falls short of recommending regulation for NHS managers.

- Care for the elderly – there should be specific approaches for older people, such as effective teamwork between disciplines, ward management, and discharge coordination.

Next steps

The fall-out from the Francis report is ongoing. There have been calls, most prominently from Cure the NHS, for the resignation of Sir David Nicholson the NHS

and NHS Commissioning Board Chief Executive who was previously a strategic health authority chief executive in the West Midlands.

NHS Medical Director Sir Bruce Keogh will investigate five trusts with high death rates. David Cameron has announced that trust boards could be suspended for quality failures as well as financial problems, with a 'single failure regime' implemented. He has asked the CQC to create the post of chief inspector of hospitals with a new inspection regime to begin in the autumn. The man who led President Barack Obama's US healthcare reforms has been engaged to introduce 'zero-harm' into the NHS culture. South Tees Hospitals Foundation Trust Chief Executive Tricia Hart and Labour MP Ann Clwyd have been asked to advise on how NHS hospitals should handle patient complaints.

The government will respond to the 290 recommendations in full next month. LGiU will produce a further policy briefing at that time.

Comment

Robert Francis has produced a fair and balanced report which sets the actions of organisations within the context of organisational pressures and limitations. Nevertheless, most organisations involved are criticised for failure to act and there are severe criticisms of the Trust and its leadership. According to Patient Opinion the problems of Stafford Hospital continued for so long and were not identified or fixed by the trust, commissioners or external agencies because no-one was listening.

Local commissioning

One of the key themes is that reorganisation is generally well-meaning but usually undertaken too quickly without adequate planning and without a thorough assessment of the impact on patients and families. 'Structural reorganisations have made implementing policies for quality and safety very difficult in practice.' (Executive summary 1.104) Clearly, this message resonates with the current round of restructuring.

The report indicates that any system must have a 'relentless focus' on patient safety and quality standards. The role of health and wellbeing boards does not figure prominently in the report, but it would seem that they have an important role in ensuring that local commissioning maintains a focus on quality and safety through difficult financial times.

Merging regulators

Another important recommendation is to merge the CQC and Monitor to plug the gap between their separate roles. Anyone following health policy in recent years will have seen continuing disputes between Monitor and the Healthcare Commission. A

complete division between economic and quality regulation would seem to inevitably lead to problems. It is disappointing therefore to read in the Health Service Journal that Health Secretary Jeremy Hunt indicates that Monitor will continue as the economic regulator and will probably run the 'single failure regime' for providers announced by the Prime Minister. HSJ further reports that the CQC does not seek to merge with Monitor.

Patient and public involvement

Chapter 6 of Volume 1 of the report provides a detailed account of the development and activity of patient and public involvement at Stafford Hospital. Anyone involved in commissioning or working with LHW will find this an interesting and salutary account.

While it is important not to slide between problems in a specific patient and public involvement mechanism to general comments about the model itself – there are some excellent LINks – there is no doubt that some of the problems identified will be immediately recognisable to anyone involved in developing patient involvement.

One of the dilemmas for local authorities is that intervening in the work of a LINk or LHW as the commissioning organisation may be viewed as oppressive and controlling. For this reason, there has been a reluctance to get involved and a tolerance of poor performance. The report's recommendation that local authorities, or Healthwatch England, should intervene should be built into LHW arrangements.

Also, it is important to recognise that LHW involves people who are volunteers. LHW members need to understand the responsibility of the role they have taken up; the Inquiry report which goes into detail about the action of named individuals should be used as an example for this.

Health overview and scrutiny

Chapter 6 of Volume 1 sets out the role and responsibilities of overview and scrutiny and describes the activity of Stafford Borough Council HOSC and Staffordshire County Council HOSC. Those involved in overview and scrutiny may wish to read this to identify potential lessons.

The role of health scrutiny has been recognised by the Government as effective and important, with increased responsibilities in the NHS reforms. However, scrutiny at Stafford Hospital concerned the specific issue of identifying bad performance, and the dilemmas identified in the report may be familiar to many HOSCs.

Some points that may be of interest to HOSCs can be drawn from the report's conclusions about the role of scrutiny.

- lack of detail in notes in some meetings about Stafford Hospital
- the need to be more proactive in seeking information

- over-dependency on information from the provider rather than other sources, particularly patients and the public
- lack of resources, particularly in small borough committees
- questions about expertise of some members of HOSCs
- need for clarity in the roles of borough/district and county HOSCs
- scrutiny better conducted at arms-length rather than as a 'critical friend'.

Finally, the recommendation for scrutiny committees to possibly have inspection powers needs further thought, since it has previously divided opinion in the scrutiny community.

Related LGiU policy briefings

Winterbourne View and the state of care

Consultation on extending the NHS Constitution

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

Haringey Council

Francis Report

Chapter 6: Patient and Public local involvement and scrutiny

Recommendations and local implications

No.	Recommendation	What can be done locally by the Adults and Health Scrutiny Panel
43	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.	Systematic monitoring of local papers by support officer, alerting the Panel of any issues reported.
145	There should be a consistent basic structure for local Healthwatch throughout the country, in accordance with the principles set out in Chapter 6: Patient and public local involvement and scrutiny.	An update on Haringey's Healthwatch is due at the Panel on 2nd April.
146	Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, whilst requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.	An update on Haringey's Healthwatch is due at the Panel on 2nd April.
147	Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.	The NHS Scrutiny Protocol developed in 2005 is due to be rewritten taking into account the new health structure and regulations.

Haringey Council

		The redevelopment should include engagement with all stakeholders. This may be an opportune time to ensure coordination and cooperation are included.
148	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.	An update on Haringey's Healthwatch is due at the Panel on 2nd April.
149	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.	Scrutiny receives support from performance and information management officers when requested.
150	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work	Locally the Adults and Health Scrutiny Panel could schedule informal visits to local wards and care homes to gain a better understanding and overview of the services. This would provide an opportunity to see how wards/homes are working and speak to patients/residents to inform the work of the Panel.
151	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they receive from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.	Locally the Adults and Health Scrutiny Panel could receive regular complaints data from NHS and Social Care services to identify any trends to inform the work of the Panel.

DRAFT MINUTES OF THE ADULTS AND HEALTH SCRUTINY PANEL THURSDAY, 10 JANUARY 2013

Councillors Adamou (Chair), Mallett, Stennett, Erskine and Winskill

Co-optees Helena Kania (LINk), Claire Andrews (HFOP)

LC31. APOLOGIES FOR ABSENCE

None received.

LC32. URGENT BUSINESS

None received.

LC33. DECLARATIONS OF INTEREST

None received.

LC34. BEH MHT DRAFT COMMUNICATING CHANGE GUIDANCE

Maria Kane, Chief Executive of BEH MHT introduced the paper. Key points noted include:

- The proposed closure of Downhills Ward and the handling of the proposal was the impetus for updating the guidance.
- The working group which was set up with the Adults and Health Scrutiny Panel following the Special meeting in November was very constructive and reached a consensus on the way forward.
- The outcome of the working group is that Downhills Ward and Finsbury Ward will remain open, and Haringey Ward will now close. Downhills and Finsbury Ward will be combined Assessment and Treatment Wards.
- These changes are interim and will be in place until the site is redeveloped.
- Maria thanked the working group for their input.

The Communicating Change Guidance needed to be strengthened both in governance arrangements and in the policy.

Changes to services now need to be signed off by an Executive Director. However, this does not negate the need for stakeholder engagement.

The Guidance is due to be signed off next week and will then be circulated to Managers and Clinical Directors.

The Guidance will also be re-launched across the Trust and discussed at Team meetings.

In response to a question Maria informed the Panel that the paper is Guidance, but that staff are expected to adhere to it and that sanctions would be in place for those who don't adhere to it. The policy/governance aspect of it is that any changes must be signed off at Executive Director level.

Comments from the Panel included:

- There is a need for a more robust statement on getting buy-in from the voluntary & community sector, service users, carers groups and staff at the start of the document.

- The expectation should be that there is two way communication between the MHT and service users, voluntary and community groups, carers etc and that this should be both engagement and listening to what each group has to say.

- The Panel noted that they were impressed with the cooperation of the MHT through the working group and that changes were made based on the input of the working group.
- The Mental Health Support Association raised the role of Non Executive Directors in the process and were informed by the MHT that the role of the Board would be added to the document for clarification.

Agreed

- The MHT would include the role of the Board in the Communicating Change Guidance.
- The importance of getting buy in from service users, the voluntary and community sector, carers and staff would be strengthened to emphasise that communication and engagement is a two way process.

LC35. BEH MHT HOME TREATMENT TEAMS AND RECOVERY HOUSES

The panel was taken through the presentation by Jackie Liveras, Assistant Director, Crisis and Emergency.

Key points included:

Home Treatment Teams (HTTs)

- HTTs have been running for 12 years across the country.
- HTTs are a meaningful alternative to hospitals.
- The National Service Framework some years ago laid out what the role of HTTs is.
- People prefer to be treated in the own homes.
- There is a target of 727 treatment episodes; MHT is currently at 700 and therefore expecting to exceed the target by quite a lot.

Issues include a slight drifting from the National Service Framework and so work is currently being done to re-focus the service.

- HTTs are a vital component of enabling the re-profiling of beds.

Future plans include:

- Work to improve service users experience and quality of services, for example ensuring that service users do not have to complete multiple assessments, GPs being able to refer to HTTs directly for assessment.
- The intake service was reviewed at the end of 2011; this work is now being re-looked at.

Recovery Houses

- The partnership with Rethink is working very well.

Issues include:

- Services are not always in place to enable people to move on.
- Recovery Houses are usually full, with an expected increased demand this will increase pressure.
- 90 admissions across the Trust.

Comments from Rethink included:

- The success of Recovery Houses is due to the partnership between Rethink and the MHT.
- Recovery Houses are a hub within the community.
- Feedback from service users is positive.
- Peer support groups are being formed and ex service users are being developed in the skills needed to run these groups.

The following discussion points were noted:

- All staff that are displaced from the closure of Haringey Ward will be redeployed, including an increase in staff numbers on HTTs.
- The ability for GPs to refer to HTTs is positive.
- If a person goes into a pharmacy with mental health queries then it would be helpful for the pharmacies to know where to signpost to and which services were open when etc. The MHT agreed to speak to the Local Pharmaceutical Committee to share this information.
- The language used on the information sheets about HTTs and Recovery Houses will be shared with service user peer groups to gain their input on how they can be improved, particularly in relation to the language used.
- Strong relationships with carers and their families is an integral part of the services.
- HTTs are moving towards a position where all assessments are done in the home, apart from in exceptional circumstances. By conducting these at home family members and carers are often automatically involved.
- Social workers are a part of all HTTs and will conduct carer's assessment where the carer says that they wish one to be undertaken.
- The MHT have a target on carer's assessment and report to the Local Authority. They also have their own records.
- It is ensured that carers are spoken to and listened to as part of the pathway.
- Care Coordinators based in HTTs are responsible for the Care Plans for service users in both HTT services and in Recovery Houses. They then liaise with the relevant staff member if the service user moves to acute care.

- The monitoring of a service user depends upon their risk assessment, when in primary care this is the GP.
- It was noted that the smallest Recovery House is in Haringey, and in the West of the borough away from the area of highest need. The MHT stated that there is not a limit on the number of Recovery Houses an area could have and that if they were offered a house in the area of most need then they would be very keen to take this on.
    - It was noted that larger houses, for example with over 15 rooms is more economically efficient and cost effective.
    - It was noted that a property review is currently taking place which may identify suitable properties which could be used for this.
- Noted that the RIO IT system is being rolled out to the Haringey Recovery House this month, and that this will make it easier for assessments to be done 24hrs a day without disturbing resting staff on night shifts.
- All information leaflets, and service users care pack include information on how to complain. If a person wishing to complain wasn't aware of a direct route they would be able to call the St Ann's helpline and be put through to the relevant department.

The Panel asked for an update on the Foundation Trust application status and were informed that the current process and next steps are unclear. The Foundation Trust application had been through NHS London and was with the Department of Health when the Trust Development Agency (TDA) was formed. The TDA have said they would like to go through some of the stages again and there is therefore a 3 – 4 month delay expected, before it goes to Monitor.

The current process and lines of responsibility are currently unclear.

The forthcoming Francis report on Mid Staffs may have implications on the process.

A recent CQC inspection resulted in some moderate concerns which other Trust intend to put right in the immediate future.

The MHT are doing some Peer Review work with a high performing neighbouring Trust.

The Mental Health Support Association stated that the interest of the Panel in HTTs and Recovery Houses has been positive and useful and requested that Panel revisit the area in future. The Mental Health Trust stated that they would be happy to bring further information to the Panel, particular as input would be useful as the care pathway changes.

It was noted that Nick Bishop, Mental Health Support Association, was stepping down. The Panel wished their thanks to be noted for Nick's valuable support and input over the years.

Agreed:

- The Panel would write to the Cabinet Member for Housing about any available property in the East of the Borough which could be used as a Recovery Houses.
- The MHT and LPC would discuss sharing information on mental health services in the borough to enable pharmacists to signpost.
- The Panel would write to the TDA and the CCG to ask for clarification on the next steps and affirm the CCG's support of the Foundation Trust application.
- The Panel would revisit HTTs and Recovery Houses at a later date for further input.

LC36. REPORT ON THE POSITION OF HEALTH VISITING AND DELIVERY OF THE NEW BIRTH VISIT IN HARINGEY - WHITTINGTON HEALTH

The Panel was taken through the report by Sam Page, AD Universal and Safeguarding Children's Services.

The following points were noted:

- Health Visitors are an unusual area of growth.
- There is a commitment to increase the number of health visitors by 2015.
- Haringey has a high trajectory of growth due to vulnerability in the population and growth.
- Expected growth in Haringey is 50 Health Visitors. This is a welcome but challenging growth target.
- There are implications on the Healthy Child Programme and work is being done to consider what this means in terms of shared outcomes with partners.
- A teenage mum's programme running in the borough has been very successful.
- The challenge with increasing the numbers of health visitors is that there are very few available health visitors, particularly in London.
- Whittington Health is working with NHS London, the Deanery and Health Visiting Training services.
- Health Visitors are trained nurses who then undertake a year graduate training to become a Health Visitor.
- Health Visitor students undertake a significant amount of training in practice, for which they need support in place.
- With a depleted workforce and a population with high vulnerability it is challenging to provide the necessary level of support to students.
- The lack of experienced Health Visitors numbers has an impact on newly qualified Health Visitors who need support to make sure they are confident and safe.
- A Health Visitor model needs both new and experienced Health Visitors as part of it.
- Some retired Health Visitors so come back into practice with flexible arrangements.
- Haringey previously worked to 28 days for New Birth Visits. This was agreed locally with Commissioners. Nationally the target is 14 days, which is now worked to.

- Whittington Health is currently at the baseline amount of Health visitors, but has not started to recruit to expansion figures. This should be an additional 14 Health Visitors by April, but is not achievable at this stage.
- Processes are currently being looked at to make them more efficient and agency staff are being used where they are needed.
- Work has been done on the information flow across the whole pathway between agencies and the format of the information. This has resulted in significant improvements on performance, as reflected in the chart at the end of the submitted report.
- A big piece of work still to be done is considering the communication with midwifery at Whittington Health and North Middlesex Hospital.
- The expansion of Health Visitors links to the work currently being done around the 54,000 project.

Discussion points noted include:

- There are not enough Practice Teachers in Haringey. Therefore Mentors have been put in place that are 'long-armed' by Practice Teachers. This is supported by strong development and training support.
- The shortage of Health Visitors is a national issue.
- There is a national push on a Return to Practice programme to get previous Health Visitors back into jobs.
- 20 new students are planned across Haringey and Islington over the next 2 years. This will be alongside the additional Health Visitors.
- It will take a couple of years to build up and embed a service of experienced Health Visitors.
- Interpretors are used when there are language barriers, this can cause an additional challenge if there are delays stemming from this.
- Whittington Health do work with local communities, however it is not always appropriate to use local community members as translators due to a variety of reasons e.g. the subject matter, cultural sensitivities and appropriateness, governance, confidentiality etc.
- The performance rates in the report relate to the whole borough. Differences in performance relate to where they are vacancies.
- Agency staff do not always have the local knowledge which is needed; however they do try and work with the same Health Visitors to maintain knowledge gained.
- Islington has about the same numbers of Health Visitors as Haringey but with a smaller population. There are more Health Visitors per baby in Islington.

The Panel congratulated Whittington Health on the significantly improved performance around New Birth Visits.

Agreed:

Whittington Health would come back to the Panel with information on the activities Health Visitors undertake at Children's Centres.

LC37. CLINICAL COMMISSIONING GROUP UPDATE

The Panel received an update from Sarah Price, Chief Officer and Dr Pelendrides, Chair.

Points noted include:

- The CCG is currently preparing for authorisation.
- An Authorisation visit took place in November; this was conducted by a group of external peers who had no experience of Haringey.
- There are a few areas left which they need to reassure Commissioners on by the end of January (12 out of 117).
- Final result on authorisation will be available in February and will include any conditions which are attached to the authorisation.
- They need to achieve a balanced budget and currently aim to do this by the end of 2013/14. The deficit has gone from £17million last year to £7 million.
- The Integrated Care Strategy is a current area of focus which is being worked on with the Local Authority.

Discussion points noted include:

- Concerns about whether the savings which have been made are sustainable or whether they will come back in more acute forms.
- The anticipated overspend this year is mainly due to the acute sector.
- There is currently a 'cap and collar' contract in place with the North Middlesex Hospital. This will end at the end of the financial year.
- There is a lot of pressure to change services and bring them closer to people's homes.
- Changes are about transformation rather than stopping services being provided.
- The Integrated Care re-ablement pilot which has been running in the North East of the borough is being extended to the central cluster. This pilot includes a weekly teleconference with all practitioners about a persons care and to plan their next phase of care.
    - The next stage is to find people at risk and intervene before they go to A&E.
- There is a link between long term conditions and mental health.
- Mental health is a priority in the Health and Wellbeing Strategy and work is being done around Long Term conditions.
- NCL are looking into concerns raised about Harmoni.
- NCL are the contract holders and are in the process of procuring a new Out of Hours service to begin in April. This may or may not be Harmoni.
- Noted that Helena Kania, LINk, sits on the Out of Hours monitoring group and that Harmoni are currently performing at 100%.
    - There are concerns that Harmoni is being taken over by Care UK, who do not have as good performance statistics.
- The Primary Care Strategy work includes looking at improving access to GPs more generally. The CCG is working with North Middlesex and Whittington Health on Urgent Care Centres.
- GP appointments are not directly in the control of the CCG.
- The LPC noted that they have experience of people saying that they are unable to get a GP appointment and therefore intend to go directly to A&E.

- The Panel queried how many GP practices were still operating 0845 phone numbers, they were informed that this is not under the control of the CCG. However, there was anecdotal evidence that the number was decreasing.
- The CCG is working with the MHT to look at improving access for GPs to mental health care services. This is a prioritised piece of work over the next few months.
- GPs do not always feel confident managing low level mental health needs as they are unsure that they will get the support that they need.
- The Health and Wellbeing Board is looking at welfare reform changes and their impact alongside work on health inequalities.

LC38. HEALTH AND WELLBEING BOARD UPDATE

The Panel received a verbal update on the Haringey Health and Wellbeing Board.

Points noted include:

- The Health and Wellbeing Board takes a strategic approach.
- It is a forum for discussion and challenge and bringing peers together.
- It has produced the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy along with its delivery plan.
- It is supporting the Clinical Commissioning Group authorisation process.
- In terms of Governance, the Act includes a minimum membership of:
    - Elected member of the local council
    - Director of adult services
    - Director of children's services
    - Director of public health
    - Member of the local Healthwatch
    - Representative of Clinical Commissioning Group
- Regulations are due out this month.
- Regulations are expected to show exemptions to Section 102 (Local Government Act 1972), political proportionality.
- Haringey Shadow Health and Wellbeing Board has been operating on a small membership basis but with discussions still ongoing about the final membership. It currently includes:
    - 3 Elected Members
    - 1 Local Involvement Network representative
    - Director of Adults and Community Housing
    - Director of Public Health
    - Director of Children and Young People
    - 4 Clinical Commissioning Group representatives (Chair, Chief Officer, GP and Lay member).
- The focus thus far has been on organisational development (alongside the Health and Wellbeing Strategy and Delivery Plan and the Joint Strategic Needs Assessment). A priority area has been consider from each of the Health and Wellbeing Strategy objectives for example a session has been held on each of the following:
    - Antenatal care;
    - Alcohol reduction;
    - Severe and enduring mental health; and
    - Teenage pregnancy.

- A Haringey Health and Wellbeing Board website will be up and running by April and this will include minutes of the board.
- The Health Select Committee has quoted the Haringey Health and Wellbeing Board as an example of best practice.
- There have only been two meetings held of the shadow Health and Wellbeing Board attended by just members of the Board; all other meetings have included various community members and council Officers.

Discussion points noted include:

- The Panel wished to know what information had been presented to the Health Select Committee on the Haringey shadow Health and Being Board.
- The Panel wished to know why the minutes of the shadow Health and Wellbeing Board would not be available any earlier than April.
- The Panel raised concerns that they need to know more about what the shadow Health and Wellbeing Board has been doing, and the future arrangements.
- The Panel were informed that the minutes of previous meetings would all be made available when the website goes live.
- With reference to the involvement of the voluntary and community sector, and their representation on the Health and Wellbeing Board the Panel were informed that this was still under discussion, however they would be involved in task groups which would feed into the Health and Wellbeing Board.
- The Cabinet Member agreed to get back to the Panel with further information on consultation which is due to take place ahead of the Terms of Reference and arrangements being agreed by Cabinet in March.
- There will be an announcement on the Haringey website when the Health and Wellbeing Board website goes live.
- Health and Wellbeing Boards do not need to go through the same kind of authorisation process as Clinical Commissioning Groups.
- Health and Wellbeing Boards are held to account by Overview and Scrutiny, in Haringey this would be the Adults and Health Scrutiny Panel.
- The previous Health and Wellbeing Partnership Board was a unique forum in which both commissioners and providers got together. The Panel raised the query as to where this void could be filled.
    - It was noted that OSC had previously held meetings with commissioner and providers of health to share information and the possibility of the A&HSP doing this was raised.
- The Co-optee member from the Forum for Older People wished it noted that she did not feel satisfied that she had enough information on the Health and Wellbeing Board to adequately inform the HFOP.
- The Panel commented that overall the work of the shadow Health and Wellbeing Board sounded positive, and it was therefore puzzled as to why it was not able to get more information on it.

With reference to Healthwatch, the Cabinet Member informed the Panel that discussions are taking place on all options; including a possible fall back option should there not be a provider in a position to be put in place.

Agreed

- The Cabinet Member would provide the Panel with information on the planned consultation arrangements for the Health and Wellbeing Board arrangements prior to approval at Cabinet in March.
- The Adults and Health Scrutiny Panel would consider holding information sharing meetings with providers and commissioners on a regular basis to ensure they are able to maintain an overview of changes and key issues in the local health environment.

LC39. RECOMMENDATIONS OF BUDGET SCRUTINY

The Panel approved the final recommendations of their budget scrutiny work, to be referred to the Overview and Scrutiny Committee on 22nd January for approval and referral to Cabinet.

LC40. MINUTES OF PREVIOUS MEETINGS

Approved.

LC41. AREA COMMITTEE CHAIRS FEEDBACK

None received.

LC42. PANEL WORK PROGRAMME

The Panel made the following changes to the proposed agenda for their meeting on 2nd April:

- Whittington Health Foundation Application update – the Panel wished for this to be a written update.
- Barnet, Enfield, and Haringey Clinical Strategy – the Panel requested a written briefing in advance to enable them to ask questions at the meeting.
- Cabinet Member questions – The Panel wished to invite Cllr Vanier to the meeting for Cabinet Member Questions as it was agreed that this would take place twice per municipal year.

The Panel agreed to consider the Integrated Care Pilot which has been running in the North East of the borough as one of their projects. The Panel requested that this is scoped with the aim of gaining service user perspectives of what worked well and what areas could work better with a view to making recommendations and lessons learnt which would be valuable to future services based on this model.

Agreed:

- The Chair and Senior Policy Officer would discuss the agenda further to ensure it is manageable.
- The Senior Policy Officer would scope the Integrated Care Pilot project.

LC43. COUNCIL FORWARD PLAN

The Panel requested to consider the Health and Wellbeing Board paper due at Cabinet in March (Establishment of New Health and Wellbeing Board –

Functions/remit and Governance arrangements) as pre-decision scrutiny prior to it being considered by Cabinet.

The Panel discussed their input into the procurement process and felt that in future it would be helpful for them to consider service specifications (where relevant) when a large contract was being tendered.

Agreed

- Senior Policy Officer would speak to relevant Officers to see when this paper would be available and arrange a special Panel meeting should this be necessary (and in line with the Overview and Scrutiny Protocol)

LC44. DATES OF FUTURE MEETINGS

2nd April, 2013, 6.30pm

LC45. NEW ITEMS OF URGENT BUSINESS

None

Cllr Gina Adamou

Chair

This page is intentionally left blank