

At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on TUESDAY, 6TH SEPTEMBER, 2011 at 5.00 p.m.

Present:-

Councillor Walker in the Chair

Councillors Fletcher, Francis, Hall, F. Miller, Shattock, Snowdon, Waller and N. Wright.

Also in Attendance:-

Councillor Allan	-	Portfolio Holder for Health and Well-Being
Ms. Karen Brown	-	Sunderland City Council
Ms. Victoria Brown	-	Age UK
Ms. Jean Carter	-	Sunderland City Council
Ms. Maureen Crawford	-	Sunderland Teaching Primary Care Trust
Ms. Kelly Davison-Pullan	-	Sunderland City Council
Dr. John Dean	-	Links Organisation
Mr. Philip Foster	-	Sunderland City Council
Ms. Carol Harries	-	City Hospitals Sunderland NHS Foundation Trust
Ms. Claire Harrison	-	Sunderland City Council
Ms. Ailsa Martin	-	Sunderland Carers Centre
Ms. Ailsa Nokes	-	NHS South of Tyne and Wear
Mr. Ralph Price	-	Links Organisation
Mr. Neil Revely	-	Sunderland City Council
Mrs. Christine Tilley	-	Sunderland City Council

Welcome and Introductions

The Chairman welcomed everyone to the meeting and invited them to introduce themselves.

Apologies for Absence

Apologies for absence were submitted to the meeting on behalf of Councillors Maddison and Padgett and Mr. Russell Patton.

Minutes of the Last Meeting of the Committee held on 19th July, 2011

1. RESOLVED that the minutes of the meeting of the Committee held on 19th July, 2011 be confirmed and signed as a correct record.

Declarations of Interest (including Whipping Declarations)

Councillor Shattock declared a personal interest in item 7 on the agenda as a parent of a child with a learning disability.

Response from Cabinet – 22nd June, 2011 – Policy Reviews – Malnutrition and Dehydration in Hospitals and Health of the Ex-Service Community

The Executive Director of Health, Housing and Adult Services and the Portfolio Holder for Health and Well-Being submitted a joint report (copy circulated), providing feedback from the Cabinet meeting held on 22nd June, 2011, which considered the Health and Well-Being Scrutiny Committee's Policy Review Final Reports into Malnutrition and Dehydration in Hospitals and the regional Policy Review of the Health of the Ex-Service Community.

(For copy report – see original minutes).

The Chairman advised that the Portfolio Holder had been invited to attend for this item of business and invited Councillor Allan to report to the Committee.

Councillor Allan advised that the Cabinet had welcomed the Policy Reviews into Malnutrition and Dehydration in Hospitals and the Health of the Ex-Service Community and thanked the Scrutiny Committee for the work it had undertaken.

Councillor Allan advised that the Cabinet had endorsed the Scrutiny Committee's recommendations and progress towards completion of the actions arising from the investigations would be monitored through an Action Plan.

The Chairman advised that a revised copy of Appendix A, the Action Plan in respect of the Policy Review into Malnutrition and Dehydration in Hospitals had been circulated around the table.

In response to Councillor Shattock, Ms. Karen Brown, Scrutiny Officer advised that the Committee would receive six monthly monitoring reports in respect of the policy reviews.

Members of the Committee particularly welcomed the introduction of the red tray system to identify those patients who are in need of greater assistance.

The Chairman commented that he was pleased to see that City Hospitals Sunderland had taken on board all of the Scrutiny Committee's recommendations from the policy reviews and stated that he was very pleased at how well the work was progressing. On behalf of the Committee, the Chairman thanked City Hospitals Sunderland for their co-operation.

The Chairman thanked the Cabinet for progressing the recommendations in respect of the policy review into the Health of the Ex-Service Community.

Mr. Neil Revely, Executive Director of Health, Housing and Adult Services advised the Committee that former Councillor Graham Hall was continuing to progress the outcomes of the Policy Review into the Health of the Ex-Service Community.

Full discussion having taken place on the report, it was:-

2. RESOLVED that the proposed actions detailed with the Action Plans be noted.

Policy Review – Monitoring of Recommendations

The Chief Executive submitted a report (copy circulated) providing the Scrutiny Committee with progress in relation to the Home Care Provision, Dementia Care and Health Inequalities Policy Review Recommendations.

(For copy report – see original minutes).

Ms. Karen Brown, Scrutiny Officer reported that 100% of the actions in respect of the Policy Reviews of Home Care Provision and Dementia Care had been achieved and she requested the Committee's approval to sign off these policy reviews as being delivered and for the Committee to receive a report back on a six monthly basis in future.

The Chairman highlighted that the Policy Review into Tackling Health Inequalities remained to progress and commented that there was a need to ensure the toolkit was pushed along.

Following some discussion it was:-

3. RESOLVED that the progress in relation to the Home Care Provision, Dementia Care and Health Inequalities Policy Review recommendations be noted and that the Committee continue to monitor the situation with standardised six monthly reports to be presented to the Committee with a view to looking to sign off the Policy Reviews into Home Care Provision and Dementia Care the next time the report is submitted.

Performance Report Quarter 4 (April 2010 – March 2011)

The Chief Executive submitted a report (copy circulated) providing the Committee with a performance update against the former national indicators relating to the period April 2010 to March 2011.

(For copy report – see original minutes).

Ms. Kelly Davison-Pullan, Lead Officer for Corporate Performance, briefed the Committee on the report and highlighted in relation to Self-Directed Support that there had been a significant improvement in the percentage of people receiving Personal Budgets. In relation to Supporting People to Live Independently, Ms. Davison-Pullan pointed out that there had been an administrative change in classification rather than deterioration in performance against the indicator in that cases of people receiving small items of previously maintained equipment are no longer classed as having “ongoing care plans” and therefore no longer included in the figures for the number of people supported to live independently.

In relation to Health Inequalities, Ms. Davison-Pullan also drew attention to the rate of self-reported smoking quitters which had declined when compared to 2009/10. With regards to Sport and Leisure, the percentage of adults participating in sport and physical activity had increased in Sunderland since the last survey from 19.5% to 22.5% and Sunderland performance levels were higher than the average scores across Tyne and Wear.

In relation to supporting people to live independently, Members of the Committee commented that it was important to ensure that the services and support people needed to enable them to live independently were in place and that there was not an over reliance and pressure on relatives to provide this support to enable a family member to live at home.

In response, Mr. Philip Foster advised that the intention of personal budgets was to provide people with the means to shape the care and services they needed for themselves with the aim of enabling more people to live at home rather than receiving care in the traditional way and living in institutions.

Mr. Foster advised that in relation to Personal Budgets there was no limit on the number of hours of care a person received. The person was assessed in order to determine their care needs and a Personal Plan and Budget determined which could be taken as direct finance, as a Direct Payment to help the person purchase their own care or its equivalent in services which the Council would provide to help meet their needs. It was the person who decided how the services they needed were delivered and thus they had greater choice and control in shaping the services they wanted.

Ms. Ailsa Martin, Sunderland Carers Centre commented that self assessment needed to be supported. The process was not consistent and universal and there had been issues with information not being available or accurate. Ms. Martin felt that there was a mismatch between some of the theory around choice and the practice and that although advances were significant there were still issues to be addressed.

Councillor N. Wright enquired whether there had been a change of policy with regards to meals at home; an issue which the Scrutiny Committee had become involved in a few years ago and which had resulted in a change in policy direction.

Councillor Shattock added that meals at home was a very important issue for the Committee and that Members needed to know what was happening in this respect.

The Chairman requested that information in respect of the Council's policy on meals at home be reported back to the Committee as soon as possible.

Councillor Shattock also enquired what changes in services and personnel were being made at Fulwell Day Centre. She commented that residents were telling Members that changes were being made however Councillors were not being kept informed by the Service Directorate of the changes through the Sunderland Way of Working in relation to what services were being delivered by the Directorate and where they were being delivered from.

Mr. Foster advised that Fulwell Day Centre was included in the area which he managed and he was not aware of any changes in service delivery. However, he felt there was a need for the Directorate to work more closely with the Committee to explain the Personalisation agenda and inform Members of the changes and menu of different options available to people to enable them to get the care they needed and improve choice and control for service users.

Full discussion having taken place it was:-

4. RESOLVED that:-

- (i) the report be noted and a briefing be provided for Members of the Committee on the services offered and the changes being made as a result of the Personalisation agenda; and
- (ii) arrangements be made for the Committee to visit a number of facilities including Fulwell Day Centre and Grindon Mews to see the services being offered.

The Chairman thanked Mr. Foster for his contribution to the discussion on the report.

Provision of Social Care for Adults with a Learning Disability

The Chief Executive submitted a report (copy circulated) providing an update to the Committee on the future provision of social care for adults with a learning disability following the announcement that the provider of the service procured by the Council, had gone into administration.

(For copy report – see original minutes).

Mr. Philip Foster, Head of Care and Support advised the Committee that he was pleased to report that a proposal had come forward to form a Local Authority Trading Company managed by the Council which would provide the Social Care Services for adults with a learning disability. Mr. Foster advised that carers of the people living in the homes had been briefed on developments and would be involved a great deal more in how the homes operated in the future. The Council had consulted with Sunderland Carers Centre which was pleased that the Council was proposing to take control of the homes and manage the services.

Ms. Ailsa Martin, Sunderland Carers Centre commented that since the meeting at which the Carers Management Board had been set up, the Health, Housing and Adult Services Directorate had worked hard to inform carers, move attitudes over the short term and assure those involved that there would be no change to the standards of care and support provided to people. This had resulted in people feeling positive about the future and that something very bad had been turned into something very positive. Ms. Martin advised the Committee that initial discussions had been held with the Council about future arrangements including exploring social enterprise options.

Mr. Foster stated that the Local Authority Company had been established in order to continue to provide the services currently provided by Choices until a medium to longer term solution could be determined and allow a period of stability for the users of the service, the staff and the families and carers. Mr. Foster reported that the Committee would be regularly updated with developments on the future provision of the service.

5. RESOLVED that the report and the information provided at the meeting, as detailed above, be received and noted.

Policy Review – Rehabilitation and Early Supported Discharge from Hospital – Scene Setting Report

A joint report of the Executive Director of Health, Housing and Adult Services and Sunderland Teaching Primary Care Trust (copy circulated), was submitted providing detailed service information to begin the Scrutiny Committee's investigation of services in support of the rehabilitation and early supported discharge from hospital policy review.

(For copy report – see original minutes).

Ms. Jean Carter, Deputy Executive Director of Health, Housing and Adult Services and Ms. Ailsa Nokes, Strategic Lead for Long Term Conditions, NHS South of Tyne and Wear, gave a detailed presentation to the Committee setting out

- the policy context;
- the principles of discharge arrangements;
- the definition of a delayed discharge;
- factors causing delays;
- Sunderland data detailing delayed discharges for the period August 2010 to July 2011;
- improvement work already underway;
- strategy development; and
- next steps for the review.

Ms. Nokes advised the Scrutiny Committee that the next steps included setting up the Sunderland Intermediate Care and Reablement Strategy Group and two Working Groups in relation to Delayed Discharge and Reablement and Accommodation. She added that she was of the opinion that the Scrutiny Committee's policy review was very positive and would help inform plans for 2012/13 and help to identify issues which had not previously been considered.

Members welcomed the presentation commenting generally, that it had been very informative and specifically, that

- the idea that discharge was a process rather than a date was to be supported;
- people should try to plan for admission into hospital; and
- it was important that any support services required following discharge were set up and therefore that collaboration between agencies was effective.

The Chairman having commented that he was hopeful the Committee would contribute positively to the policy review; it was:-

6. RESOLVED that the information contained in the report be received and noted and used to launch the policy review.

Policy Review – Appointment of Co-opted Members

The Chief Executive submitted a report (copy circulated) seeking the Scrutiny Committee's endorsement to the nomination of representatives on the Health and Well-Being Scrutiny Committee for a time limited project in relation to Rehabilitation and Early Supported Discharge from Hospital.

(For copy report – see original minutes).

The Chairman advised that four nominations from three organisations had been received as detailed at paragraph 4.2 of the report. He welcomed three of the nominated individuals who were available to attend the Scrutiny Committee meeting that evening.

7. RESOLVED that the four nominations be endorsed by the Committee and referred to Council for appointment to the Scrutiny Committee as outlined in the report accordingly.

Annual Work Programme 2011-12

The Chief Executive submitted a report (copy circulated) appending an updated copy of the Committee's work programme for Members' information.

(For copy report – see original minutes).

Ms. Claire Harrison, Scrutiny and Area Support Officer presented the report.

8. RESOLVED that the contents of the report be received and noted.

Forward Plan – Key Decisions for the Period 1st September, 2011 to 31st December, 2011

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider the Executive's Forward Plan for the period 1st September, 2011 to 31st December, 2011.

(For copy report – see original minutes).

Ms. Claire Harrison, Scrutiny and Area Support Officer presented the report to the Committee.

9. RESOLVED that the contents of the report be received and noted.

The Chairman announced that Ms. Harrison was leaving the Council to go back to University and on behalf of all Members he thanked Ms. Harrison for the work she had done and wished her well for the future.

Members of the Committee added their best wishes to those of the Chairman. The Chairman then closed the meeting.

(Signed) P. WALKER,
Chairman.

END OF LIFE FACILITIES**REPORT OF THE CHIEF EXECUTIVE****1. Purpose of Report**

- 1.1 To provide progress to date, highlight the current priorities and timescales and request the support of Health Scrutiny Members in taking forward a project to secure a sustainable future proofed hospice facility within Sunderland.
- 1.2 Mark Girvan, Project Manager and Sheila Cooper, Strategic Lead Planned Care from the NHS South of Tyne & Wear will be present at the meeting to provide a briefing to members.

2. Background

- 2.1 Members were informed in July 2011 that the PCT was starting to consult on proposals regarding a new hospice facility to be provided in Sunderland to replace St Benedicts at Monkwearmouth.
- 2.2 The project required that an Outline Business Case (OBC) was submitted to the Strategic Health Authority (SHA) during the summer. A Full Business Case was subsequently developed to be submitted to the SHA following consultation with overview and scrutiny.
- 2.3 Members, having seen the outline proposals in July were supportive of the business case and were supportive of proceeding towards securing a fit-for-purpose facility.

3. Project Objectives

- 3.1 The Full Business Case (FBC) is attached to this report. The proposed development is expected to deliver the following objectives:
 - a) To provide a sustainable palliative care facility for the residents of Sunderland
 - b) To future proof service delivery for specialist palliative care services
 - c) To ensure that the facility is able to meet demand over the next 10 years, taking into account national, regional and local priorities
 - d) To develop a facility which is fit for purpose and able to provide first class hospice facilities
 - e) To provide patient access to services (inpatient and outpatient) within a fit for purpose facility
 - f) To improve the quality of hospice premises in Sunderland

- g) To provide specialist services which are able to facilitate rapid discharge from hospital for patients at the end of life.

4. Conclusion & Recommendations

- 4.1 NHS South of Tyne and Wear are committed to taking this project forward in collaboration with all partner organisations across health and social care. Sunderland Primary Care Trust (PCT) has committed to funding a new purpose built facility which will provide access to appropriate facilities and the physical environment which is conducive to this patient group.
- 4.2 The Scrutiny Committee has received the FBC for consultation purposes, comment and support in going forward with the project. Members are asked to consider the proposals and provide comments at the meeting.

5. Background Papers

Outline Business Case – End of Life Facilities

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Sunderland

Teaching Primary Care Trust



FULL BUSINESS CASE

ST BENEDICT'S HOSPICE

September 2011



'How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services'
(Department of Health, End of Life Care Strategy 2008)

EXECUTIVE SUMMARY

1 Introduction

This document is a full business case (FBC) to develop a new purpose built hospice facility in Ryhope. The facility will provide sustainable accommodation for Sunderland Integrated Specialist Palliative Care services, including the provision of 14 inpatient beds. The proposal has the support of the Sunderland Teaching Primary Care Trust (TPCT) Board, Sunderland Clinical Commissioning Group and the Local Authority.

The business case has been developed in full collaboration with partner organisations across the city, including South Tyneside NHS Foundation Trust, host to community services for Sunderland and Sunderland Local Authority. The Project Board which has been established to oversee the development of this case has begun the consultation process with existing service users and has a programme of engagement exercises in place to ensure consultation is continued throughout the project.

2 Background

Palliative care within Sunderland is currently provided through an integrated model of specialist services based within St Benedict's Hospice. The establishment of services within this model includes;

- 12 inpatients beds, (Including 2 three bed, shared wards)
- Day Care
- Outpatient facilities
- Lymphoedema
- Community Specialist Palliative Care Nursing team
- Out of hours palliative care team

The integrated model for service delivery helps support Primary Care to provide sustainable care in the community and reduce the need for admission to Acute Care. Whilst its allied services provide access to specialist support in the community the inpatient unit provides care for patients with particularly complex needs outside of secondary care.

St Benedict's has been praised for providing first class specialist care to one of the most vulnerable patients groups (Marie Curie, Delivering Choice Programme Phase I report 2008). However, despite significant levels of investment by the Board of Trustees, the physical building remains not fit for purpose. The hospital in which the hospice is located is over 70 years old and does not provide the appropriate environment for palliative care patients or the opportunity for redevelopment to the required standard. This full business case proposes to fund a new purpose built facility which provides access to appropriate facilities and a physical environment which the patients and the service provision deserves.

The overriding aim of this project is to provide a sustainable, state of the art facility which is able to provide a range of specialist palliative care services to the residents of Sunderland. The development of this facility will give consideration to future proofing the

delivery model in order to ensure it is able to respond to and accommodate the anticipated demand for palliative care services now and in the future.

The drivers for this project include:

- Continued uncertainty with current estate facilities
- Current estate facilities are dated and not fit for purpose
- Secured budget to fund a new build (2010/13)
- The need to promote privacy and dignity at the end of life
- National (End of Life Strategy 2008) and regional emphasis on improving choice at the end of life and establishing services which are able to maintain patient care in the community if that is their preferred place of care.
- National and local direction towards care provision closer to home (Our health, our care, our say: a new direction for community services)

3 Strategic Case

This section sets the investment proposal in its strategic context describing the national policies and local initiatives that have influenced the TPCT's strategic direction in general and the strategy to develop a purpose built facility in particular.

The hospice facility is fundamental in the realisation of national policy to deliver a range of services in community settings to support patient choice. The hospice facility will house the services which form Sunderland's integrated service for specialist palliative care and will ensure these services meet future priorities for service delivery and are able to meet the increase in demand from the growing ageing population.

The new build will provide accommodation which is functional, fit for purpose, sustainable and focused on meeting patient and clinical need.

This case will provide assurance that the proposal is in accordance with National, Regional and Local strategies.

4 Economic Case

Economic considerations include:

- Capital funding for the project has been identified and provision made by Sunderland TPCT
- Within the 2011/12 Strategic Plan for Sunderland TPCT, revenue investment funding was identified to support the commissioning intention to re-provide St. Benedict's hospice
- The preferred site is already the property of Sunderland TPCT, releasing a cost saving of circa £1 million
- The proposed site will be co-located with an existing 24 hour facility providing the opportunity to share support services

5 Involving the public

The TPCT and the Project Board have carried out an extensive engagement programme and are committed to consulting, engaging and involving the residents of Sunderland in achieving its core aims throughout the project. This philosophy has been a significant part of previous, successful capital projects.

- A focus group was held with existing service users (Patients and families) to identify what their priorities would be when considering the selection of the new hospice site. Information collated was used to determine questions for consideration in the options appraisal and their weighting scores
- Staff, patients and carers from the hospice inpatient unit were asked to list their 'vision' for a new hospice build. They were specifically asked to include the non tangible (softer issues); their thoughts and feelings of what the hospice would represent
- 2 patient 'design champions' were included in the sub group who reviewed the selection of architects as part of a design competition
- A paper has been submitted to the Sunderland Local Engagement Board with an agreement to attend their next meeting to present a progress update
- A detailed programme of consultation exercises has been developed in collaboration with the TPCT's PPI engagement officer
- Attendance at an open event of Houghton Primary Care Centre is providing an opportunity to carry out significant public consultation and engagement
- Confirmation of preliminary support in principle from Sunderland Local Authorities Overview and Scrutiny Committee

6 The Preferred Option

A full options appraisal was carried out on all feasible site options which identified Ryhope as the preferred location. NHS South of Tyne and Wear (SoTW) already own the estate which is located on the Southern perimeter of Cherry Knowle hospital. The wider hospital site is owned and controlled by NTW who are in the process of redeveloping the whole estate through an initiative called 'Pride- Ryhope'.



Whilst the services and facilities will not be co-located in the same buildings, the NTW redevelopment will provide the opportunity for economies of scale throughout the operational life of the building via ongoing shared service arrangements.

The hospice will be a detached building of circa 3100 m². It will include 14 single inpatient beds along with a number of additional clinical and administrative rooms to support the delivery of the integrated model for palliative care services. The proposed hospice also includes a large regional educational facility to support the delivery of training for specialist and generalist staff to promote more choice and better care for patients.

The FBC focuses on creating a facility which is 'fit for purpose', improves accessibility and capacity whilst supporting a future proofed service delivery model that enhances patient choice at the end of life.

The services currently provided by the existing staff are recognised as exemplar within a facility that is not 'fit for purpose' and poses significant privacy and dignity issues for end of life patients.

The decision to increase the bed capacity within the inpatient unit from 12 to 14 was informed by a comparison of population predictions over the next 10 years against the recommended average number of hospice beds from the National Council of Palliative Care. (5 per 100,000 head of population, National Council of Palliative Care).

Currently the 12 bed unit runs at 80% utilisation with its two 3 bedded wards. Moving to single bedrooms will allow an increase to 85% utilisation providing a growth in patient access by 27%.

Consideration has been given to the demand from neighbouring areas of Sunderland, in particular Gateshead and South Tyneside, however service provision appears to be adequate and sustainable within these localities and the recommendation is for the hospice to predominantly serve the residents of Sunderland.

A review of public and private access to the site demonstrated current ease of access that will be further increased through the instillation of a new major road linking Ryhope to Doxford Park. The availability of land will also provide the opportunity to include sufficient dedicated car parking.

7 Financial Case

The financial appraisal is predicated on the recommended option 4 to move to a new purpose built facility. The conclusion of the economic and financial appraisal confirms that a purpose built facility in Ryhope represents the most effective use of NHS resources as it delivers the greatest range of non-financial benefits for the capital investment.

8 Management Case

The TPCT has put the same project management structure in place to oversee this project as was implemented in the recent development of 4 Primary Care Centres. A number of roles will be carried out by the same TPCT staff, allowing for continuity which will be advantageous to project planning and implementation.

The project sponsor leads a multi-disciplinary, multi-agency project team reporting to the project lead who is accountable to the Sunderland TPCT Board. The project manager for construction acts as the interface between the project team and the Principal Supply Chain Partner (PSCP) and controls and oversees the performance of the contractor on the construction of the project.

9 Conclusion

The new hospice will provide one of the most vulnerable patient groups with access to specialist services in a first rate, fit for purpose facility which is in keeping with NHS Sunderland TPCTs ISOP and estates strategy. The range of services included within the integrated model will help ensure care is available in community settings outside of hospital and supports the delivery of choice at the end of life.

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1 INTRODUCTION

This section outlines the purpose of the document, summarises the project proposal explaining the process that has been undertaken to produce the document and demonstrates the TPCTs past achievements in related areas illustrating its readiness and capabilities to utilise investment.

1.1 Purpose of the Full Business Case

This document is a full business case (FBC) for the provision of a sustainable, state of the art specialist facility which is able to provide a range of palliative and end of life care services to the residents of Sunderland.

The case includes an outline of the strategic drivers behind the proposal and describes how the proposal supports the delivery of national, regional and local strategies and initiatives. Several options for both the delivery model and site locations are included along with the outline of an options appraisal which identifies the preferred option.

The FBC will demonstrate that the project to develop a new hospice facility aligns with organisational strategic aims and objectives, is economically sound and financially viable. It will provide assurances that the project team have the necessary skills, experience and stakeholder engagement to ensure that the process will be well managed and executed in full accordance with the proposed plan.

1.2 The Service Proposal in Summary

Often the perception of a hospice is one of a place of death. However, the aim of a hospice is to provide supportive high quality physical, psychological, social and spiritual care for both patients and their families. This includes supporting complex physical and social needs with multidisciplinary holistic care, both within the hospice itself and within the local community. Whilst the inpatient unit provides access for patients with particularly complex needs, the wider establishment of services in the integrated model provides access to specialist services in a community setting, helping to sustain care at home and avoid unnecessary admission to Acute Care.

St Benedicts Hospice has provided specialist palliative care to the people of Sunderland and the surrounding area since 1984. The existing hospice facility is set within the grounds of Monkwearmouth Hospital a site owned and controlled by Northumberland Tyne and Wear NHS Trust (NTW). The arrangement for this agreement is through an annual leasing arrangement.

In 2008, SoTW were informed by NTW Trust that the organisation was engaged in discussions around proposals to redevelop all or part of the Monkwearmouth site, including implications for the building housing St Benedict's Hospice. The plans include a reduction of clinical activity and site development to provide administrative accommodation. The reduction of this clinical activity has the potential to impact on the availability of shared services and increased running costs in the future for St Benedict's.

There is wide spread recognition that services provided through the hospice are exemplary. Within a recent region wide review of Palliative Care Services (2009 Marie Curie Delivering Choice Programme Phase I review) the hospice was highly commended for its service provision and delivery. The Board of Trustees play a very active role and

have donated significant funds to refurbish the interior of the facility, however, the physical building in which the hospice is located is over 70 years old and provides limited opportunity for re-development, modernisation or expansion. There is a recognition that access to facilities and the physical environment of the hospice are in need of improvement and in parts are not fit for purpose.

Whilst staff have made best use of the space available significant problems still remain:

Patients and carers;

The inpatient unit has two 3 bedded bays which are inappropriate for this client group with specific reference to privacy and dignity



- The use of single sex wards creates issues in relation to bed blocking
- The available space makes it impossible to comply with the latest bed spacing requirements in a multi bed ward and has implications for infection control



Due to lack of space on the ward a sofa bed in the interview room/toilet shower is currently used by relatives wishing to stay overnight.



- Patient flow is fragmented due to an inability to co-locate services. For example, the lymphoedema clinic is on a corridor external to the hospice facility



The hospices front entrance can only be accessed by patients who are able to walk or are in a wheelchair. Patients on stretchers enter via a side entrance. The lift can only accommodate a limited range of wheelchairs

- Access to the day care facility is at the rear of the building through a car park which is entered from a narrow side road with restricted access for ambulances



- The treatment rooms are restrictive both in terms of wheelchair access and ability to carry out some procedures, in particular those patients with significant lower limb problems

The lymphoedema clinic is provided in a small footprint with the waiting area, including reception directly outside of 2 small treatment rooms. Privacy and dignity issues exist due to this close proximity.





The limited clinical room size means that clinical records and stores need alternative storage. These are co-located behind the reception desk in the small waiting area which is counter intuitive to a smooth work flow and could undermine the patient experience

- The entrance to day care is shared with the hospice mortuary with patients being exposed to the collection of deceased inpatients.
- The outdoor patient garden is immediately overlooked by neighbouring residential properties



Staff;

The limited size of the education department severely restricts the ability to provide a full educational programme training e.g. issues around transfer of sound



- The education facility is immediately adjacent to the outpatient ward creating specific issues around patient experience and delivery of training



There is severely limited space for the provision of both complementary therapies and day care



- The 3 specialist palliative care consultants are currently sharing one small office
- The disparate layout of the hospice footprint is counter productive to patient flow and dis-joints service provision



With an ageing population and the inherent burden of health care, development is required to ensure the hospice facility is fit for purpose and provides one of the most vulnerable patient groups access to first rate facilities in Sunderland.

Given the ongoing risk in relation to the sustainability of accommodation and restricted ability to develop the current site, Sunderland TPCT committed to completing a review of options. This was to ensure that a sustainable, future proofed, fit for purpose hospice facility was secured (Sunderland Integrated Strategic Operational Plan (ISOP) 2011/15, Sunderland TPCT Estates Strategy 2010/2015). The work included anticipated demography and epidemiological information and gives consideration to the implications of the wider catchment areas of Gateshead and South Tyneside.

The TPCT and Project Board has remained mindful of the imminent opening of the 24 rehabilitation beds within Houghton Primary Care Centre. Consideration of the impact of these beds and their utilisation by palliative care patients has been discussed throughout the development of this business case. Additionally the Project Board for the PCC gave consideration to palliative care patients within the development of their business case. Both boards discussed the appropriateness of co-locating rehabilitation with end of life care patients and agreed that due to a number of issues such as different care approaches, staff skills needed, environment and adjacencies, that the PCC was not the appropriate location for end of life care. The additional facilities available within the PCC, for example x-ray, will be potentially utilised by the hospice. The availability of clinical rooms within Primary Care Centre across Sunderland will also be considered within future developments of the Sunderland integrated service, for example lymphoedema clinics.

This document identifies Ryhope as the preferred site option and highlights the decision making process which was undertaken to identify the site on the southern perimeter of the Cherry Knowle hospital site. Although the wider site is again owned by NTW, SoTW have a plot of land on the south of the site, which provides the required space for a build and provides a south sloping aspect facing the North Sea. NTW are in the process of undergoing a significant redevelopment process to the main site. As such it is anticipated that there will be potential cost saving opportunities including during the operational development and economies of scale through access to some shared services going forward.

The preferred development option provides a purpose designed and purpose built building of circa 3,100 m². It will include the provision of 14 inpatient beds, outpatient facilities and capacity to accommodate 16 patients per day within the day care facility. There will also be provision of an education unit, a multi faith room, consulting room and mortuary (a full schedule of accommodation is available in Appendix 8.6)

The hospice will continue to provide all of its current services, which can be broadly summarised as;

- Inpatient specialist palliative care beds
- Day care
- Outpatient facilities
- Lymphoedema service
- Complementary therapies
- Community Specialist Palliative Care

- Out of Hours Specialist Palliative Care service

The development of the new build will include the expansion of the inpatient unit into 14 individual bedrooms. The facility will also provide the opportunity for future development, for example of;

- Psychotherapy
- Music therapy
- Art therapy

The revenue consequences for provision of relocated services into the new facility have been fully considered within a separate commercial business case which has been approved by NHS SoTW Clinical Executive Team.

Further detailed work is underway to complete a review and consultation exercise to identify future service requirements. This work is being carried out in collaboration with the End of Life Strategy Group for SoTW.

Sunderland TPCT has funds lodge with the Strategic Health Authority (SHA) and will also undertake revenue to capital transfers to fund the business case. Additionally SoTW has made provision within its 2011/13 budget to accommodate revenue consequences of re-providing the service in another location.

The proposed hospice will constitute a significant modernisation of accommodation for services within the integrated model for palliative care for Sunderland patients. The hospice element will provide patients and their relatives with first class facilities and an accompanying physical environment which is appropriate to their care needs. The vision is the local response to national, regional and local policies and objectives for palliative care services. Specifically it will aim to support and maintain the provision of patient care in the community, helping to increase patient choice in relation to preferred place of care and place of death.

This proposal is designed to ensure that NHS SoTW is able to provide an inpatient hospice facility and allied services which deliver the outcomes set out within:

- NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer
- Department of Health's Building on the Best: end of life care initiative (2004)
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2007)
- The Preferred Priorities for Care, NHS End of Life Programme, December 2007
- Gold Standards Framework www.goldstandardsframework.nhs.uk
- Department of Health Transforming Community services (2009)
- Palliative and End of Life Care Quality Markers 2009

It is also intended to support the delivery of the outcomes set out within:

- Our Health, Our Care, Our Say: making it happen. DH (2006)
- End of Life Care Strategy (2008)
- Commissioning for Health and Wellbeing Framework. DH (2007)

- NHS NE – Our Vision, Our Future (2008)
- Sunderland Integrated Strategic Operational Plan 2010/15
- Sunderland Estate Strategy 2010/15
- Sunderland TPCT Commissioning Intentions (2011/12)

1.3 Sunderland TPCTs achievements

The TPCT has recently undertaken a significant capital investment programme to fund the build and implementation of 4 Primary Care Centres across the city, the capital cost of which was circa £50 million. The implementation of each was successfully managed and all were operationally active on budget, within the specified timescales and to the agreed standard.

Although learning opportunities will be sought from other organisations who have recently undertaken similar builds, the TPCT has significant internal knowledge and relevant experience at its disposal to provide assurances that this process will be similarly well managed and implemented.

1.4 Overview of the process

Partnership and collaborative working has been key to the development of this proposal. A multiagency Project Board has been established to oversee the development of this project and recommendations are reported internally to the Planned Care Programme Board and Commissioning Executive Team and externally by the individual members through their respective governance structures. The full composition of the Project Board is documented in appendix 8.13.

The Project Board has carried out 2 options appraisals. The first appraisal reviewed the options for providing specialist inpatient facilities in Sunderland including:

- Do nothing
- Further extension and refurbishment of the existing facility
- Develop existing NHS accommodation
- A new purpose built facility on a new site.

Following the completion of this exercise a second appraisal was carried out to identify a preferred site for the new facility. A robust review was carried out to identify sites which were available and able to accommodate the size of building required. Options considered included the purchase of land on Monkwearmouth hospital, any estate within the local Acute Trust, sites already owned by the TPCT and additional sites owned by Gentoo or the Local Authority.

As detailed below, there is limited opportunity to redevelop and expand within the current location. The only option to develop the current site would require demolition work, a phased project and the vacation of the outpatients department operated by City Hospitals Sunderland. Currently there are no plans to vacate this neighbouring space, but for completeness the project has looked at the potential costs which exceed the new build by circa £3 million.

Additionally, as the estates strategy for NTW is to reduce clinical activity and increase office accommodation on the site, this option would not provide the opportunity for co-

location with a 24 hour facility. There are also likely to be ongoing accessibility issues around car parking.

Additionally, space at the Sunderland Royal NHS Foundation Trust is at a premium and the Trust has bed pressures of their own on a restricted main site.

A small working group of the Project Board developed a benefit criteria against which shortlisted site options were assessed. The weighting of each of the criteria was based upon feedback from the results of a questionnaire completed by existing service users.

The working group scored the options in terms of their ability to deliver the required benefits. The financial consequences both in terms of value for money and affordability were then calculated and from this exercise the preferred option of a new build in Ryhope was derived.

Consideration has been given throughout to ensuring a sustainable service delivery model is in place with the capacity to meet the anticipated demands of the future population. Implications for the wider catchment areas of Gateshead and South Tyneside have also been considered.

Consultation will be a recurring theme throughout the ongoing development of this project. The FBC will demonstrate that this process has already been initiated both with patients, carers and health and social care professionals. It documents the support received to date and outlines the proposed programme of consultation events.

The views and experiences of patients and carers has already been sought in the selection criteria of the new site, selection of preferred architect and the provisional designs for the hospice. In addition the TPCT has consulted with Sunderland Clinical Commissioning Group to identify their priorities for the future development of services and to ensure their ongoing support. The elected members of Sunderland Local Authorities Overview and Scrutiny Committee have also provided their initial support for the process and its recommendations to date.

In parallel to the development of a capital business case a separate business case has been developed, and approved which outlines the revenue funding implications. It includes the full range of services to be provided within the facility and the detail plans for the accommodation.

2. LOCAL CONTEXT

This section aims to set this document in a context, in terms of the role of the TPCT, the health status of Sunderland. It describes how the proposal has been developed in partnership and in consultation with key stakeholders

2.1 Profile of Sunderland Teaching Primary Care Trust

Sunderland TPCT came into being as a formal statutory body on 1st April 2002, bringing together the three existing Primary Care Organisations in the city as well as community based nursing staff and staff from the former Strategic Health Authority. The organisation operates an integrated management structure in conjunction with South Tyneside and Gateshead PCTs through NHS SoTW.

Until recently community based services were part of NHS SoTW; as of the 1st July 2011 these now form part of South Tyneside NHS Foundation Trust. Until March 2013 the TPCT remains an independent statutory body with its own Trust Board, following which it is anticipated that the developing Clinical Commissioning Groups will take over the statutory responsibility for the commissioning of health care.

2.2 Sunderland population and health

The city of Sunderland is a metropolitan Local Authority covering 55 square miles with a population of circa 281,500. It is an area with high levels of deprivation, unemployment and poor health with a high incidence of cancer and chronic disease leading to premature death. (Health profile 2010: Sunderland www.healthprofiles.info) People from deprived and less affluent backgrounds are more likely to get some types of cancer and overall are more likely to die from it once diagnosed (NHS Plan 2000).

The residents of Sunderland die an average of 8 years earlier compared to those people who live in the healthiest parts of England. In general residents;

- Feel that they have poorer health and well being than the rest of England
- Are admitted to hospital more often
- Die earlier than people elsewhere in England.

Levels of obesity are significantly worse than national and regional averages (www.healthprofiles.info). Alcohol consumption is one and a half times higher than the national average, whilst smoking is also higher than the national average and accounts for one sixth of all deaths.

Data published in 2006 by National Council for Hospices and Palliative Care Services (NCHPCS) rank Sunderland TPCT 19th out of 152 PCTs for palliative and end of life care resource needed per head of population in relation to mortality from all cancers.

Sunderland has a significantly higher rate of people living with a long term illness compared to national and regional averages. Furthermore it has a disproportionate number of residents who class their health as 'not good' compared to 'Good'.

Table 1 – Health Self Rating

	Sunderland	Regional	National
People with a limiting long-term illness	24.05%	22.73%	17.93%
'Good Health'	63.92%	64.32%	68.76%
'Not good Health'	12.86%	11.98%	9.03%

Life expectancy rates have been improved in Sunderland over the past ten years, however the rates for both male and female are still lower than for both the region and the nation. Furthermore, the gap between life expectancy nationally and locally has not narrowed during this period.

Table 2 – Life Expectancy

	Sunderland	Regional	National
Life expectancy (Male)	75.9	76.8	78.3
Life expectancy (Female)	80.7	80.9	82.3

Sunderland has a higher level of unemployment than England and Wales, with 3.3% of the population registered as unemployed compared to 2.3% nationally (Jan-Dec 2007).

Place of Death

Research has shown that that most people would like to be cared for and die at home if they had a terminal illness. However in reality the highest percentage of people still die in hospital with only a relatively small number able to achieve care at home.

This national pattern is replicated within Sunderland with 61% of deaths occurring in hospital (above the national average of 57%). 21% of deaths occur at home, which is also slightly above the national average of 19%.

Table 3 - Place of Death Sunderland

PCT (Residence)	Place of Death	Year			
		07/08	08/09	09/10	10/11
Sunderland	Care / Nursing Home	346	348	338	289
	Home	697	632	572	571
	Hospice	136	129	140	143
	Hospital	1724	1776	1692	1675
	Other	43	34	47	56
	Total	2946	2919	2789	2733

Table 4 - Place of Death Sunderland (%)

PCT (Residence)	Place of Death	Year			
		07/08	08/09	09/10	10/11
Sunderland	Care / Nursing Home	12%	12%	12%	11%
	Home	24%	22%	21%	21%
	Hospice	5%	4%	5%	5%
	Hospital	59%	61%	61%	61%
	Other	1%	1%	2%	2%
	Total	100%	100%	100%	100%

Current performance data indicates a fairly static level of place of death across the 3 SoTW localities. The table above highlights place of death for Sunderland over the last 4 years. Within Sunderland the percentage of hospital deaths has risen over that period by 2%, from 59% to 61%. For deaths at home the opposite trend is apparent with a decrease of 3%, from 24% to 21%. In line with national guidance the TPCT is committed to decrease

deaths which occur in hospital by 5% over the next 5 years (Sunderland ISOP). The implementation of a new hospice facility will be a key initiative within a wider programme of increasing patient choice through the provision of a sustainable integrated model of care and community based services.

Table 5 - Cause of Death Sunderland

PCT (Residence)	Cause of Death	Year			
		07/08	08'09	09/10	10/11
Sunderland	Cancer	871	907	865	819
	Circulatory	909	846	827	821
	Other	726	696	709	652
	Respiratory	433	465	379	435
	Total	2939	2914	2780	2727

Table 6 - Cause of Death Sunderland (%)

PCT (Residence)	Cause of Death	Year			
		07/08	08'09	09/10	10/11
Sunderland	Cancer	30%	31%	31%	30%
	Circulatory	31%	29%	30%	30%
	Other	25%	24%	26%	24%
	Respiratory	15%	16%	14%	16%
	Total	100%	100%	100%	100%

The principal causes of death and reduced life expectancy locally are circulatory disease and cancer both accounting for 30% each. Respiratory disease accounts for a further 24%, almost half of which relates to COPD. These figures clearly demonstrate that chronic disease is the major cause of death above cancer and this has determined the strategic direction of prioritising equity of access to specialist palliative care for all patients regardless of diagnosis.

Table 7 - Cause of death projections 2011-2031 (Sunderland)

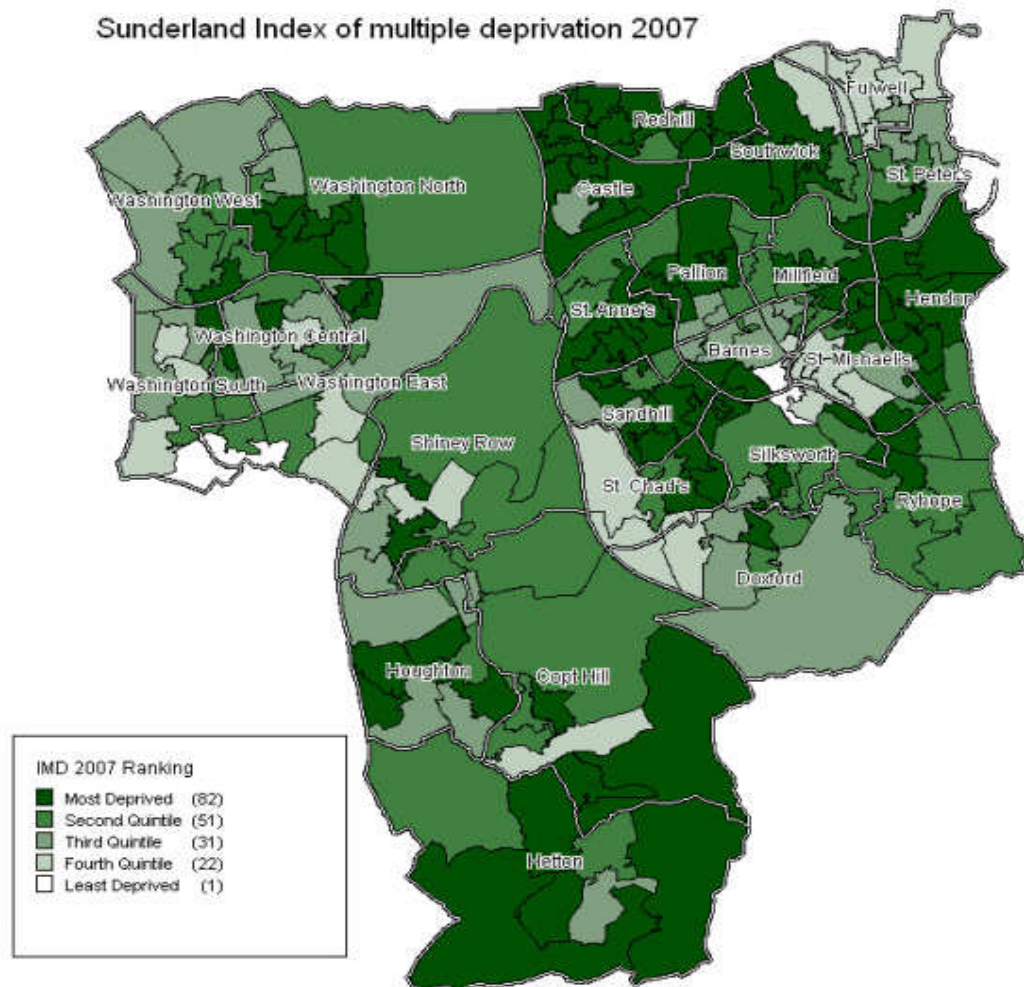
Cancer																							
PCT	Expected Deaths (Over 65s)					Percentage Growth				Expected Deaths (Over 75s)					Percentage Growth				Expected Deaths (Over 85s)				
	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031
Sunderland	1,964	2,237	2,530	2,974	3,341	14%	29%	51%	70%	1,240	1,421	1,626	1,946	2,203	15%	31%	57%	78%	354	427	514	621	721
SOTW	3,061	3,408	3,802	4,401	4,909	11%	24%	44%	60%	3,061	3,424	3,865	4,539	5,093	12%	26%	48%	66%	956	1,115	1,318	1,564	1,796
Circulatory																							
PCT	Expected Deaths (Over 65s)					Percentage Growth				Expected Deaths (Over 75s)					Percentage Growth				Expected Deaths (Over 85s)				
	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031
Sunderland	2,195	2,500	2,827	3,324	3,734	14%	29%	51%	70%	1,802	2,065	2,363	2,827	3,201	15%	31%	57%	78%	860	1,038	1,249	1,509	1,752
SOTW	5,225	5,817	6,490	7,512	8,379	11%	24%	44%	60%	4,275	4,782	5,398	6,340	7,113	12%	26%	48%	66%	2,116	2,468	2,917	3,461	3,975
Respiratory																							
PCT	Expected Deaths (Over 65s)					Percentage Growth				Expected Deaths (Over 75s)					Percentage Growth				Expected Deaths (Over 85s)				
	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031
Sunderland	1,178	1,342	1,517	1,784	2,004	14%	29%	51%	70%	959	1,099	1,258	1,505	1,703	15%	31%	57%	78%	469	566	681	823	956
SOTW	2,671	2,974	3,318	3,840	4,283	11%	24%	44%	60%	2,226	2,490	2,811	3,301	3,704	12%	26%	48%	66%	1,105	1,289	1,524	1,808	2,076
Other																							
PCT	Expected Deaths (Over 65s)					Percentage Growth				Expected Deaths (Over 75s)					Percentage Growth				Expected Deaths (Over 85s)				
	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031
Sunderland	1,588	1,809	2,045	2,405	2,701	14%	29%	51%	70%	1,347	1,544	1,767	2,113	2,393	15%	31%	57%	78%	747	902	1,085	1,311	1,522
SOTW	3,682	4,099	4,574	5,294	5,905	11%	24%	44%	60%	3,435	3,842	4,337	5,094	5,715	12%	26%	48%	66%	1,752	2,044	2,416	2,866	3,291
Total																							
PCT	Expected Deaths (Over 65s)					Percentage Growth				Expected Deaths (Over 75s)					Percentage Growth				Expected Deaths (Over 85s)				
	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031	2016	2021	2026	2031	2011	2016	2021	2026	2031
Sunderland	6,925	7,888	8,919	10,486	11,780	14%	29%	51%	70%	5,348	6,128	7,014	8,391	9,500	15%	31%	57%	78%	2,430	2,934	3,530	4,264	4,952
SOTW	14,639	16,298	18,184	21,046	23,476	11%	24%	44%	60%	12,997	14,538	16,411	19,274	21,624	12%	26%	48%	66%	5,929	6,916	8,175	9,699	11,137

The tables above document the projected rates for disease prevalence and cause of death over the next 20 years. Over the next 10 years, in line with the predicted increase in population numbers in table 7 there is expected 32% increase in total deaths within Sunderland.

The most notable percentage increase is the death rate within the over 85 age range. The predicted rate for cancer related deaths is the slowest at an estimated 31% increase compared to 33% for circulatory, respiratory and other causes of death.

2.3 Geographic profile of the locality

The maps below show the distribution of overall deprivation across Sunderland. Areas shaded dark green are amongst the upper 5% of deprived areas in England, whilst those that are shown as white feature amongst the least deprived. It is evident from the map that a number of wards and boroughs within Sunderland fall within the 'most deprived' category.



The Index of Multiple Deprivation measures deprivation in six domains: employment, income, health, education, housing and access to services. At electoral ward level, across all six domains, eleven of the twenty five Sunderland wards are in the top 10% most deprived in England. This reflects the status of Sunderland in terms of key wider determinants of health.

2.4 Working in partnership

The development of this proposal has been carried out through a multi-organisational collaborative approach. The TPCT has facilitated this partnership led development primarily through a Project Board with representation from partner organisations across Local Authority, GP Commissioning, Acute Care, Community Services and St Benedict's

Board of Trustees. This board has been established to oversee the entire process and will lead on the planning and implementation of the whole project. Letters of support and commitment from each, including Sunderland Clinical Commissioning Group, are included within the appendices to this report.

Informal consultation with the elected members of Sunderland Local Authorities Overview and Scrutiny Committee (OSC) has already been undertaken. On review of the proposal and timeline, the members have granted their preliminary support for the development and have invited the project management team to present the proposal formally to their October committee meeting. *'Members of Sunderland's Health and Well Being Scrutiny Committee, having seen the outline proposals are supportive of the project proceeding and would welcome the development of a fit-for-purpose facility in the City'*. A subsequent formal letter of support will be made available after attendance at the October meeting.

A Key member of the hospice team, and as such this project, is the Board of Trustees for St Benedict's. The Board has 12 members who meet on a monthly basis to oversee the income generation and expenditure of fund raising contributions. The group is represented on the Project Board by The Chair of the Trustees who has provided a link between the two Boards throughout the development process.

The remit of the Board is to: increase income through fund raising, approve funding applications for monies generated through donations. In particular for items or services which improve patient care and comfort in addition to those funded through the NHS.

Examples of initiatives the Board has funded include;

- The pump priming of a 2 year chaplaincy post now funded through an NHS contract
- £400,000 fund raising campaign to increase the provision of hospice at home
- New TVs and beds for the inpatient unit
- The ongoing funding of complementary therapies

In relation to the new build the Board have committed to launching a specific fund raising campaign in order to generate income which will be allocated to the funding of items which enhance the patient care and comfort.

The engagement of partner organisations will continue to be important in the ongoing development of this project. The Project Board will remain in place and will maintain focus on delivery of the project plan and make appropriate recommendations within the governance arrangements.

The proposal has been presented for discussion at the End of Life Strategy Group which has multiagency representation from across the 3 SoTW localities.

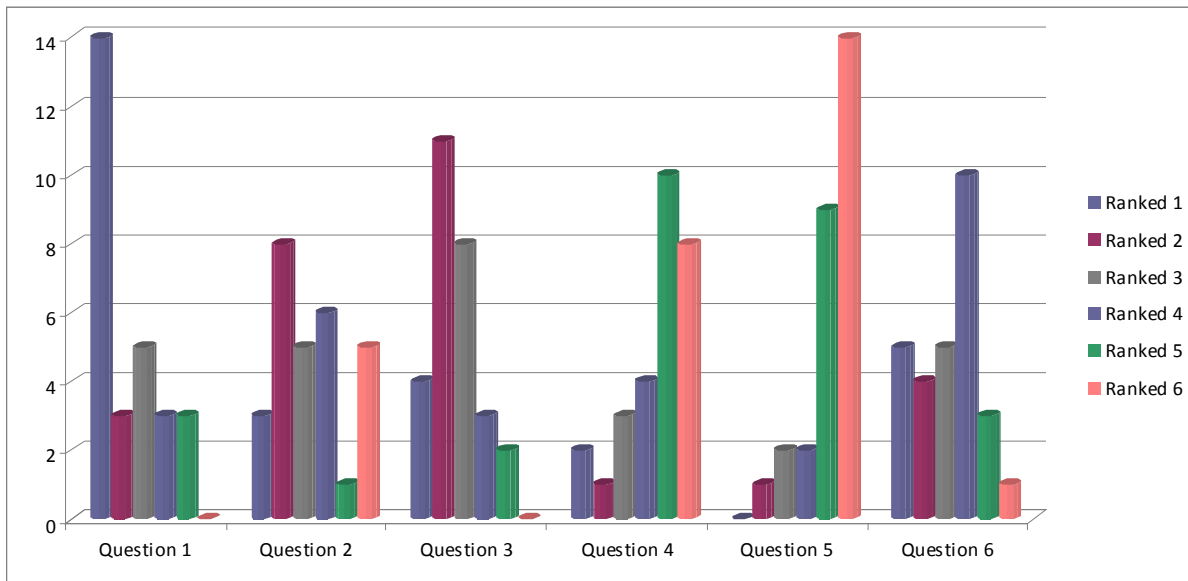
2.5 Consultation

The TPCT and the Project Board are committed to consulting, engaging and involving the residents of Sunderland in achieving its core aims. Consultation was a key part of the development of Sunderland's 4 Primary Care Centres. This process has already been initiated for the project and will continue to be a priority.

The hospice and its services are accessed by a discrete patient group. Therefore the Project Board has focussed consultation on this informed reference group. The consultation process has commenced with this group with their opinions being sought in regard to priorities when considering the selection of the new hospice site. The information was gathered through a questionnaire that was distributed over the course of a one week period by the ward staff. 53 completed questionnaires were returned from patients accessing inpatient and outpatient services, along with visiting relatives.

Patients were asked to rank 6 different selection criteria in terms of importance when considering the location of a new site (1 being the most important, 6 the least important).

Chart 1 – Selection Criteria



Key:

- Question 1 - Is the building accessible by public transport?
- Question 2 - Is the building easily accessible by private transport?
- Question 3 - Has the site got room to provide a communal outside space?
- Question 4 - Does the building have good views?
- Question 5 - Is the building away from a residential area?
- Question 6 - Is there room for an adequate sized car park?

The information provided was used to influence the scoring and weighting criteria used within the options appraisal.

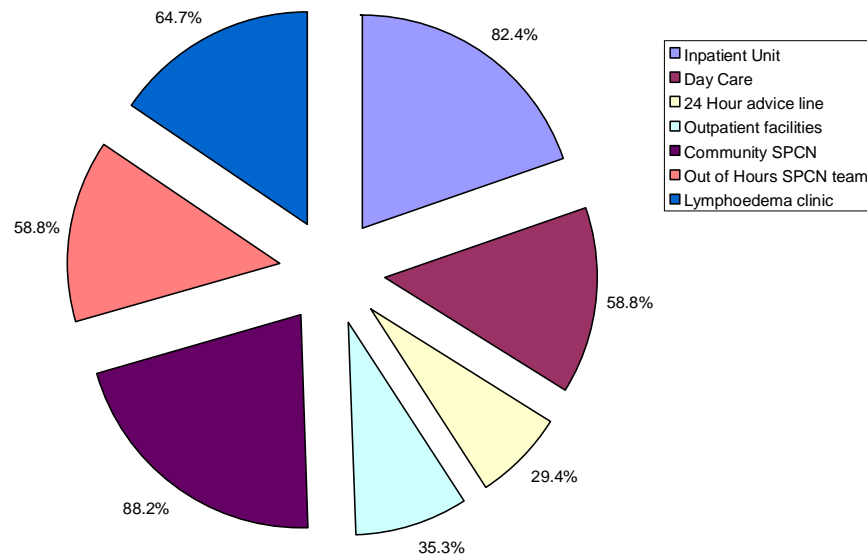
Two hospice volunteers were also included as part of the group who interviewed and selected the chosen architectural firm. Within this process it was a requirement that each design team included a proposal of how they planned to incorporate patient and public consultation within the design process. This element was seen as a key element of their bid package.

In order to gain a 360 degree, whole system understanding of the success and challenges of the current service delivery model, an extensive consultation process is underway which

will continue to be built upon throughout the project. The views and experiences of existing service users and GPs are being sought to provide a detailed understanding of accessing service from their perspective. To this end an electronic questionnaire was forwarded for completion by every General Practice (54) within Sunderland. In total 17 were returned (31% response rate). Collaboratively produced by the project team and a lead GP the questionnaire was disseminated through the Commissioning Development Unit and sought to understand the future priorities of Primary Care for the specialist palliative care integrated team.

Question 1) Please could you highlight which services you have accessed in the last 12 months?

Chart 2



Question 2) Please could you rank on a scale of 1-4 how important you think it is for the integrated team to include the following services?

Table 8

	Not important	Quite important	important	Very important	Rating average	Response count
Inpatient unit	0%	0%	5.9%	94.1%	3.94	17
Day Care	0%	0%	17.6%	82.4%	3.82	17
24 Hour advice line	0%	12.5%	25%	62.5%	3.50	16
Outpatient facility	0%	17.6%	11.8%	70.6%	3.53	17
Community SPCN	0%	0%	18.8%	81.3%	3.81	16
OOH SPCN	0%	5.9%	17.6%	76.5%	3.71	17
Lymphoedema Clinic	6.3%	18.8%	43.8%	31.3%	3.00	16

Question 3) Please list any additional services or facilities which you like to be included within the integrated model of specialist services

- Support for Care homes in looking after patients at the end of life and especially with non-cancer diagnoses
- More hospice beds and greater prospect of getting patients into them
- Invasive intervention e.g. pleural catheter, paracentesis, IV therapy and transfusion
- More nurse prescribers
- Specialist pain relief
- Speak to Dr on call for advice 24/hours if possible

Question 4) If provision of specialist education was to be included in the remit of the integrated team, what topic areas would you like it to include?

- Pain management, syringe drivers for nausea and vomiting, preferred place of care
- The annual palliative care course is already very good
- Care pathway, analgesic review, prescribing
- Symptom control
- Symptom control, ACP, PPC and LCP
- EoL Communication skills

Question 5) Are there any other comments you wish to make in relation to the provision of palliative care services within Sunderland?

- Seems to be a very high quality service when available, but can at times be difficult to access at the time of need- e.g. access to in-patient beds and advice from a named consultant
- Excellent service that needs to continue
- Poor access to inpatient beds. Poor response time to domiciliary visits deteriorating overnight, services taking too long to respond
- Overall excellent. Always willing to provide advice by phone. Often difficulty accessing inpatient bed. Not always day care bed available

Consultation is also being carried out with existing hospice staff to ensure any potential to influence future service is included.

This ongoing commitment to PPI engagement is demonstrated through the attendance of the TPCTs patient and public involvement officer on the Project Board. They have the responsibility to ensure that information is accessible and the community is consulted and updated throughout. Attendance at the Sunderland Local Engagement Board (LEB) will provide an opportunity to consult with a wide ranging group of patients on a regular basis throughout the project. A briefing paper has already been submitted for their September meeting and, having met with the Chair of the Board the project team have agreed to formally present the proposal at a meeting later in the year. LEBs are public meetings held in venues across Sunderland there are four meetings throughout the year with presentations to update and inform local people about health services and developments which are important to them. The agenda consists of two or three short updates on specific health topics and a main agenda item followed by round table discussions where the audience has the opportunity to share their views and opinions with facilitators.

An open event for Houghton Primary Care Centre in October will provide an opportunity for the hospice project team to carry out further significant public engagement and consultation. Upwards of 700 members of the public are expected to attend the event where the project team will present a display and engagement stall raising awareness of the proposed development and actively seeking feedback and suggestions from the public which will be used to inform the design process as well as the future service delivery model. The event will also provide the opportunity to engage with a wide range of allied health professionals.

The table below provides the plan for this consultation process

Table 9

Project area	Group consulted	Aim	Proposal
Building design	Patient and relatives	Gain feedback on the draft designs to ensure they meet the requirements and the vision for the service users	Expand on work completed to date. Present the preliminary designs to patients and relatives and to consult with this group, potentially through an established reference group, throughout the design and development phase
Service delivery	Patient, carers and relatives	To ensure the views of service users are incorporated into service redesign proposals. Service users are best placed to provide information on the success and challenges with accessing services.	<p>In collaboration with the PPI officer a number of public consultation events will be carried out focusing on existing service users and their relatives, but also offering the wider public opportunity to share their views. This will be carried out through a combination of open events: focus groups and question and answer sessions with communities of interest; on line-survey questionnaire and paper questionnaires all of which will help inform the required changes to service delivery model. The proposed plans are on the agenda for consideration and discussion at the at the September meeting of the Sunderland Local Engagement Board. An update is also scheduled for the November meeting of the same group.</p> <p>The opportunity to comment on the consultation process will be extended to</p> <ul style="list-style-type: none"> • Age UK (Sunderland) • Sunderland Carers Centre • Local Involvement Network (LINK) – for circulation across their membership • Voluntary and Community Action Sunderland (VCAS) – for circulation across their membership • Local Authority VandCS Network – for circulation across their membership <p>Attendance at the official launch event of Houghton Primary Care</p>

			Centre will provide the opportunity to consult with a large cross section of members of the public
	GPs	To ensure the views and experiences of GPs in relation to accessing the hospice services are considered.	The process is already underway through the Dissemination of a questionnaire to all Sunderland based GP. Consultation will continue through quantitative and qualitative methods. In collaboration with lead EoL GP to identify proposed amendments to service provision; discussion at the Sunderland CCG.
	Hospice staff	To complete a consultation process with staff to highlight suggested amendments to service delivery from their perspective	Through a sub group with representatives from each of the services (inpatient, outpatient, day care etc). Dissemination of an all staff survey. Through involvement and discussion with the lead nurse. And business manager on the Project Board
Awareness raising	General public	To complete a publicity campaign ensuring awareness of the new hospice	On going process, which will increase as the build nears completion. Information will be provide in a number of formats and locations to ensure the general public are aware of the relocated service. Attendance at the official launch event of Houghton Primary Care Centre, and through attendance at the LEB will provide the opportunity to awareness raising and consultation with a large number of members of the public.
	Allied health and social care professionals	To ensure the relocation of the service is known to all allied professionals.	On going process. Awareness raising of the proposed move is already been carried out through attendance at meetings. This will formalise as the build nears completion with a programme of awareness raising sessions being put in place. This will include; attendance at regional meetings, e-mail bulletins, open day, opening ceremony.

Given the complex needs of the patient group accessing the hospice facilities, involvement of specific groups of interest which may not appear automatically within the above process will be proactively sought. We will seek their opinions and requirements in regards to both aspects of the physical building design and service delivery elements relevant to their needs for example, but not limited to;

- Visually impaired
- Hearing impaired
- People with physical disability
- People with learning disability
- People with mental health issues
- Issues related to faith and culture
- Members of BME groups and
- Members of lesbian, gay, bi-sexual and transgender communities

Accessibility was a key issue considered within the selection of the preferred option. An independent consultancy company was commissioned to carry out an access mapping exercise. The report (Appendix 8.7) documents travel times to all shortlisted site options via public and private transport for each of the wards in Sunderland. A review of public and private access to the site demonstrated current ease of access that will be further increased through the installation of a new major road linking Ryhope to Doxford Park. The availability of land will also provide the opportunity to include sufficient dedicated car parking.

The Project Board has representation from the Sunderland Clinical Commissioning Group (SCCG) through Dr Henry Choi, the GP lead for end of life care. Provision of end of life care services has been identified by SCCG as a priority area and they have offered their full support to the proposal. Dr Choi has been responsible for updating and consulting with the wider SCCG and will continue to act as a conduit for information as the project develops. The project manager and project lead have been afforded the opportunity to present updates at the SCCG, including a full review of this business case.

3. STRATEGIC CASE

This section sets the proposal within its strategic context outlining how national policy has influenced local policy development and the TPCT's strategic direction. It shows how this proposal satisfies key strategic drivers at national level and is wholly consistent with the business objectives of the TPCT. It also makes the case for developing hospice as they support the achievement of the national strategy of shifting care away from the acute sector into the community.

3.1 National context

The establishment of the delivery model for specialist palliative care services in Sunderland have been developed in context with:

- NHS Operational Plan (2008-2011)
- NHS Next Stage Review
- The NHS End of Life Care Programme (2004–2007)
- End of Life Care Strategy (2008)
- NICE Supportive and Palliative Care Guidance (2004)
- Gold Standards Framework (2006)

- Palliative and End of Life Care Quality Markers (2009)
- Marie Curie Delivering Choice Programme (Phase I report 2008)
- Developing capacity: Estates and facilities in the NHS (2004)
- NHS Estates Strategy

End of Life care services have been a national priority area since the publication of the 2008 End of Life Care Strategy which set the strategic policy direction for the commissioning and provision of end of life care services. At its core it placed an emphasis on patient choice and the provision of equitable, 24/7 models of care across all care settings.

The End of Life Care Strategy recognises that the physical environment in different settings, including hospitals and care homes, can have a direct impact on the experience of care for people at the end of life and on the memories of their carers and families. Central to this is the importance of providing environments that encourage dignity and respect and recognise the need for:

- Rooms where an individual and their family can go to talk privately
- Informal gathering spaces where families can meet
- Guest rooms where close family and friends can stay overnight, with facilities for catering and communication.

In addition, following death, particular attention needs to be given to:

- The transfer of the body to the mortuary
- The location of the mortuary and how it is approached by families, friends and carers
- The viewing room
- Rooms where families, friends and carers can sit quietly and receive the deceased person's property and collect the death certificate.

The importance of these spaces is recognised in the Quality Markers (1.7.2) which require that "All providers have assessed their current environments for care from the perspective of people at the end of life and their carers and have incorporated plans for improvement into their formal estates strategies."

Prior to the strategy the profile of end of life care within the NHS and social care services was relatively low. The Implementation of the 2008 document was intended to make a step change in access to high quality care for all people approaching the end of life. The intention was for this to be 'irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic deprivation'. The aim was to ensure high quality care was available in all settings: at home, in a care home, in hospital or in a hospice.

The strategy provides a clear message that a whole systems approach is required, with a care pathway approach both for commissioning services and for delivery of integrated care for individuals. It set out key areas, with the related actions and recommendations:

Table 10 – End of Life Strategy Key Areas and Actions

Key area	Actions
Raising the profile	Improving end of life care
Identifying people approaching the end of life	A skilled and knowledgeable workforce to deliver end of life care
Care planning	All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan
Coordination of care	Each person approaching the end of life should receive coordinated care, in accordance with the care plan, at all times of day and night
Rapid access to care	Services should be available without delay. Specialist palliative care outreach services will be established in every area
Delivery of high quality services in all locations	
Last days of life and care after death	Implementation of the Liverpool Care Pathway for the dying
Involving and supporting carers	

The recommendation for hospice provision was that:

‘Good PCTs will wish to ensure that the uncertainties involved with short term contracts for voluntary hospices are removed. They should work towards three year rolling contracts, as set out in the Compact Code of Good Practice for commissioning with the voluntary sector’

Following the publication of the strategy it was recognised that commissioners and providers needed support and guidance in helping to deliver the required improvements in care. This led to the development of; ‘*Quality Markers and measures for end of life care*’ (2009). These non mandatory standards were intended to be used by PCTs to facilitate work with their joint local partners to formulate their plans for end of life care. They could be used within local commissioning processes to set levels of expectation of improvement to services.

The markers include standards for all care settings and provide suggested measures for achievement. Section one includes a list of standards for commissioners of end of life care. This includes;

- There is appropriate provision of specialist palliative care services to meet the needs of the population. These include:
 - Inpatient services

The recommended measurement for this standard is the sufficient provision of inpatient hospice beds for the local population (per 100,000).

Since the introduction of the strategy and its allied quality markers there have been numerous national and regional initiatives focussed on improving the provision of palliative care services.

The latest NHS Estates strategy suggests that service providers who have over 50% occupancy rate have an option for ownership of the building. Discussions are ongoing with the community services provider. However they have confirmed that they have been working collaboratively with the TPCT in the development of this proposal and that key managers are working on the planning and the transition of services. A copy of the Final Business Case will be presented to Trust Board on 27 September. A formal letter of approval and support will be forwarded after this date.

3.2 Regional and local context

NHS North East launched its first ever 'vision' for health and well being within Better Health, Fairer Health in 2008. The vision within this strategy aimed to ensure *'The North East will have the best and fairest health and well-being, and will be recognised for its outstanding and sustainable quality of life'*

It was proposed that this would be achieved by pursuing seven distinct aims:

- No barriers to health and well being
- No avoidable deaths, injury or illness
- No avoidable suffering or pain
- No helplessness
- No unnecessary waiting or delays
- No waste
- No inequality

Within the 10 key themes 'A good death' is included as one of the SHA 10 priority areas.

'The North East will have the highest quality services to support individuals (along with their families and carers) in their choices as they approach death. By a good death we mean one which is free of pain, with family and friends nearby, with dignity and in the place of one's choosing

A regional advisory group has been established to take this work forward and its members are in the process of producing a region wide end of life care charter.

In line with the regional guidance, NHS SoTW has developed a vision for its residents:

- **Better health** to ensure people live longer, with a better quality of life and fair access to services.
- **Excellent patient experience**, ensuring safe care, effective treatment and quality services.
- **Wise use of your money** with the right services at the right place, first time, reducing waste and ensuring value for money.

The strategy for local provision of end of life care services has been influenced by, and developed in accordance with the aforementioned national priorities. There has been a

significant emphasis and investment directed towards the improvement and modernisation of services for patients.

Specifically in relation to its provision of end of life care services the TPCT is in the process, through its End of Life Strategy Group, of refreshing its end of life strategy for 2012/13. The strategy will outline the organisations plans and priorities for end of life care services across the 3 SoTW localities, including an implementation plan and the success indicators. This will build on its current plans to provide integrated services to patients at the end of life with an emphasis given to care closer to home. Due consideration will be given to patient choice for those patients or family members who require respite or have hospice as their preferred place of care.

The TPCT has been a key partner organisation of a region wide whole systems review of palliative care services across Northumberland, Tyne and Wear. The Marie Curie Delivering Choice Programme was sited as an example of good practice within the End of Life Care Strategy and the local project has been in place since 2008. The TPCT are in the process of procuring and implementing the service redesign models which were recommended as part of this review. The aim is to provide increased capacity within out of hours services through the implementation of a dedicated palliative care nursing service across SoTW, Sunderland has already been hailed as an exemplar for this service. A central Palliative care Coordination centre, operating across all 3 SoTW localities is also being established to provide a cohesive and coordinated approach to service delivery across the 3 localities. It is anticipated that these services will be in place for the commencement of 2012/13. All of this work has been addressed in order to improve patient care and help the TPCT achieve its strategic objective in relation to end of life care to:

'Ensure that all people entering the end of life have their needs, priorities and preferences identified and met, with the same standard of care in all settings.'

In response to this strategic objective the 2010/15 estates strategy for Sunderland TPCT documents the concern around the current leasing arrangement with NTW and acknowledges that 'Capital is set aside for potential scheme (New hospice build)'.

The TPCT is required to produce a commissioning intentions document annually which outlines the plans to deliver the organisation's strategic objectives. The paper reflects the issues which the TPCT expects to address in the forthcoming contract year, and focuses in particular on investment and disinvestment priorities. The stated priority within the Sunderland document for End of Life care is to 're-provide St Benedict's hospice'.

Palliative and End of Life Care Services are also a documented key priority within the Sunderland ISOP and are therefore the subject of regular discussion and consultation at the SoTW End of Life Care Strategy Group.

This proposal fits within the delivery of the Sunderland ISOP which has as a strategic objective; 'Providing those at the end of life with a good death' and states, 'increases in deaths which take place outside of hospital' as a desired outcome.

The ISOP highlights 'A better death, greater choice' as one of its 7 objectives and identifies a goal to achieve a 5% reduction in numbers of people dying in hospital, through choice, by 2015 (0.5% by 2012). The stated initiative to help delivery of this is the 'review and redesign of services'. At the core of this aim is the objective to provide patient choice at the end of life and improve access to care in all settings and is the fundamental basis of SoTW's model for end of life care.

Across SOTW approximately 600 people die within 2 days of admission to hospital (NHS SOTW Secondary Care Commissioning Business Intelligence). Access to palliative care specialist nurses and doctors avoids unnecessary admissions or facilitates rapid discharge back home where appropriate and offers patients choice through holistic interventions of all complexities i.e. communicating with patients and carers and professionals, managing specialised drug regimens and providing the full range of medical and nursing care.

A national and local priority is increasingly to reduce an over reliance on acute care and is moving towards the provision of care closer to home, utilising community based services to keep patients in their preferred place of care. A sustainable hospice will help contribute to this through the provision of services which help to maintain care in the community and avoid admission to secondary care, for example lymphoedema services and outpatient appointments.

It is acknowledged that the funding models for palliative care are not consistent across SoTW. For example St Benedict's benefits from a higher proportion of NHS funding compared to hospice provision across other localities. The reasons for this are historical and the rationale for continuing with the arrangement is that the hospice and its funding streams are part of a well established infrastructure of integrated services which have been hailed as an exemplar. It is felt that any decision to re-procure the service and change the funding model at this point in time would result in a significant destabilisation of services within Sunderland. However, in line with the recent publication of the Palliative Care Funding Review (July 2011) which sets out a 5 year plan to implement a tariff based model for End of Life care, a Task to Finish group has been established to review our funding models and implications for the future. In addition capital and revenue monies have already been identified to fund the proposal, which has as previously identified, the support of local stakeholders for example, Sunderland Clinical Commissioning Group and the Local Authority Overview and Scrutiny Committee.

4. ECONOMIC CASE

This section examines the economic case. Constraints on achieving the investment objectives are identified. The option appraisal process is described and the appraisal of the shortlisted options summarised. The preferred option is identified.

4.1 Project objectives

The proposed development is expected to deliver the following objectives:

- To provide a sustainable palliative care inpatient facility for the residents of Sunderland
- To future proof service delivery for wider specialist palliative care services
- To improve privacy and dignity and help reduce inequity

- To ensure that the facility is able to meet demand over the foreseeable future; taking into account national, regional and local priorities
- To develop a facility which is fit for purpose and able to provide first class hospice facilities
- To improve the quality of hospice premises in Sunderland
- To provide specialist services which are able to facilitate rapid discharge from hospital for patients at the end of life
- To provide a range of services which support the delivery of care in the community

4.2 Project deliverables

It is expected that the hospice will:

- Provide a new, functional and robust specialist palliative care facility which is fit for purpose
- Help improve and provide choice for patients at the end of life by raising the profile of end of life services.
- Help deliver community based services which are able to provide sustainable care in the community if that is the preferred place of care
- Contribute to the 5% decrease in deaths in hospital within Sunderland
- Improve access to inpatient and outpatient specialist palliative care services for the residents of Sunderland
- Improve patient experience through improved physical facilities and appropriate environment
- Help to prevent unnecessary hospital visits through the co-location of services within the integrated model

4.3 Option Appraisal

The original options considered by the Project Board included:

- 1) Do Nothing
- 2) Further extension and refurbishment to the existing premises
- 3) Develop existing NHS accommodation available elsewhere in the city
- 4) Fund new purpose built facility

Option 1- Do nothing

The 'do nothing' option is not viable and impractical. The risks associated with the current short term lease agreement and uncertainty on future estate plans for NTW leave St Benedict's future uncertain. Furthermore, as documented earlier the site is in need of modernisation and expansion. The hospice in its current establishment cannot provide the appropriate environment or physical facilities for this patient group. For example the two 3 bedded units offer less flexibility in terms of bed utilisation and could be perceived as a challenge in relation to privacy and dignity.

Option 2- Extension and refurbishment of St Benedict's in it's current location

At the very start of the project discussions were held with NTW around the potential use of a number of single storey units on the Monkwearmouth site. The first option was to use Wearmouth view and the second was to use two of the existing units on the South of the site (linking them with a new entrance/atrium) and refurbishing the residential wings. In both cases we sought to acquire a freehold interest. NTW's plans have since developed (and business case approved). The 'direction of travel' for Monkwearmouth site is more towards a NTW staff admin hub with a number of the current health facilities and covered links being demolished to make way for parking. The plans include a new dementia care centre (to be located on our 'option 2' site).

The option was therefore dismissed by the project board for the following reasons;

- There is limited opportunity to redevelop and expand within the current location. The only option is to develop the current site which would require demolition work, phased construction with increased associated costs and forced relocation of the City Hospitals outpatient department. Additionally the overall projected costs associated with this option exceeded the development of a new site by circa £3 million (Appendix 8.4)
- Any proposals would require the demolition of a significant part of the existing building stock, as the existing configuration could not be effectively developed into an economical design to provide best practice standards of care. In addition the existing floor areas are insufficient to provide the level of accommodation required by the hospice. Demolition of any existing buildings could only be carried out in a phased manner, as the existing services cannot be disrupted or temporarily relocated, which gives rise to a number of issues
- The phased proposals inevitably increase the construction period, which in turn extends the period of noise and disruption. Access to the existing building areas for demolition is difficult, and the demolition process is costly and noisy. The noise in particular would be difficult to deal with when bearing in mind the level of care needed for the patients.
- The areas available for re-development are adjacent to main roads which have a considerable level of background noise. There are only limited areas to provide pleasant external spaces for any re-design scheme further compromising any potential solution.
- Additionally, as the estates strategy for NTW is to reduce clinical activity and increase office accommodation on the site, this option would not provide the opportunity for co-location with a 24 hour facility. The existing car parking assignment to the hospice is limited and it is unlikely that additional spaces could be provided as part of any re-development.

Option 3- Develop existing NHS accommodation available elsewhere in the city

Consideration was also given to the use of the 24 in-patient beds in the new Houghton Le Spring Primary Care Centre. These beds are dedicated to provide rehabilitation services

and although considered for use by palliative care patients by both the hospice Project Board and the Primary Care Centre board, it was agreed that the co-location of these patients was not appropriate. Additionally the required staff skill mix and patient needs differ greatly for both services.

The exercise included a review of estates owned by the Local Acute and Mental Health Trusts. The review concluded that space is at a premium and that in particular the Acute Trust has bed pressures of their own on their restricted main site.

Option 4- Fund new purpose built facility

This is the only option which provided the opportunity to fully achieve the project's aims and objectives of providing a:

- Sustainable, state of the art facility which is able to provide a range of specialist palliative care services to the residents of Sunderland.

It was agreed that this option would provide a number of additional benefits including;

- The building will have a secured and sustainable projected life span and will be designed and developed to specifically meet the needs of palliative care patients and their families
- Improved access and
- The construction of a car park adjacent to the hospice would improve ease of access for patients and their relatives.

Option 4 was selected for further appraisal. A sub group of the Project Board developed a list of requirements for the new site which were used to provide an estimate of the size of estate required. An initial trawl of available sites with adequate space to accommodate the new build identified 8 estates, predominantly in the North of Sunderland.

A small sub group of the Project Board developed a draft list of criteria (informed by the patient consultation exercise) against which all potential site options were measured. A second options appraisal was subsequently carried out by a sub group of the project board to identify the recommended preferred site.

Initial site options included:

Option 1) Rhondda Road , Down Hill



Option 2) Cricklewood Road, Sunderland



Option 3) Faber Road, Carley Hill



Option 4) Hylton Lane, Blaydon Avenue



Option 5) Glebe, Washington



Option 6) Southwick Primary School, Sunderland



Option 7) Westgarth Terrace, Sunderland.



Option 8) Ryhope (Within the grounds of Cherry Knowle hospital)



4.3 Short list of Options

Options 6 and 7 were immediately eliminated by the Project Board due to access and location issues. Similarly option 2 was not considered for short listing as it became apparent that the land management company who own the site were in discussions with another interested party. Options 1, 3, 4, 5 and 8 were selected for further appraisal and formed the designated shortlist.

Option 1- New build in Downhill behind Bunnyhill PCC

Option 3- New build in Carley Hill on site adjacent to Grace House children's hospice (due for completion in 2012)

Option 4- New build Hylton Lane on site near Bunnyhill PCC

Option 5- New build in Glebe opposite Washington PCC

Option 8- New build in Ryhope site owned by NHS SoTW, part of the wider hospital grounds owned by NTW Mental Health Trust

Prior to the optional appraisal exercise taking place preliminary planning advice was sought for all 5 sites from the Head of Planning and Environment from Sunderland City Council. He was able to confirm that the initial site options appeared to comply with the planning policies for the area. Formal approval will be gained for the preferred site option through the submission of the relevant applications. As part of this process an extended phase 1 habitat survey and noise survey and assessment have already been commissioned (appendix 8.10 and 8.11).

4.4 Criteria for selecting preferred site option

In order to establish a clear and defined preferred option to meet the project's objectives, an option appraisal was completed which brought together a variety of information on costs and benefits to aid decision making. This process was informed by:

- Application of non-financial benefit analysis and
- Cost benefit analysis

4.6 Non-financial benefit criteria

The following criteria were developed as the benefit criteria against which to measure each option. This list was developed by a sub group of the Project Board, based on the information provided through the patient consultation exercise and reviewed by the whole group:

Access

- Is the site easily accessible by public transport? (patients and relatives)
- Easily accessible by private transport? (patients and relatives)
- Improves equity of access through a location which is accessible to a significant catchment population
- Provides a 'central location' which is accessible to a significant catchment population
- Allows the delivery of more effective care and treatment which improve the overall patient experience

Estates

- Increases the range and scope of services provided in community settings in accordance with national and local policies
- Supports delivery of new service models
- Provides co-location of services and staff to improve quality of care and economies of scale
- Generates added value due to the sites adjacency to other facilities
- The site is free of practical challenges and constraints associated with delivering a scheme. E.g. Ground Conditions, existing utility infrastructure
- Facilities which provide opportunities for future expansion enabling the building to meet changing requirements in use, e.g. space for expansion, electrical capacity
- Provides an attractive building and environment which is sustainable and fit for purpose

Patient experience

- Provides the opportunity to develop a facility with an appropriate vista and presence
- The surrounding environment provides an appropriate location for a hospice build
- Provides the capacity to develop an outside communal area(s)

Added value to local community

- Reduces health inequalities by improving access in relation to identified health need
- Fits with Local Authority plans for the area
- Has strategic fit for NHS SoTW
- Aligns with the commissioning intentions of the Sunderland Clinical Commissioning Group
- Co-location with adjacent 24 hour facilities bring opportunities for economies of scale and reduction in revenue consequences

4.7 Benefit weighting criteria

Weighting and scoring is a technique to compare and rank options in terms of their benefits. The relative importance to each criterion is established by estimating a weighting. The benefit criteria were weighted by the Project Board in accordance with feedback from the service users and are documented in the table below.

Table 11 – Benefit Criteria

Benefit Criteria	Weighting
Access	30
Estates	25
Patient experience	25
Added value to local community	20
Total	100%

Benefit Analysis

Each option was assessed in a workshop session to determine the extent to which the benefits identified in Section 4.7 could be realised. Scores from 0 – 6 were awarded to reflect the degree to which each criterion was met and the scores were then multiplied by the weights allocated to the criteria.

The results of the benefit analysis are summarised in the table below:

Table 12 – Benefit Analysis

Benefit Criteria	Weight	Weighted Benefit Score									
		Option 1 Downhill		Option 3 Carley hill		Option 4 Hylton Lane		Option 5 Glebe		Option 8 Ryhope	
Access	30	12	360	13	390	10	300	11	330	12	360
Estates	25	9	225	10	250	10.5	262.5	11.5	287.5	15	375
Patient experience	25	9	225	9	225	11	275	6	150	14.5	362.5
Added value to local community	20	10.5	210	11	220	10.5	210	11	220	12	240
Total	100	40.5	1020	43	1085	42	1047.5	39.5	987.5	53.5	1337.5
Rank			4		2		3		5		1

The benefits analysis identified option 8 (Ryhope) as the preferred location of the Project Board for the new hospice site.

The site scored well on all aspects of the options appraisal and was the unanimous winner. It benefits from good access, which will continue to be improved through the planned development of additional infrastructure and link road. The TPCT already owns the land which releases cost savings which can be reinvested into the physical build. The NTW redevelopment will provide the opportunity for economies of scale through shared operational service arrangements. Additionally, the Ryhope site is also conveniently located close to the proposed Seaham Primary Care Centre which is due to be operational before the hospice and will provide ready access to facilities such as x-ray.

Once the preferred site option was selected a design competition was held with 4 architectural firms in order to identify a project design team. An initial design brief was forwarded which included a 'vision' provided by staff, patients and carers from the hospice who were asked to list their needs for a new hospice build. They were specifically asked to include the non tangible, their thoughts and feelings of what the hospice would represent.

The design teams were invited to present their proposals to a sub group of the Project Board along with 2 'design champions' (existing hospice volunteers). Each submission was scored based on 4 topic areas. The table below documents the result of this exercise which identified P+HS as the preferred design team. P+HS and Willmott Dixon were the design and construction organisations employed to develop Houghton Primary Care Centre. A number of key personnel from that project will be involved within the development of the hospice providing continuity and an opportunity for shared learning.

Table 13 - Selection of design team

	Question Number (Quality)				Quality score total	Commercial score	Total score
Architect	1 Design	2 Sustainability	3 staff	4 Collaborative working	(Out of 65)	(Out of 35) Pricing	(Out of 100)
	Out of 35	Out of 10	Out of 10	Out of 10			
P+HS	27.36	8.00	7.80	8.00	51.16	31.50	82.66
JDDK	23.80	8.00	7.20	7.40	46.40	17.50	63.90
MAPP	15.40	6.00	6.40	7.00	34.80	28.00	62.80
ADP	19.25	6.00	6.10	6.20	37.55	10.50	48.05

4.8 Financial benefit criteria

This section estimates the capital cost of the 3 options

Table 14 – Capital Costs

Capital Costs (inclusive of VAT)	Option 1- Do Nothing	Option 2, New hospice- Buy land	Option 3, New hospice- own land
Land purchase	0	1,000,000	0
Building works and fees	0	9,470,304	9,470,304
Equipment, Furniture and Fitting	0	840,000	840,000
Design/Optimism bias contingency	0	2,165,164	2,165,164
Subtotal	0	12,475,468	12,475,468
VAT recoverable	0	-167,616	-167,616
Total	0	13,307,852	12,307,852

Appendix 8.3 contains the FB Cost Forms giving a more detailed breakdown of the Capital expenditure associated with the preferred option including contingency and optimism bias. The optimism bias has been derived using related optimism bias guidance and utilising the gateway risk assessment.

Costs for clinical services are not included in the above table but have been considered within a separate Commercial Business case.

The estimated value of the land at the Ryhope site, as documented within the TPCTs balance sheet is £1 million (calculated at 31st March 2011). This amount is comparable to the estimates quoted for the purchase of the additional sites. In relation to potential opportunity costs the only potential loss would be in relation to the difference between the potential sales proceeds compared to the £1 million costs in the TPCTs balance sheets. The TPCT has owned the land for a number of years and to date has had no enquiries in relation to the sale of this piece of land. Furthermore it should be noted that the original acquisition of the site was through an arrangement with English Partnerships and was on the basis that land must be used for the provision of health care. It is far from clear that the TPCT could dispose of the land for other uses, and indeed part of the agreement required the land to be offered to City Hospitals Sunderland if the TPCT declared the land as surplus.

Even when taking in to consideration the potential resale value, it is likely that option 3 would remain the most cost effective option.

There is no depreciation charge applied to land that the TPCT already owns, similarly no charge would be applied to any new land purchased. Therefore the impact compared to purchasing the land would be the same.

Capital costs are higher in option 2 as they include purchasing the land.

4.9 Revenue costs

The table below shows the revenue costs for the shortlisted options

Table 15 – Revenue Costs

	Option 1 Do Nothing	Option 2 – Buy New Land	Option 3 - Use Own Land
	3,100	3,100	3,100
Square Area	New Hospice Estimates	New Hospice Estimates	New Hospice Estimates
REVENUE (Estimated Full Year Costs)	£	£	£
Administration	0	60,900	60,900
Security	0	60,257	60,257
Domestics/Ancillary staff	0	60,187	60,187
NON PAY			
Capital Charges - Buildings	0	401,000	401,000
Rates, Water and Sewerage	0	58,420	58,420
Utilities	0	110,905	110,905
Waste Disposal	0	717	717
Maintenance costs	0	28,400	28,400
Postage, printing, stationary	0	19,656	19,656
Continuing SLA Costs to NTW plus Catering	306,305	N/A	N/A
Catering	110,000	129,000	129,000
Travel/Training etc	0	3,000	3,000
Total Service and Operational Costs	416,305	932,442	932,442
Less existing costs paid via SLA to NTW NHS Foundation Trust		-416,305	-416,305
Anticipated Additional Revenue costs of new build		516,137	516,137

Revenue consequences are being considered within a separate commercial business case which is being developed in parallel to this capital case.

4.10 Economic Appraisal

The Net Present Value calculations over 25 years for the shortlisted options are shown in the table below

Table 16 – Net Costs

Financial Benefits	Option 1 Do Nothing £	Option 2 New Hospice Buy Land £	Option 3 New Hospice Use own Land £
Net Present Cost	5,048,370	23,707,688	22,707,688
Rank	1	3	2

4.11 Cost benefit analysis

Table 17

Cost Benefit Analysis	Option 1 Do Nothing £	Option 2 New Hospice Buy Land £	Option 3 New Hospice Use own Land £
Benefit Score/Net Present Cost	N/A	26,429	20,692
Rank			

The cost-benefit analysis tries to take account of both financial and non-financial attributes of the project. This method of appraisal involves dividing the net present value calculations over 25 years by the weighted benefit score to show how each option compares in terms of cost and benefits:

Option 1 was not considered in the above table as it was eliminated prior to the weighted options appraisal taking place.

Option 3 has a significantly lower cost benefit score and represents considerably better value for money.

4.12 Summary of options

Table 18

Criteria	Option 1 Do Nothing £	Option 2 New Hospice Buy Land £	Option 3 New Hospice Use own Land £
Initial Build and Fit out/Estimated Upgrade Cost	0	13,307,852	12,307,852
Revenue cost – Full Year Effect (£)	416,305	932,442	932,442
Net Present Cost (£)	6,861,337	28,675,908	27,675,908
Benefit	N/A	1085	1337.5
Cost (NPC)/Benefit (£ per benefit score)	N/A	26,429	20,692

Having explored the non-financial, financial and economic benefits of each of the options option 3 emerges as the preferred option. Option 1 is the lowest cost, however was eliminated due to ongoing issues in relation to sustainability and quality of the current location. The drivers for this project are not in relation to financial savings. Option 2 would be the most expensive option as it includes the purchase of land.

5 PREFERRED OPTION

This section describes the proposal in terms of the clinical configuration of services illustrating how the services meet the vision of national and local priorities and address health needs of the locality. The design considerations and the provisional design solution for the proposal are also detailed in this section. The site location of the planned investment proposal and the role of accessibility planning are also considered here. This section explains the procurement method and concludes with a list of commissioner and partnership support for the proposal

5.1 Proposed service content

In order to identify the capacity requirements of the facility a review of current bed provision was undertaken and measured against a recommended average from the National Council of Palliative Care. Future population projections were then used to assess the change in need across the next 10 years.

Table 19 - Provision of hospice beds in SoTW (actual, average and recommended)

Area	Population	Current number of hospice beds	Average (National Council for Palliative Care; 5 beds per 100,000)	Recommended need (Tebbit; 1 bed per 15,000)
Sunderland	281,500	12	14	19
Gateshead	191,000	0*	10	13
South Tyneside	152,600	8	8	10
SoTW Total	625,100	20	32	43

* There are currently no inpatient specialist palliative care/hospice facilities available within Gateshead. Gateshead Health NHS FT has provision for 8 designated “palliative care beds” provided within Dunston hospital, including day care and outpatient services. A review and business case for the re-provision of these beds has been completed and discussions are ongoing about their re-provision on the main Queen Elizabeth hospital site. This facility does not currently provide ‘Specialist Palliative Care’, patients with particularly complex end of life problems are referred to either St Oswald’s or Marie Curie hospice in Newcastle.

Hospice care in South Tyneside is provided by St Clare’s hospice in Jarrow. The hospice has recently undergone a major refurbishment programme to the inpatient unit. The hospice includes the provision of 8 inpatient beds, day care, outpatient and lymphoedema services.

Concern was raised over the future sustainability of the Primrose site which houses St Clare’s. This has been mitigated by South Tyneside NHS FT who have confirmed they have no short term plans for changes to the Primrose site.

Given the information presented above the Project Board recommended that the project progresses with a focus on the development of a hospice facility which was able to provide sustainable services to the residents of Sunderland.

The table below demonstrates using population predictions, what the average recommended number of beds will be over the next 10 years.

Table 20 - Provision of hospice beds based on predicted population

		Sunderland	Gateshead	South Tyneside
2011	Population	281,500	191,000	152,600
	Recommended Average	14	10	8
2016	Population	283,100	193,900	155,200
	Recommended Average	14	10	8
2020	Population	284,800	196,700	157,700
	Recommended Average	14	10	8

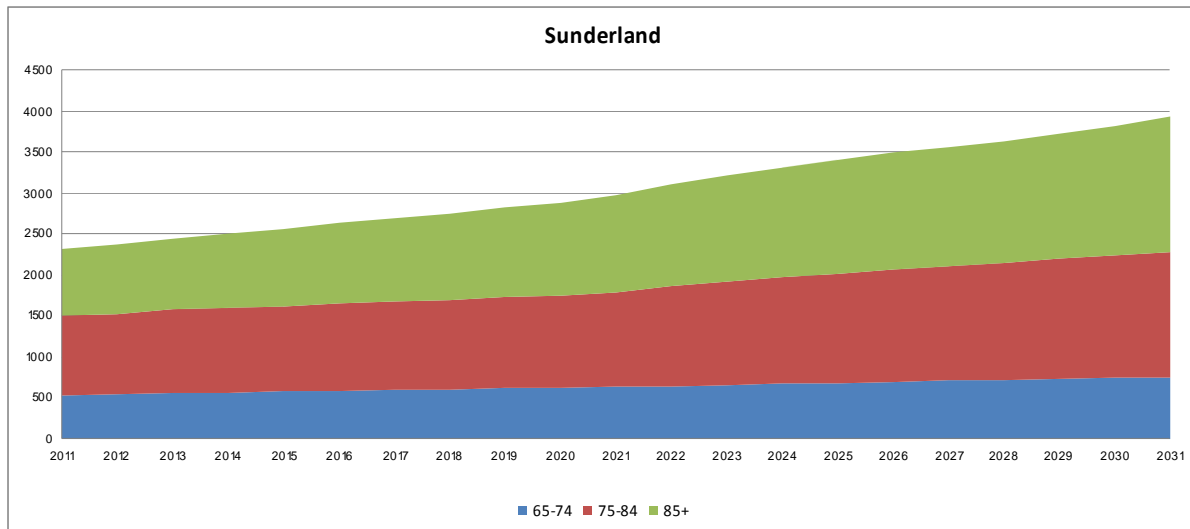
Based on the current population the average number of beds for an inpatient hospice facility primarily serving Sunderland patients would be 14 with a recommended number of 19. Based on population predictions, these numbers would remain constant over the next 9 years despite the predicted increase in the general population.

An alternative methodology is to look at the age range of people currently accessing St Benedict's. The bed occupancy rate for the hospice is currently 80% and the vast majority of patients are aged 65 or over. The table below shows the number of individuals that live in Sunderland that are aged 65+ over the next 10 years using ONS National Population Statistics.

Table 21 - Population predictions (65+ age group)

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
65+ (000s)	46.8	47.4	48.9	50.1	51.1	52.2	53	53.8	54.6	55.4	56.3

Chart 3 - Over 65s Population predictions (Sunderland 2010-2020)



The current utilisation rate of inpatient beds at St Benedict’s is 80%, therefore it could be assumed that the 12 inpatient beds is currently meeting the need of the population. However, in 10 years time the population of this age group (65+) is expected to increase to 56,300 (an increase of 20%). Applying this percentage age increase to the number of beds currently available in St Benedict’s would suggest a required increase from 12 to 14 beds. This would support the number of average beds recommended by the National Council for Palliative Care. Increase in the provision of community based service within the integrated model will provide capacity for growth beyond 2020.

Consideration was also given to the likely increase of referrals to specialist services for patients with a non cancer diagnosis. It is recognised that this group of patients have traditionally not received equity of access. Nationally there has been a recent move towards improving equity of access for this patient group through a referral based on need as opposed to disease. Locally this is being taken forward as part of the work of the End of Life Strategy Group for SoTW. In order to understand the impact of strategy further work was undertaken around predicted disease profiles.

It is important to note that the aim of a hospice is to provide ‘specialist’ and ‘supportive’ care for patients with complex needs. The increase in bed stock is intended to provide capacity to support inpatient episodes for this specific group, not to act as additional community generalist or care of the elderly beds. The utilisation data collected and produced through the palliative care coordination centre will provide management information to inform future commissioning.

The hospice inpatient unit currently runs at an 80% utilisation rate. The two 3 bedded units and single sex accommodation agenda can cause delays in accommodating patients. An increase of 2 additional beds and a move to a single bed system for all 14 rooms within the new facility will improve access and have a positive impact on the utilisation rate. It is anticipated that an 85% utilisation rate for 14 beds would provide a 27% increase in patient access to beds.

Our plan is to develop the integrated model and improve access to specialist palliative care within the community setting in order to address the growth in the elderly population and a reduction of deaths in hospital by 5%.

A programme of consultation exercises has been initiated with patients, health professionals and existing staff members in order to identify if there are any capacity or process issues with the current provision of services. The information provided will be used to shape the agreed future service delivery model. The plan for this programme of consultation is included in section 2.5.

In broad terms the hospice will;

- Improve access to specialist palliative care services across Sunderland
- Increase choice at the end of life
- Provide a cost effective delivery model for these services
- Help to increase the availability of care provision within the community, maintaining patients in their preferred place of care
- Help to avoid unnecessary, expensive admissions to acute care
- Provide patients access to a range of services within first rate facilities which are fit for purpose

This will be achieved through the provision of services including;

Table 22 – Future service provision

Service	Service detail
Inpatient	14 inpatient specialist palliative care beds
Outpatient	3 Clinics per week
Day care	Monday to Friday 12 places per day (60 per week) Nurse led service
Lymphoedema service	Clinics daily within hospice, plus outreach at Houghton and Washington PCCs and home visits Nurse led service
Complementary therapies	26 hours of service via lifespan (funded through charitable donations)
Occupational therapy, Physiotherapy, Social work	0.5 WTE covering in patient and day care predominantly Provided through SLA by SRH, covering in patient day care and community Social care input, referred via social services
Community Specialist Palliative Care	8.6 WTE (2 based in SRH) There is additional consultant input within this team

Out of Hours Specialist Palliative Care service	Work from 4.00pm-9.15am evening and overnight with the aim of enabling patients to be cared for in their own homes by responding to and managing pain and other symptoms. They provide advice and support to the patient, carer and other professionals. Planned and crisis calls
Bereavement	Monthly bereavement support group
Education	Lecturer practitioner plus modernisation facilitators – providing range of education and training, developments across primary, secondary, care home sector

5.2 Location

The site for the new development is located adjacent to the existing Ryhope Hospital within the old Cherry Knowle site boundary. Sunderland council have partially completed the A1018 radial route along the coast connecting the site to the city centre. The attached master plan illustrates the long term intention to extend this route to Doxford Park, thus providing easy access northwards to the A19. The first stage of this section of the route is due to be completed within the next 2 years.

Although Ryhope is located to the south of the city centre, the new improved road links and associated improvements to public transport have dramatically reduced travel times from other parts of the city. The proposed additional section of road will further improve this situation

5.3 Building design consideration

The Hospice will be a purpose built facility and will incorporate the best design principles to ensure that the facility functions as effectively as possible.

Patient experience

The building is designed to ensure that the patient's experience is made as pleasant as possible, to be easily approachable and non-threatening. The role of the building in the final experience of a patient's life is important, and the building will provide a comforting and supportive environment for patients, friends, relatives and staff.

The building will feel light and airy and provide a homely feel. Sufficient spaces are provided to respect the privacy and dignity of patients and areas are provided to allow for sensitive consultations and treatments to take place providing both acoustic and visual privacy, the mix of rooms will allow patients to be alone if they wish, however larger day rooms are provided to allow for the company of others.

Rooms where patients and staff will spend significant amounts of time will be provided with large windows which afford good, pleasant and interesting views. The bedrooms have been designed particularly with this in mind, and these spaces all allow direct external access to spaces of semi-privacy.

All bedrooms are provided with en-suite facilities with separate bath and toilet facilities throughout the building.

To further enhance the patient experience careful consideration has been given to the siting of the building to create a parkland setting. The building design allows the ability to create a number of varying landscaping areas and tranquil gardens to walk around or just sit in, providing choice for the patient. The landscaping design around the building will be designed to be therapeutic in its qualities.



Section through In-patient bedrooms

Non Clinical Environment

The design of the Hospice will seek to maximise the sense of a 'non clinical' environment wherever possible. The choice of materials, both internal and external, will be carefully selected to be functional but at the same time recognisably domestic in feel and appearance allowing the environment to be more visually accessible to patients and visitors. The clear planning arrangement of the building with clear views in circulation areas and the introduction of plenty of daylight will further enhance the welcoming feel.



External view of bedroom spaces

Flexibility and Future Expansion

The building has been designed to ensure flexibility in the future when there is always the possibility, through service development, for clinical spaces to be modified allowing the Hospice to meet changing needs of healthcare accommodation.

Wherever possible the room sizes, layouts and clusters of rooms have been designed to allow for the multi-use of a space and the flexibility of the service provided.

The site layout has been designed to ensure that potential future expansion can be accommodated with minimal disruption to the operational facility. An area for future expansion has been identified to accommodate six additional beds at lower ground floor level. The landscape design will ensure any areas of future expansion will achieve the same quality of external aspect and access as will be achieved in the original facility.

Environmental performance and sustainability

The NHS identifies environmental performance of its estate as one of its key objectives for all new buildings. The designers are assessing the facility using BREEAM for Health (the latest version of the Building Research Establishment's assessment tool) and will strive to design the facility to achieve 'outstanding' grade as stipulated by the TPCT in its performance brief. Houghton Primary Care Centre was the first healthcare facility in the UK to achieve a BREEAM rating of Outstanding, leading to the design team being recognised in the Department of Health's guidance document 8758:0:6:England, Tomorrows healthcare environment.

The design and performance brief of the new facility demands that it sets an aspiration towards 'zero carbon'. The precise definition of 'zero carbon' is yet to be fully defined nationally but the target is being used to fully convey the highly sustainable aspirations for the facility by the TPCT. We also intend to incorporate some of the Passivhaus design principles into the scheme.

On-site generation of electricity will be provided by wind generation and photovoltaics (PV). Surveys are being commissioned to verify the suitability of the ground for the implementation of ground source heating. The TPCT has also initiated further features including solar water heaters on other schemes and will include such features for the Hospice. Cost allowances have been made to ensure highly sustainable technologies are affordable as well as incorporating high levels of insulation and solar protection within the construction.

The specification and sourcing of materials is being carefully examined to ensure that the carbon footprint generated by the transportation of materials is minimised. Wherever possible materials will be sourced locally, particularly the massive, large quantity materials such as stone, bricks and steel.

Integrated art and design

The Arts support team at Sunderland council has previously been very supportive and continues to assist the SOTW TPCTs to realise their aspiration to integrate commissioned artwork within health facilities within the City. The cost plan includes implementation

funding for both glasswork/sculpture and original print based media and for works located within the landscape which forms such an important element of the scheme.

Excellence in Design and the Design Champions

The Trust has appointed a variety of members to the Project Board including representatives from the public following the success of similar appointments on previous schemes. The Project Board has been involved with the design of the building from the outset and supports the design champions for the scheme.

The Project Board has appointed a small working group to ensure that the building design meets the guidance set out in the Achieving Excellence Design Evaluation toolkit (AEDET), the recommended tool to be used in P21 schemes but also a useful tool for non P21 schemes including the Hospice. (see appendix for details). This working group includes two design champions, both have voluntary links to the current Hospice.

Security

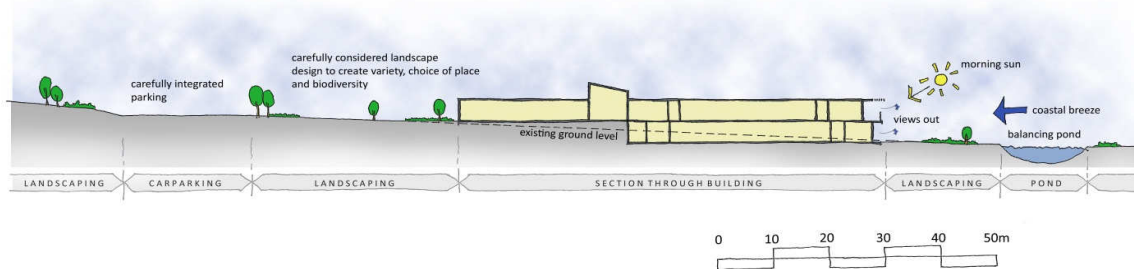
The TPCT recognises that security is a vital component of the building because of the nature of the services provided and the extended hours of operation of the site. Arrangements including CCTV and panic alarms will be incorporated as part of a comprehensive security system and the building will be designed to 'Secured by design' standards.

5.4 Building design solution

The design of the new Hospice has been developed by Architects appointed by Sunderland TPCT. The Architects have designed and located the building to take best advantage of its landscaped setting alongside the proposed new 'Pride' project to be delivered by NTW.

The building has been designed to respond to the Design Brief, Clinical Brief and the preferred site option.

The preferred site presents both opportunities and constraints. The site opportunities being; Good highway links, opportunities for shelter, view of the North Sea, view of the surrounding countryside. The site constraints being; busy main road and new link road, prevailing wind and sea breezes, new housing opposite the site. The sloping site provides many opportunities to create a truly outstanding building.



Main Site Section

The design proposes to exploit the sloping site to the building's advantage, effectively creating two "ground floors". Car parking is located on the highest level of the site allowing the inevitably high numbers of parking spaces to be sensitively designed into the landscape and maintain uninterrupted views out from the site. Beyond the site to the east, south and west, only the building and landscaped setting will meet the eye, avoiding the "sea of car parking" effect often encountered in healthcare facilities.

The main entrance is approached directly from the upper "ground" level creating an easily accessible central wayfinding point. Additional discreet entrances allow ambulances and service vehicles to approach the facility separately with minimal impact on the visitor and patient experience.

The building is clearly defined in its layout – visitor / day facilities occupy the upper ground floor, with in-patient facilities occupying the lower ground floor. Both therefore have appropriate levels of privacy and tranquillity. External gardens are accessible at both upper and lower ground levels.

Support and servicing elements of the building are located to ensure accessibility and appropriate adjacencies.

The building solution has been designed to accommodate LEAN building practices.

Upper floor site plan



Lower floor site plan



5.5 Accessibility

Accessibility, especially for those from disadvantaged groups and areas, is a key consideration for this development.

To inform discussions at the options appraisal sub group meeting a local consultancy company were commissioned to review the accessibility of all 5 shortlisted sites. The report (Appendix 8.7) outlined the percentage of households across Sunderland who were able to access the sites within set time bands using both public and private transport.

Travel Planning

The TPCT has commissioned a travel plan for the proposed hospice. The plan demonstrates that there are good public transport links. The site is serviced by a number of bus stops. The site is surrounded by an extensive pedestrian network. The site is also located within close proximity to numerous cycle routes highlighted on Sunderland City Council's Strategic Cycle Route Network. The travel plan focuses on encouraging people who attend the hospice to travel by other means than private car. There are a number of objectives in the plan (detail can be found at appendix 8.9) and these will be monitored to measure its success.

Parking

Recognising that many service users prefer to travel by car, initial calculations based upon the recommendations of HTM 07-03 'Transport Management and Car parking' have identified that there will be provision for the parking of 61 vehicles within the site, including 6 dedicated disabled car parking bays and 3 family spaces. Provision for 5 motorcycle racks and 20 cycle racks will be provided. There are also parking and drop off facilities for buses, patient transport/ambulances, service and maintenance vehicles and the nearest bus stops are adjacent to the site.

5.6 Site plan

The area of land available for the development is approximately 2.606 hectares [6.44 acres]. A Site Investigation [SI] has been completed by NTW to the surrounding land and we have based costing assumptions on this document. The results of the SI have been used to develop sub-structure proposals which have been used in the detailed cost build up. Further ground investigations are being undertaken to determine the suitability of the ground for the use of ground source heat pumps. If appropriate these will be designed and incorporated to provide under-floor heating for the entrance and central atrium areas amongst others.

Vehicular access to the site will ultimately be from a spur road from the new Doxford link road for all cars, coaches and delivery vehicles. Pedestrian access to the site is separated from the vehicular access to minimise potential conflict between vehicles and pedestrians and ensure a safe environment. These routes include linkage through the new 'Pride' development. Initial discussions with Consulting Highways and Transport Engineers have determined the numbers of parking spaces on the site required to serve the hospice. This has resulted in the following provision:

- 6 disabled vehicle spaces, located close to the main entrances
- 61 car parking spaces
- Drop off areas at the main entrance
- 1 ambulance bay, covered for use
- 1 delivery / collection vehicle space
- Spaces for 5 motorcycles, and
- Secure racks for 20 cycles

The external vehicular circulation has been given careful consideration to minimise potential conflict between patients/visitors vehicles and delivery, service and public transport vehicles.

Scheme design

Proposed Upper floor

The scheme for the hospice comprises a design over two floors with a gross internal floor area of approximately 3100m² as shown within the Schedule of Accommodation. The design of the building provides three clearly designated separate entrances:

Main Entrance

The main entrance to the hospice will be the focal point of the building. This provides a light; airy and welcoming foyer area and the day patients and visitors will be welcomed by the main reception within. The centralised main reception point will control visitors to the various parts of the building. This main entrance provides the primary access for visitors to the In-patients unit during normal opening hours and by the visitors and patients to the Out-patients and Lymphoedema Clinic, staff will also use the main entrance during normal working hours. The Education Unit is also adjacent to the main entrance, so access to this area will again be controlled, and its location ensures that it causes no disruption to the remainder of the facilities.

The main entrance contains the primary building staircase and lift for all visitors and patients to the lower floor. The design of the staircase allows out of hours access for the staff without the need to pass through spaces and departments which may be locked off.

The external design of the main entrance allows for the safe transportation of patients via a mini-bus or by relatives, and the ability to drop off patients under cover is an integral part of this area. As would be expected the appropriate number of accessible and family parking spaces are located close to the main entrance.

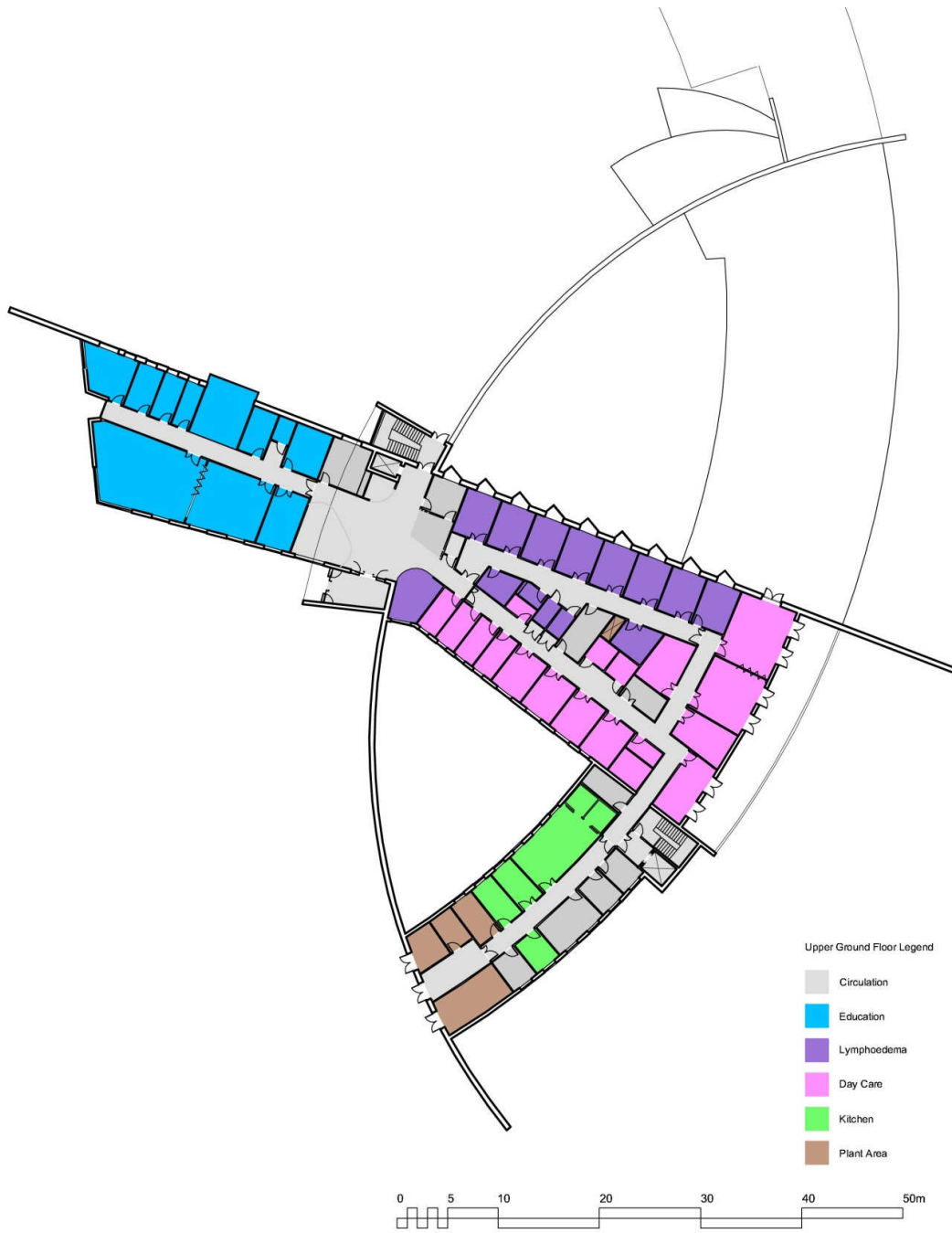
Services Entrance

A separate screened entrance is provided as close to the site boundary as possible allowing direct access for all deliveries into the building. This entrance clearly separates any pedestrian and visitor routes from delivery vehicles, avoiding any conflict and following best practice.

Out of Hours / In Patient Entrance

The third and building entrance is provided close to the In-patient Unit, and the topography of the site allows direct access to this area at the lower level. This entrance allows the safe delivery of patients via ambulance into the In-patient unit without the need to pass through any other areas of the building. This also allows relatives to visit the building outside normal visiting hours without the need to keep other areas of the building open, enhancing the security and sustainability of the building.

In this location the mortuary will also be provided within a screened design allowing direct access for the funeral services, thus minimising any potential stress to patients and relatives visiting patients outside normal visiting hours.



Upper Ground Floor Plan

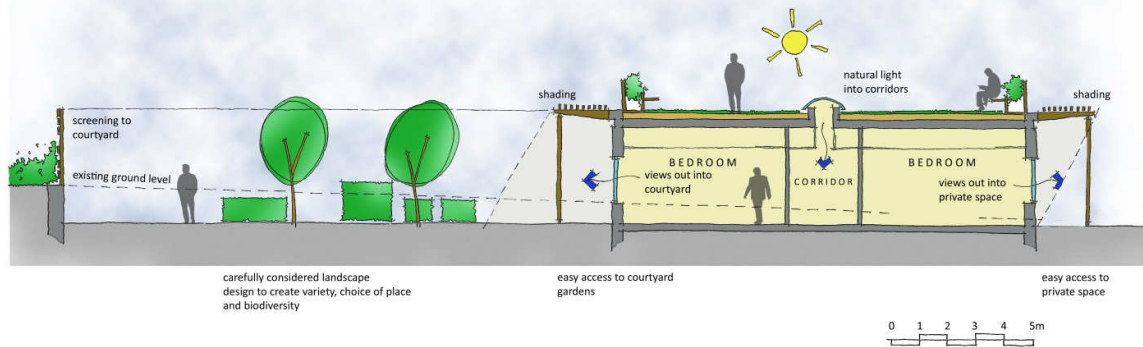
Upper floor accommodation

The main entrance provides access to both the upper floor and lower ground floor levels during normal operational hours. The upper floor of the building contains the following departments;

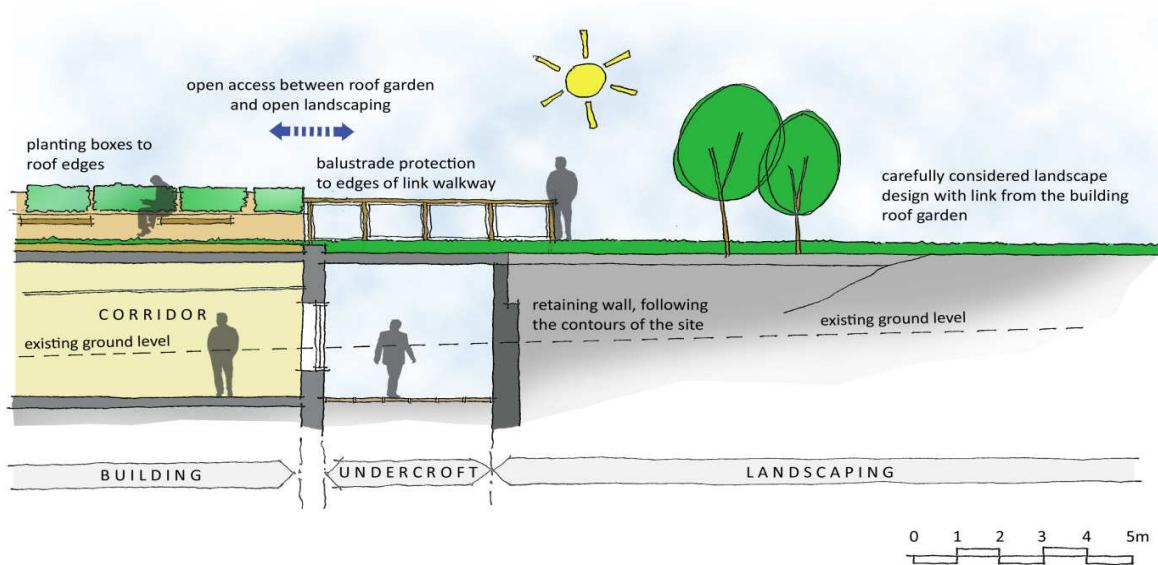
The Education Unit is self-contained and is directly accessed off the main entrance and is provided with a range of toilets and refreshment areas, together with flexible multi-use spaces. The location of the unit allows these rooms to be locked off as a whole area, or if necessary operated independently of the main building.

The Lymphoedema Clinic and Out-Patients Departments are located adjacent to the main entrance area with access to the department controlled by the main reception. A sub-waiting area is provided opposite the reception with natural light and ventilation providing a place to wait prior to being collected by a member of staff. The design of the department means that it is self-contained with a range of clinical rooms, toilets and stores.

The Day Care Unit entrance is adjacent to Out Patients and again the entrance to this department can be clearly observed from the main reception desk. All of Day care is located at the upper floor level, reducing travelling distances for the regular patients. The patient environment is further enhanced within this department by the provision of an external terraced area with views out towards to the North Sea and direct access to a rooftop garden carefully designed with raised planters and walkways, providing further patient choice.



Section through In-patient bedrooms with day care garden over



Section through end of In-patient bedrooms with day care garden over

The services entrance provides direct access to the 'back of house' facilities required to service a building of this type. The design allows for the regular deliveries, such as clean and dirty linen, and clinical disposal, with general delivery stores and kitchen services incorporating a goods-in point for control by the building porter. In the same vicinity direct external access is provided to the mechanical and electrical plantrooms and gas bottle stores.



Lower Ground Floor Plan

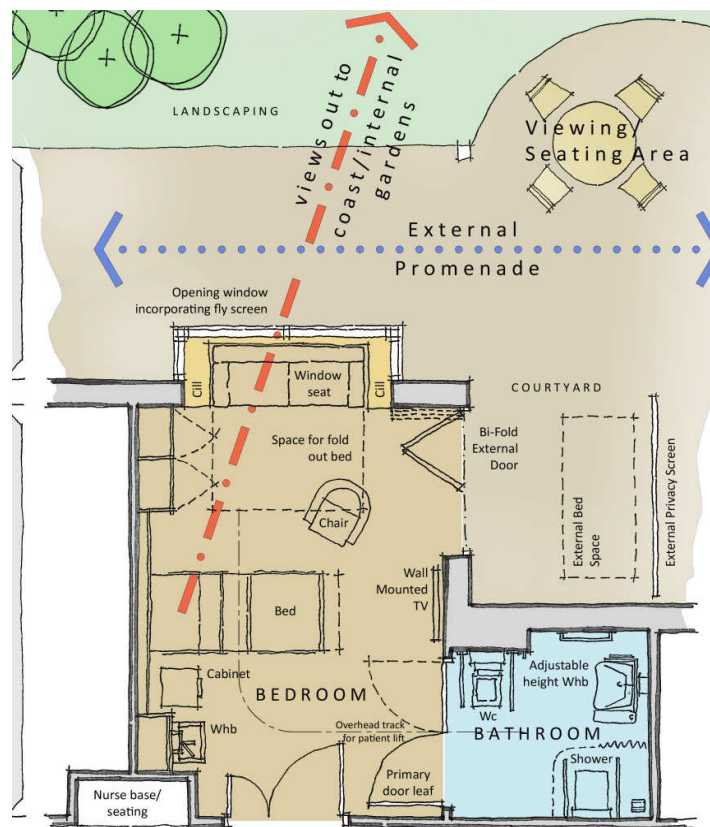
Proposed Ground floor

The lower level of the development covers those spaces that require less public access and at this level there are two specific areas clearly separated from each another.

The Administration and staff areas are grouped together at the lower level and contain the centralised staff changing, locker, toilet and shower areas. In addition grouped together for efficient co-working are the administration offices, stores and staff room. The primary access to this area from outside is via the main staircase and lift however the additional staircase at the edge of the Day care unit provides direct access for staff between floors.

The staff areas generally look out towards one of the enclosed courtyards providing external space to be shared with patients and visitors alike, but also provide staff with the opportunity of accessing a peaceful external area for rest breaks.

The lower level also contains the multi-faith room, linked to this courtyard, with the room positioned such that easy access can be gained off the main circulation routes.



Typical bedroom configuration

The In patients unit is situated at this level and the 14 number single bedrooms are arranged in an arc on a separate wing of the building, placing the most sensitive areas furthest away from the other clinics and departments in the building. The positioning and design of the bedrooms provides each with ample natural light and clear views to landscaped areas, either out towards the surrounding countryside or to the carefully designed and planted internal courtyard gardens.



Bedroom images

The In-patients department is arranged such that there is no need to pass through this area, providing a safe and secure environment for the patients, the centrally located staff base and nurses office will allow for enhanced control. Within the department all the necessary spaces are provided together including activity, sitting and dining rooms with direct external access to the courtyard gardens.

Access to this area can be gained from two directions. The normal entrance during working hours for visitors and relatives will be via the controlled main reception at the upper floor level, however outside of these hours a dedicated entrance is provided at the lower level directly in to the In-patient wing. This lower entrance will be used to deliver all patients to the In-patient wing.

The mortuary is also located at this end of the building, within a screened design. This allows a direct route for relatives to view their loved ones, and also provides access for funeral services.

5.7 Statutory approval

Sunderland TPCT has been part of the Cherry Knowle planning group chaired by English partnerships/Homes and Communities Agency (HCA) for many years. The current master plan for the overall site prepared by GVA is appended to this report. Sunderland council's planning team also attended these meetings to ensure the evolving proposals for all stakeholders could be supported in terms of planning and highways policy. The use of the proposed site for health activity has been confirmed as acceptable. The Planning Application for this scheme is currently being prepared. The formal pre application process is already underway.

5.8 Commissioner support

This proposal is supported by:

- NHS SoTW Clinical Executive Team
- NHS SoTW Integrated Board - Non Executive Members
- Chair of TPCT (Chairs actions pending September meeting of the board)
- NHS SoTW Planned Care Programme Board
- Sunderland Clinical Commissioning Group
- Sunderland TPCT Commissioning Business Group
- Local Authority Overview and Scrutiny Committee (Preliminary support pending full update)

6 FINANCIAL CASE

This section describes how the estimated revenue impact of the preferred option will be met drawing upon previous experience of developing and delivering such schemes. It indicates the contingency arrangements to meet unexpected affordability issues relating to revenue costs

6.1 Financial strategy

As stated above a separate business commercial case is being developed in parallel which demonstrated funding streams for the operational costs associated with this move. The impact of the preferred option on revenue expenditure is approximately an additional

£500,000 over and above what is currently being paid through an SLA to NTW. These costs include all anticipated additional costs arising from the scheme and include direct costs of servicing the building itself. The approach which has been used at the previous Primary Care Centres has been to estimate the pay costs etc.

6.2 Capital costs

The preferred option is costed at £12.3m which is identified within the Sunderland ISOP 2011/12 and 2012/13. This cost has been generated through an independent cost consultant working on behalf of the TPCT.

The degree of risk associated with the preferred option in terms of unforeseen problems affecting affordability is deemed low. This is based upon experience from the development of the 4 Primary Care Centres. Additionally, there is £551,908 incorporated within the cost form for planning contingencies.

6.3 Revenue costs

This project is recurrently affordable. The additional revenue costs identified have been included within the ISOP 2011/12 and 2012/13 which shows remaining uncommitted financial resources allowing flexibility to manage financial pressures arising from this development.

The impact of the implemented services are the subject of a separate commercial business case.

7 MANAGEMENT CASE

This section explains how the project will be managed detailing both the project management and contract management structures. It describes how the project will be controlled and monitored and how risks will be managed and monitored throughout the life of the project. The section concludes with a summary of the project's implementation plan.

7.1 Procurement strategy

Scape is a Local Authority controlled "for profit" company established by a Consortium of Local Authorities to enable public sector works to be procured efficiently. The six shareholding authorities are Derbyshire County, Derby City, Nottinghamshire County, Nottingham City, Warwickshire and Gateshead. Scape is a Central Purchasing Body for the purposes of the Public Contract Regulations 2006.

Scape has entered into a national strategic partnering framework with Willmott Dixon. The arrangement is accessible by all public sector bodies and is for construction projects in the range £2m to £20m. The benefits of this arrangement to its customers are:

- Early building occupation through shortened procurement times.
- Reduced cost of procurement for the customer
- An established quality of product.
- A framework intent on achieving continuous improvement in time, cost and quality.

The framework brings together Willmott Dixon's expertise in project delivery and Scape's position as central procurement body for the public sector. Willmott Dixon and Scape share common values:

- Environmental sustainability is given a priority.
- Processes that fully engage the customer and community are essential.
- Delivery through partnering and collaboration.
- Buildings are to be inclusive and welcoming.
- Promote procurement which encourages local economic and social sustainability.
- Support modern methods of construction.

The Scape/Willmott Dixon Framework is part of a wider initiative by the East Midlands Centre of Excellence to promote efficiency in the procurement of construction work. Following a substantial competitive process through OJEU, Willmott Dixon are now "on-board" from "day one" and can provide all services from inception/feasibility through to completion of construction. The appointment was in April 2010, following the formal OJEU tender, and the Framework Contract covers the country, and is available to any public sector body. The OJEU Award notice 2009/S 176-253640 provides further more detailed information. The TPCT has taken independent legal advice on the OJEU process undertaken by SCAPE and can confirm it is suitable for health use – See appendix 8.25. SCAPE is an open book procurement method almost identical to Procure 21 plus. Not only are the tendered packages of each area of work signed off by the Trust but as an additional governance measure the TPCT has retained the services of Turner and Townsend to audit construction costs. Turner and Townsend have acted for the Trust as cost advisers on Grindon Lane, Washington and Blaydon PCCs as well as 3 health centre refurbishment schemes. This provides an additional cost overview of each work package to ensure the framework is achieving value for money. It should be noted that the projected outturn cost is lower than that anticipated through Procure 21 plus as overhead and preliminary costs are significantly lower in the SCAPE framework agreement. The actual New Engineering Contract (NEC) building contract will mirror the format used on Procure 21.

7.2 Project organisation and management

The TPCT has established a project management structure to oversee this project through to completion. The project management team will lead a multi-disciplinary, multi-agency Project Board reporting to the project sponsor in her role as delegated representative of the TPCTs integrated management Board. The TPCTs Head of Estates acts as the interface between the Project Board and Principal Supply Chain Providers (PSCP) and controls and oversees the performance of said contractor on the construction of the project.

The structure is similar to those which were established for the aforementioned 4 Primary Care Centre projects and numerous refurbishment schemes, all implemented on time and on within budget. The project management structure is depicted diagrammatically in Appendix 8.13. The roles and responsibilities of the Project Board are outlined in Appendix 8.14.

7.3 Contract management

The TPCT is proposing to enter into a direct NEC contract with Willmott Dixon for the construction of the hospice facility. Payment will be made on monthly certificates and we propose to retain an independent cost adviser (Turner and Townsend) to add a further level of audit to the cost control mechanism.

We are still at an early stage of developing the operational maintenance procedures and structures for the scheme but currently the proposal allows for the TPCT to clean and maintain the hospice. We are in dialogue with NTW to investigate what aspects of operational services we can share to achieve mutual savings.

Commercial and legal progress

The TPCT has completed the transfer of part of the old Cherry Knowle site in March 2009. The shaded part of the drawing shows the land which is now owned freehold by the TPCT. This not only accommodates all of the hospice facility but also the car park including the part of the site defined for future expansion.

Subject to SHA approval we intend to enter into a direct NEC form of contract with Willmott Dixon to construct the Hospice through the SCAPE framework.

7.4 Risk management

All developments have some level of uncertainty and risk. In order to enable the TPCT to understand and quantify the likelihood of the potential impact on the project the known risks to the project have been identified and documented in the Risk Log (Appendix 8.16).

Risk is considered throughout all the stages of the project. Project planning is underpinned by a comprehensive risk assessment process involving all major stakeholders, e.g. PSCP and the Project Board, to gain a shared view of the risks and how they will be managed.

The risks will continue to be monitored and identified throughout and categorised. For example: legal, planning, commercial, design, construction, operational, client. The risks will be assessed in terms of their effect on the project, if they were to occur, and scored in terms of the likelihood of the risk occurring.

7.5 Implementation plan

An overview of the proposed implementation process and indicative timescales is detailed below:

Task	Deadline
Appointment of design team for FBC preparation	15 th August 2011
Preliminary design development	30 th August 2011
FBC Sunderland TPCT approval (Commissioning Business Group, Planned Care Programme Board, PCT Integrated Board (Chair), Commissioning Executive Team)	31 st August 2011
Project logged with planning for pre-application	22 nd August 2011
FBC Submission to SHA	1 st September 2011
PCT Board ratification of Chairman's action	14 th September 2011
FBC Approval	29 th September 2011
Planning approval	March 2012
Complete construction detailed design	April 2012
Commencement of construction	May 2012
Completion of construction	June 2013
Handover	June 2013
Mobilisation plan executed, transfer of service	August 2013
Post project evaluation	August 2014

The construction plan is set out in a gantt chart in appendix 8.12.

7.6 Post project evaluation plan

The post project evaluation plan will provide a formal mechanism to assess and evaluate the impact of the project and to determine in particular:

- Whether the investment objectives have been achieved
- How costs, benefits and risks compare against the estimates in this business case
- The impact of the project on patients and
- The lessons learned from developing and implementing the project.

The project objectives and deliverables outlined in sections 4.1 and 4.2 form the basis of the evaluation. The appraisal process will incorporate service, patient, staff, technical quality and financial perspectives. The plan is appended to this document in appendix 8.15 and will be overseen and implemented by the Project Board.

8. SCHEDULE OF APPENDICES



8.1 Optimism bias- Contributory factors and mitigation calculation

Upper Bound for this Project		
Length of Build	< 2 years	0.5%
Number of phases	1 or 2 Phases	0.5%
Number of sites involved (i.e. before and after change)	Single site*	2.0%
Location	New site - Green field New Build	3.0%
Facilities Management	Hard FM only or no FM	0.0%
Equipment	Group 1 and 2 only	0.5%
IT	No IT implications	0.0%
Organisations	1 or 2 local NHS organisations	1.0%
Service changes - relates to service delivery e.g NSF's	Stable environment, i.e. no change to service	5.0%
Gateway - RPA Score (Risk Project Assessment)	Low	0.0%
Total		12.5%

Mitigation at current stage		
Progress with Planning Approval	Conceptual understanding with Planner	1
Other Regularatory	Initial Dialogue - problems possible	1
Depth of surveying of site / ground information	Site known - limited information available	1
Detail of Design	1:500 drawings only	1
Innovative project/design (i.e has this type of project been undertaken before)	some innovation	1
Design Complexity	Standard design some complexities	3
Likely variations from standard Contract	Standard Contract	2
Contractors' capability and capacity (excluding design team covered above)	Contractor proven - capable with capacity	3
Contractor involvement	Contractor Involved at all relevant stages	2
Detail of Design	Limited detailing	0
Client Capability and capacity (NB do not double count with design team capabilities)	Proven capability and capacity	6
Robustness of output specification	Output specification developing	10
Involvement of Stakeholders, including Public and Patient involvement	Limited involvement from some stakeholders	2

Agreement to output specification by Stakeholders	Limited agreement from some stakeholders	1
New service or Traditional	All traditional	3
Local community consents	Some initial community involvement	1
Stable policy environment	No changing policies	20
Likely competition in the market for the project	Considerable competition	1
Mitigation %		59

Optimism Bias Calculation	
Actual Upper Bound for this project	13%
Mitigation	59%
Optimism Bias	5%

Optimism Bias- Upper bound calculation

Mitigated Optimism Bias	5% (as calculation)
Planning Contingency	-5 %
Total Optimism Bias and Planning Contingency	10%

8.2 Discounted cash flow

Option 1 Do nothing				Option 2 New Hospice Build - With Land				Option 2 New Hospice Build - Own Land			
Discount Rate		3.50%		Discount Rate		3.50%		Discount Rate		3.50%	
Current Costs				Recurrent Revenue				Recurrent Revenue			
<u>Year</u>	<u>Base</u>	<u>£'000 Revenue Cashflow</u>	<u>£'000 NPV</u>	<u>Year</u>	<u>Base</u>	<u>£'000 Revenue Cashflow</u>	<u>£'000 NPV</u>	<u>Year</u>	<u>Base</u>	<u>£'000 Revenue Cashflow</u>	<u>£'000 NPV</u>
2011/12	0	0	-	2011/12	0	13,307,852	13,307,852	2011/12	0	12,307,852	12,307,852
2012/13	1	416,305	402,227	2012/13	1	932,442	900,910	2012/13	1	932,442	900,910
2013/14	2	416,305	388,625	2013/14	2	932,442	870,445	2013/14	2	932,442	870,445
2014/15	3	416,305	375,483	2014/15	3	932,442	841,009	2014/15	3	932,442	841,009
2015/16	4	416,305	362,786	2015/16	4	932,442	812,569	2015/16	4	932,442	812,569
2016/17	5	416,305	350,518	2016/17	5	932,442	785,091	2016/17	5	932,442	785,091
2017/18	6	416,305	338,664	2017/18	6	932,442	758,542	2017/18	6	932,442	758,542
2018/19	7	416,305	327,212	2018/19	7	932,442	732,891	2018/19	7	932,442	732,891
2019/20	8	416,305	316,147	2019/20	8	932,442	708,107	2019/20	8	932,442	708,107
2020/21	9	416,305	305,456	2020/21	9	932,442	684,162	2020/21	9	932,442	684,162
2021/22	10	416,305	295,126	2021/22	10	932,442	661,026	2021/22	10	932,442	661,026
2022/23	11	416,305	285,146	2022/23	11	932,442	638,672	2022/23	11	932,442	638,672
2023/24	12	416,305	275,504	2023/24	12	932,442	617,075	2023/24	12	932,442	617,075
2024/25	13	416,305	266,187	2024/25	13	932,442	596,207	2024/25	13	932,442	596,207
2025/26	14	416,305	257,186	2025/26	14	932,442	576,046	2025/26	14	932,442	576,046

2026/27	15	416,305	248,489
2027/28	16	416,305	240,086
2028/29	17	416,305	231,967
2029/30	18	416,305	224,122
2030/31	19	416,305	216,543
2031/32	20	416,305	209,221
2032/33	21	416,305	202,146
2033/34	22	416,305	195,310
2034/35	23	416,305	188,705
2035/36	24	416,305	182,324
2036/37	25	416,305	176,158
Totals		10,407,625	6,861,337

2026/27	15	932,442	556,566
2027/28	16	932,442	537,745
2028/29	17	932,442	519,560
2029/30	18	932,442	501,991
2030/31	19	932,442	485,015
2031/32	20	932,442	468,614
2032/33	21	932,442	452,767
2033/34	22	932,442	437,456
2034/35	23	932,442	422,663
2035/36	24	932,442	408,370
2036/37	25	932,442	394,560
		36,618,902	28,675,908

2026/27	15	932,442	556,566
2027/28	16	932,442	537,745
2028/29	17	932,442	519,560
2029/30	18	932,442	501,991
2030/31	19	932,442	485,015
2031/32	20	932,442	468,614
2032/33	21	932,442	452,767
2033/34	22	932,442	437,456
2034/35	23	932,442	422,663
2035/36	24	932,442	408,370
2036/37	25	932,442	394,560
		35,618,902	27,675,908

8.4 Options appraisal- Re-Development at Monkwearmouth

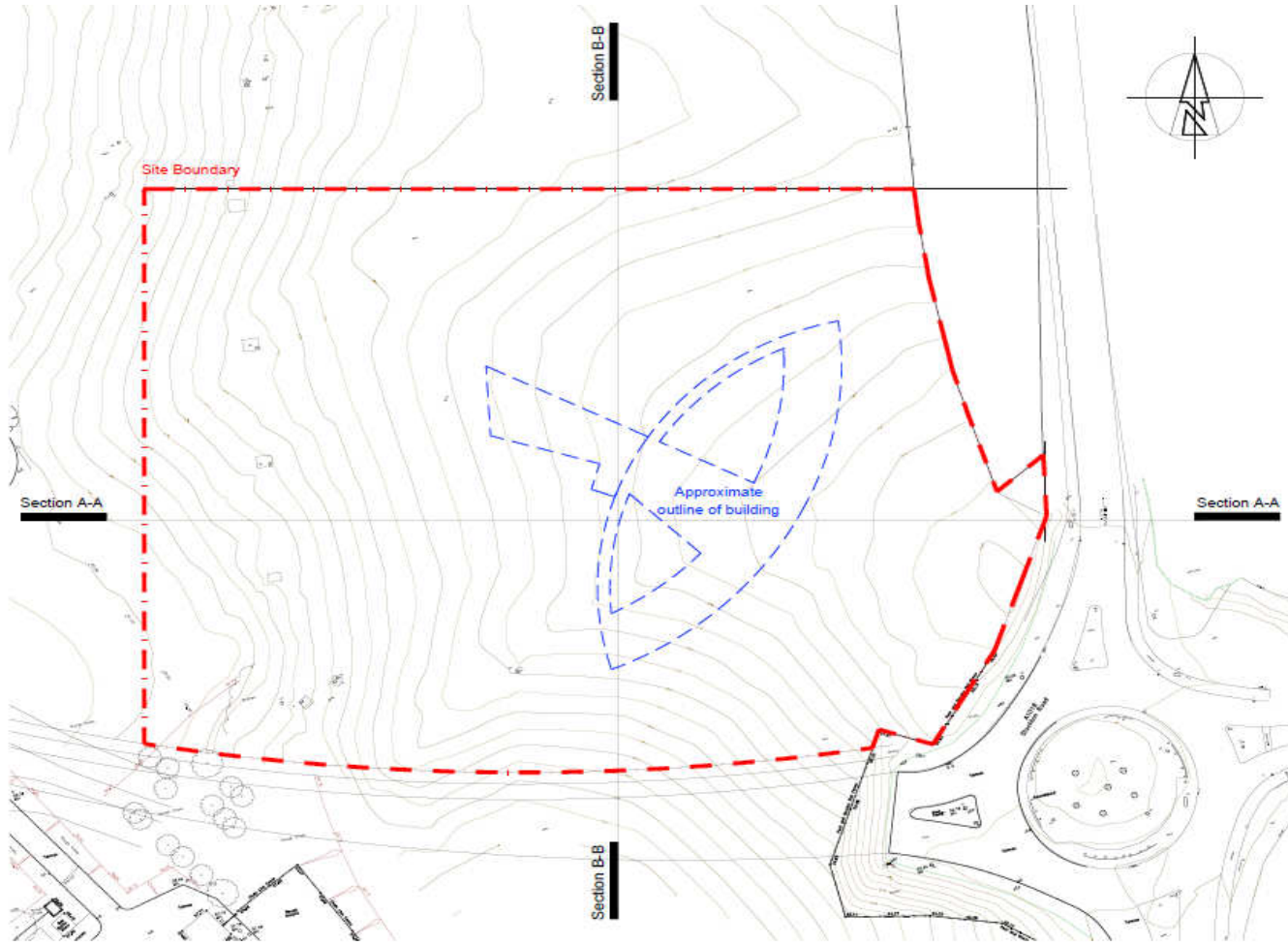
Monkwearmouth Hospital, Sunderland			
Option Appraisal for Potential Hospice - capital cost summary			
		St Benedicts Hospice, Monkwearmouth	notes
Refurbish existing two storey hospital wing		2,000	
New build single storey		1,000	
	total area m2	3,000	
	Refurbishment	3,400,000	based upon cost/m2 of £1700
	New Build	2,900,000	based upon cost/m2 of £2900
Construction Costs		6,300,000	
On Costs			
Abnormals; Demolitions, Asbestos, service diversions, phasing, prolonged contract duration approx 22 months		1,200,000	
External works		300,000	
Total Works cost at 3Q2011		7,800,000	
		7,800,000	
Furniture & Equipment (Group 2 & 3)		150,000	
Fees (full design team and surveys)	12%	936,000	
Trust In-house fees	1%	78,000	
Non-works costs			
Art work		50,000	
Decommissioning		0	
Decanting		0	
Removals		50,000	
Land Purchase		1,500,000	
Legal fees		20,000	
		10,584,000	
Planning Contingencies	10%	1,058,400	
		11,642,400	
Optimism Bias	10%	1,164,240	
		12,806,640	
		12,806,640	
Value Added Tax	20%	2,561,328	
Reclaim VAT on Professional fees		-187,200	
Total		15,180,768	

8.5 Site view

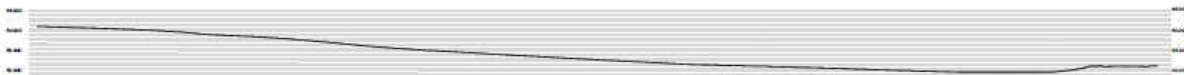


This official copy issued on 7 May 2009 shows the state of this title plan on 7 May 2009 at 13:05:33. It is admissible in evidence to the same extent as the original (s.67 Land Registration Act 2002).
This title plan shows the general position, not the exact line, of the boundaries. It may be subject to distortions in scale. Measurements scaled from this plan may not match measurements between the same points on the ground. See Land Registry Public Guide 19 - Title Plans and Boundaries.
This site is dealt with by Land Registry, Durham Office.

Cherry Knowle, Sunderland



Section B-B



Section A-A

Issue Purpose: INFORMATION

P+HS			
Client	Geotechnical	Project No.	2166-D-90-001
Project	2166-D-90-001	Issue No.	001
Date	11/08/2011	Scale	1:1000
Author	J. H. ...	Checked	J. H. ...
Drawn	J. H. ...	Approved	J. H. ...
Issue	Information	Project Manager	J. H. ...

8.6 Schedule of Accommodation

P+HS ARCHITECTS		
St Benedict's Hospice : Sunderland		
Schedule of Accommodation : 14 Bedrooms		
Prepared 17 July 2011		
Function		Total Net
Entrance / Reception		76.00
Staff facilities		100.00
In-patient unit		700.50
Day care unit		311.00
Lymphoedema clinic		194.00
Education unit		252.50
Administration / Staff		311.00
Food preparation kitchen		72.00
Mortuary		35.00
Additional accommodation		147.00
Externally	In-patient garden	
	Day care garden	
	Parking	
	Ambulance access	
	Gas storage	
	Waste compound / recycling store	
	Cycle store	
Total Net Internal Floor Area		2199.00
Planning	calculated at 5%	109.95
sub-total		2308.95

Services zone	Calculated at 3%	69.27
sub-total		2378.22
Circulation	calculated at 30%	713.47
sub-total		3091.68
TOTAL GROSS INTERNAL FLOOR AREA		3091.68

Function	Notes	Total	Area	Total Net
Entrance / Reception				
Entrance lobby		1	10	10.00
Reception desk	For all reception activity	1	12	12.00
Reception seating area	incl beverage facilities	1	20	20.00
Reception office		1	15	15.00
Interview room		1	10	10.00
Visitor's disabled wc's	unisex	2	4.5	9.00
sub-total				76.00
Staff facilities				
Staff room	Large enough for all staff incl bev facilities	1	24	24.00
Staff wc's / showers		2	20	40.00
Staff disabled shower / wc		1	6	6.00
Staff locker area		2	15	30.00
sub-total				100.00
In-Patient unit				
Reception / staff base	For ward clerk and reception	1	12	12.00
Single bedrooms		14	20	280.00
En-suite bath / shower rooms		14	6	84.00
Isolation lobbies	Facility attached to 2 bedrooms	2	4	8.00
Assisted bathroom	Arjo Hi-Lo bath with hoisting facilities	1	16	16.00
Clinical room / controlled drugs store		1	18	18.00
Sluice room / dirty utility		1	10	10.00
Clinical store		1	10	10.00
General store		1	20	20.00
Linen store		1	5	5.00
Sitting room		1	30	30.00
Conservatory	Links to landscaped garden	1	18	18.00
Dining room	Seating for 14 patients plus 6 visitors plus staff	1	40	40.00
Kitchen	For patient and visitor use and rehab	1	12	12.00
Activities room		1	30	30.00
Smoking room		1	10	10.00
Overnight room for relative's		1	12	12.00
En-suite to relative's room		1	4.5	4.50
Cleaners store		1	8	8.00
Team office		2	10	20.00
Sister's office		1	10	10.00
Nurses office		1	15	15.00

Interview / counseling rooms		2	10	20.00
Staff wc's		2	2	4.00
Visitor's wc's		2	2	4.00
Medical gas store	External store with manifolds piped to IPU	1	20	
sub-total				700.50

Function	Notes	Total	Area	Total Net
Day Care unit				
Heated coat lobby		1	12	12.00
Sitting room	Main activity area	1	40	40.00
Dining room	16 patients incl wheelchair and servery	1	35	35.00
Kitchen	Rehab / ADL type kitchen	1	12	12.00
Clinical room		1	18	18.00
Sluice / dirty utility		1	10	10.00
Interview / consulting room		2	14	28.00
Sister's office		1	10	10.00
Team office	MDT team	1	20	20.00
Therapy room	Art and craft etc	1	20	20.00
Craft store		1	10	10.00
Equipment store		1	10	10.00
Quiet room	For resting or ill patients	1	14	14.00
Complementary therapy room		2	16	32.00
Hairdresser's salon		1	16	16.00
Fully assisted wc's		2	6	12.00
Staff wc's		2	2	4.00
Cleaner's store		1	8	8.00
sub-total				311.00
Lymphoedema Clinic / OP				
Reception office		1	10	10.00
Waiting area	For up to 8 people with wheelchair access	1	20	20.00
Beverage area		1	6	6.00
Team office		1	15	15.00
Clinic rooms		4	16	64.00
Clinic rooms	Out-patient clinic rooms	3	16	48.00
Sluice / dirty utility		1	10	10.00
Equipment store		1	10	10.00
Patient wc's		2	5	9.00
Staff wc		1	2	2.00
sub-total				194.00
Education unit				
Education room	To accommodate up to 60 people	1	75	75.00
Meeting room	To accommodate up to 30 people linked to above	1	45	45.00
Education room	For up to 10 people	1	20	20.00
Refreshment / breakout area		1	30	30.00

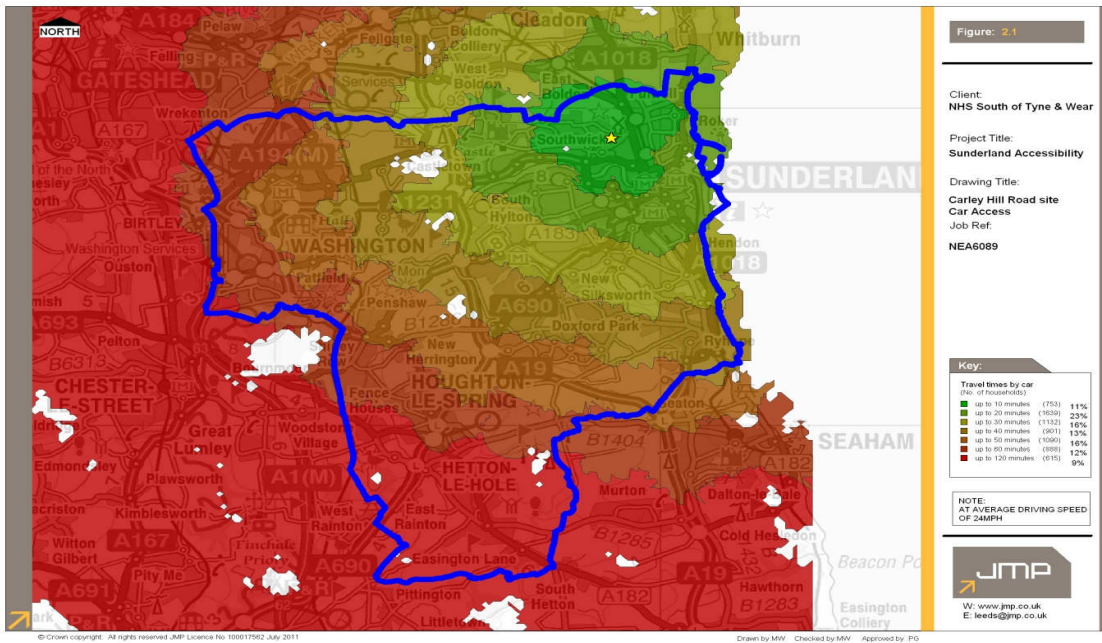
Male wc's		1	15	15.00
Female wc's		1	15	15.00
Disabled wc		1	5	4.50
Office	Lecturer x 2	1	15	15.00
Library	Quiet reading plus 2 computer workstations	1	15	15.00
Equipment store		1	10	10.00
Cleaner's store		1	8	8.00
sub-total				252.50

Function	Notes	Total	Area	Total Net
Administration / Staff				
Office	Senior doctors	4	12	48.00
Office	Junior doctors	1	12	12.00
Office	OOH office for up to 4 people	1	25	25.00
Store room	For OOH supplies and drugs	1	10	10.00
Office	Specialist nurses and secretary	3	18	54.00
Office	EOL nurses x 2	1	12	12.00
Office	Management staff	3	12	36.00
Office	Administration staff x 4	1	18	18.00
Records store	For records currently in basement	1	18	18.00
Office	Fundraising office for 3 staff and display etc	1	20	20.00
Equipment store	For promotional goods / records etc	1	10	10.00
Office [AHP's]	Pharmacist, Physio, OT, Chaplain	4	12	48.00
sub-total				311.00
Food preparation kitchen				
Kitchen	Main kitchen for food preparation	1	25	25.00
Wash-up area		1	10	10.00
Dry goods store		1	15	15.00
Cold store		1	10	10.00
Equipment store		1	10	10.00
Kitchen staff wc		1	2	2.00
sub-total				72.00
Mortuary				
Mortuary		1	15	15.00
Viewing room		1	15	15.00
Store		1	5	5.00
sub-total				35.00
Additional accommodation	For review / discussion			
IT Hub		1	12	12.00
Multi-faith room		1	25	25.00
Laundry	2-3 rooms dependant upon regime	1	30	30.00
Plant room	Boiler plant and calorifiers	1	25	25.00
Ventilation plant room		1	25	25.00

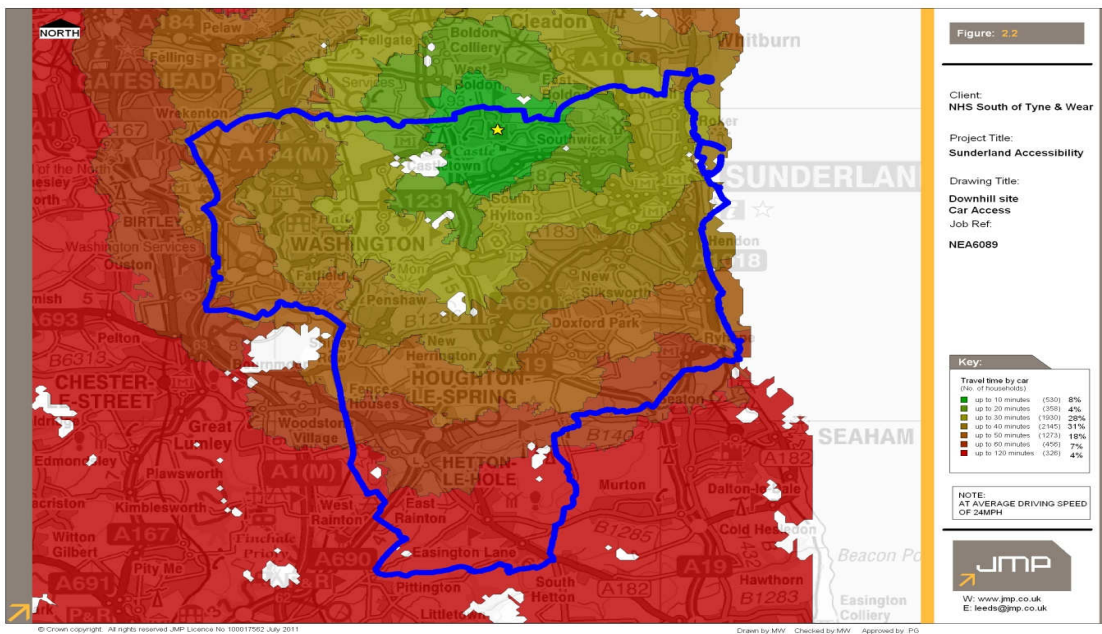
Electrical switchroom		1	10	10.00
DB cupboards		5	1	5.00
Maintenance workshop		1	15	15.00
sub-total				147.00

8.7 Accessibility assessment

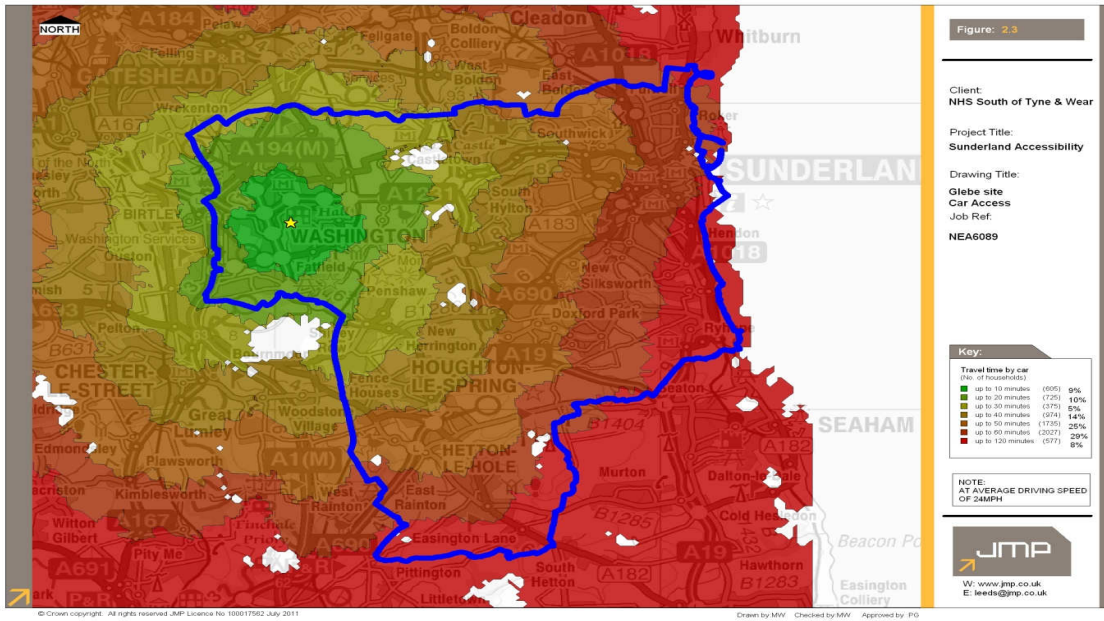
Car Accessibility (24mph) – Carley Hill Road



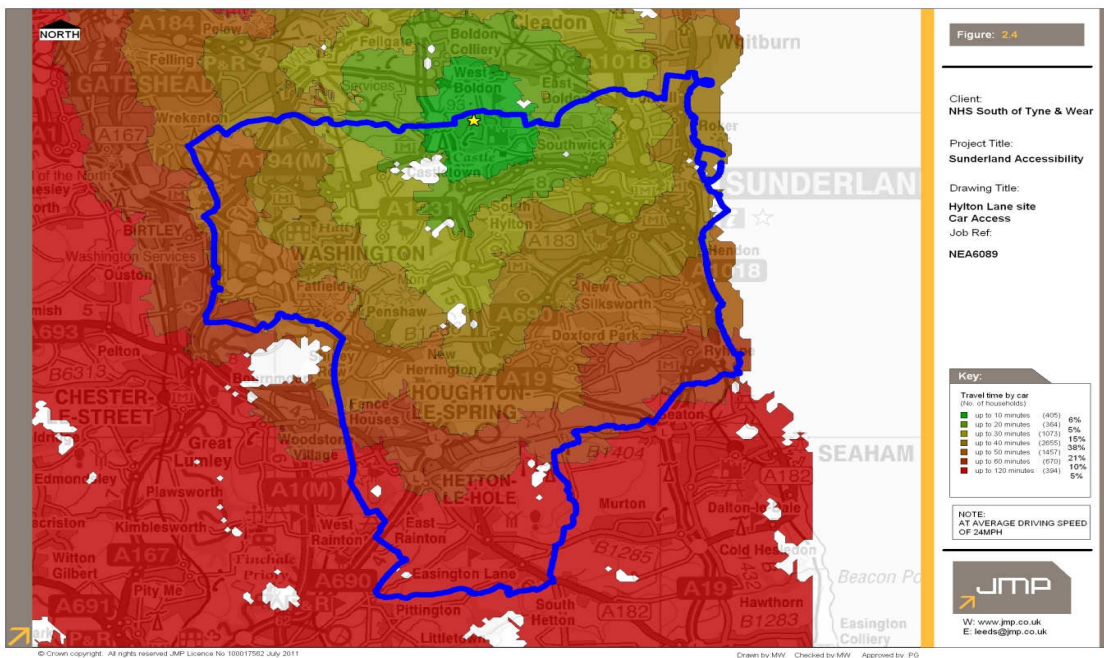
Car Accessibility (24mph) - Downhill



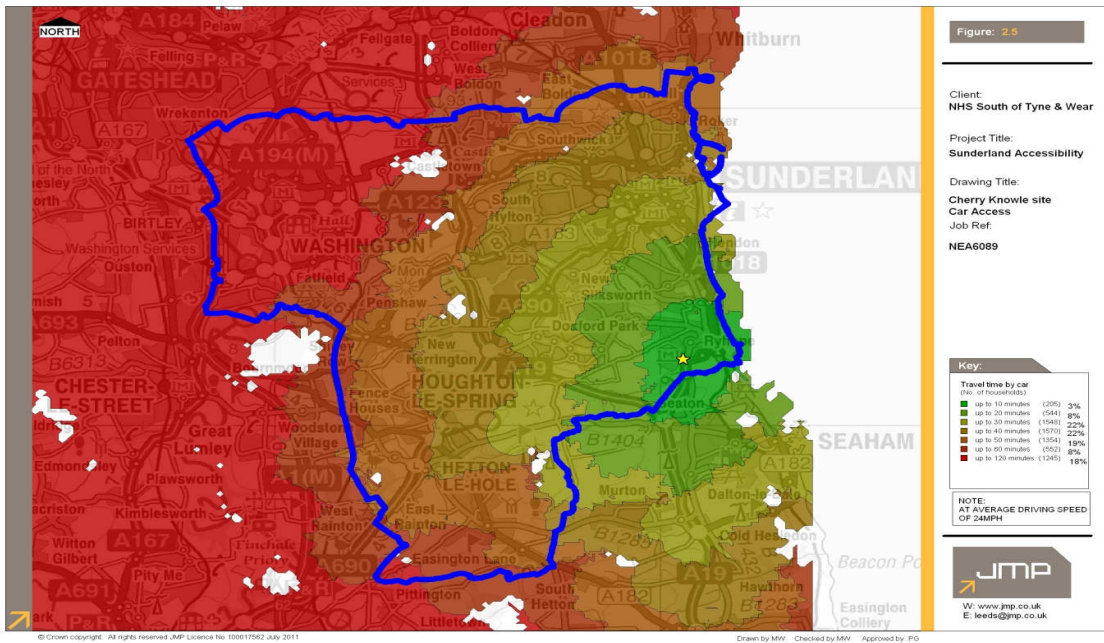
Car Accessibility (24mph) – Glebe



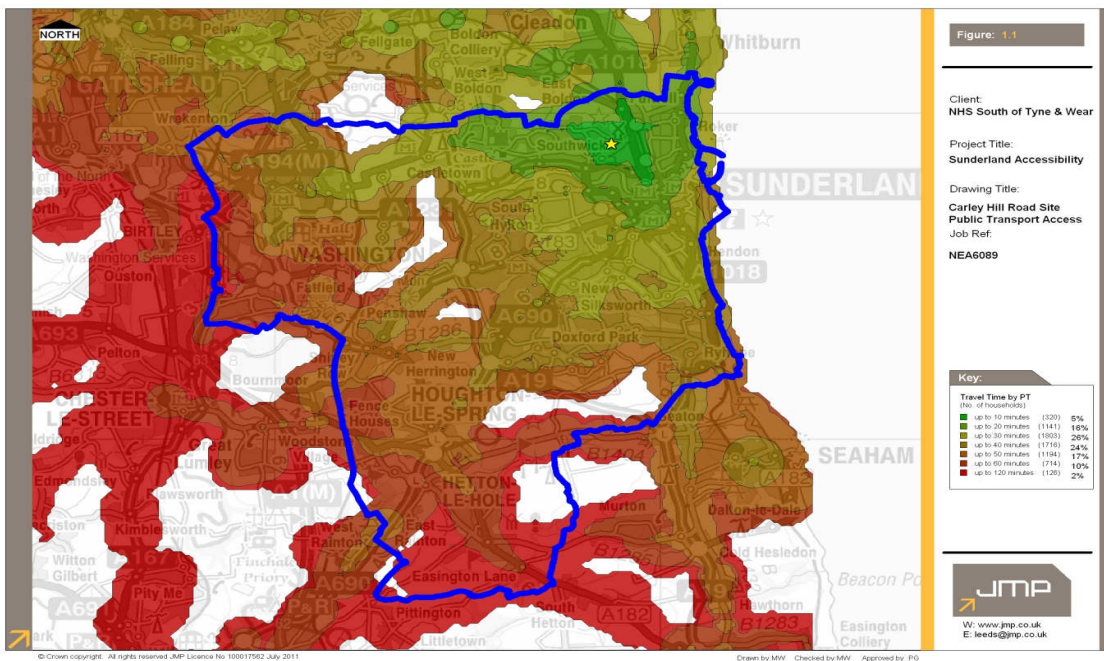
Car Accessibility (24mph) – Hylton Lane



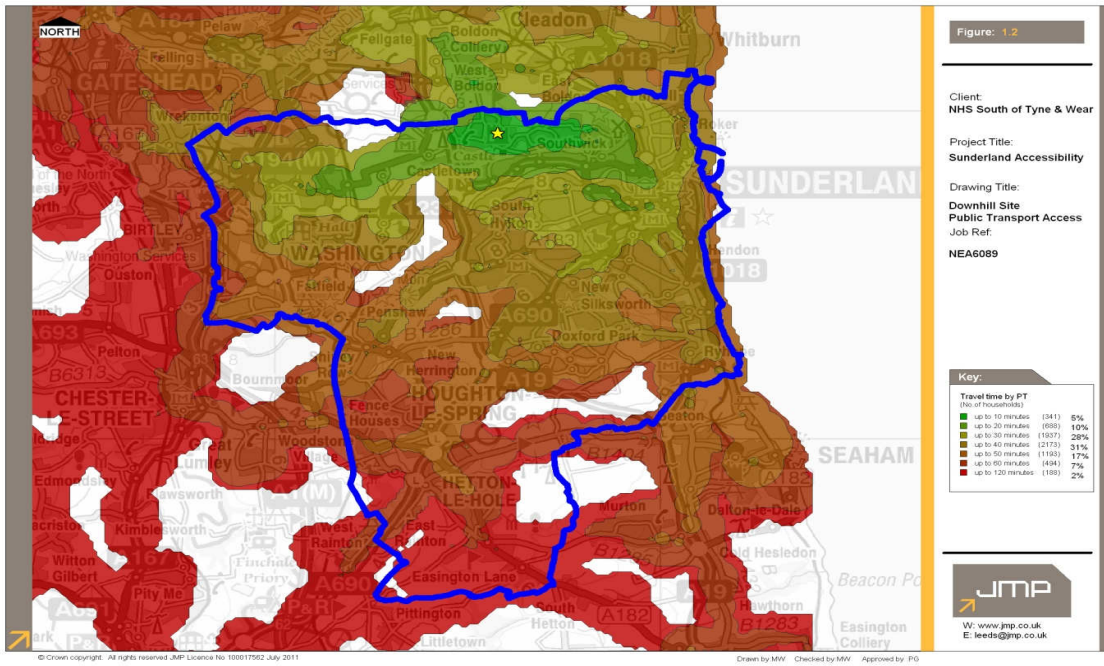
Car Accessibility (24mph) – Cherry Knowle



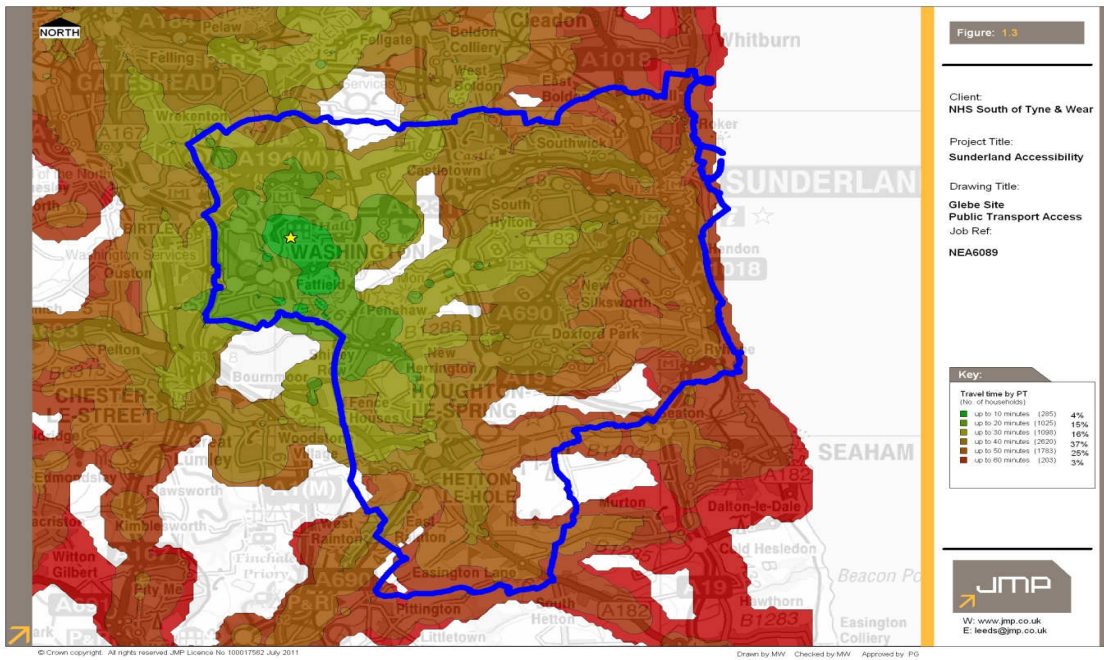
Public Transport Accessibility – Carley Hill Road



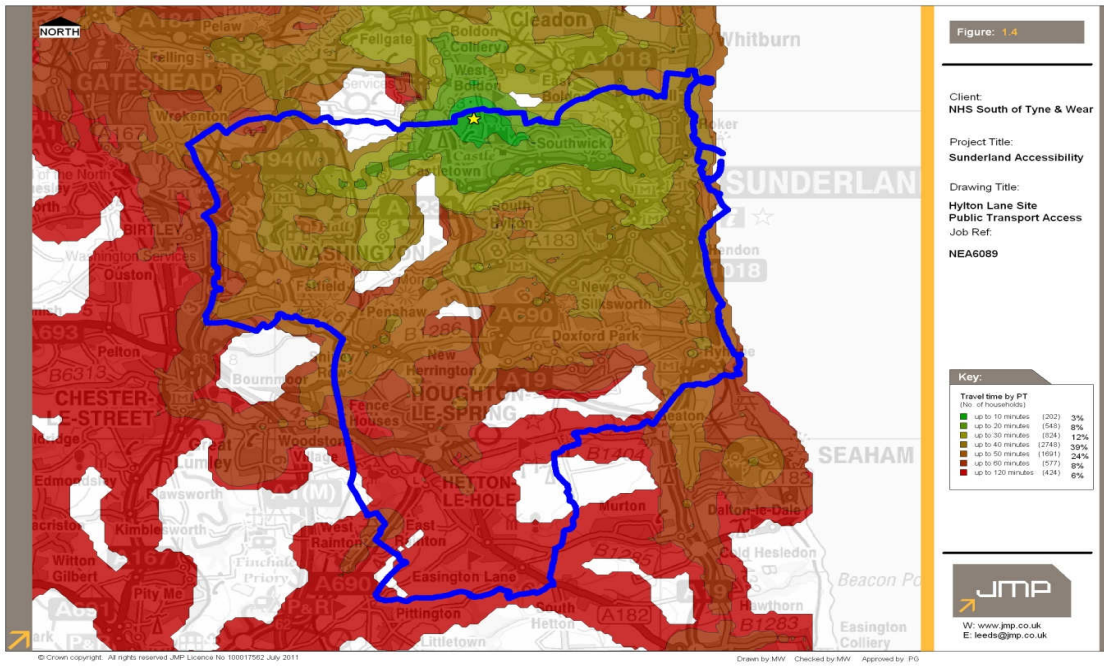
Public Transport Accessibility – Downhill



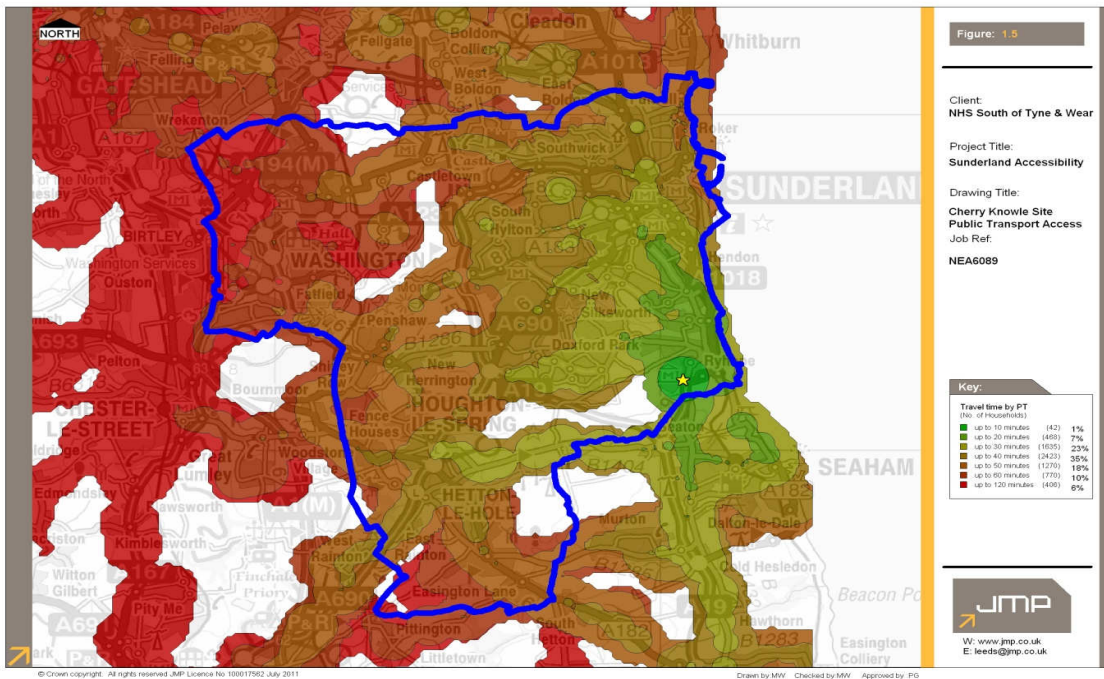
Public Transport Accessibility – Glebe



Public Transport Accessibility – Hylton Lane



Public Transport Accessibility – Cherry Knowle



Summary tables- Access time to 5 sites via public transport (All Sunderland residents)

	Up to 10 Mins	Up to 20 mins	Up to 30 mins	Up to 40 mins	Up to 50 mins	Up to 60 mins	Up to 120 mins
Cherry Knowle	1%	7% (8%)	23% (31%)	35% (66%)	18% (84%)	10% (94%)	6% (100%)
Hylton Lane	3%	8% (11%)	12% (23%)	39% (62%)	24% (86%)	8% (94%)	6% (100%)
Downhill	5%	10% (15%)	28% (43%)	31% (74%)	17% (91%)	7% (98%)	2% (100%)
Glebe	4%	15% (19%)	16% (35%)	37% (72%)	25% (97%)	3% (100%)	NA
Carley Hill	5%	16% (21%)	26% (47%)	24% (71%)	17% (88%)	10% (98%)	2% (100%)

() Cumulative

Summary table- Access time to 5 sites via Private transport (All Sunderland residents)

	Up to 10 Mins	Up to 20 mins	Up to 30 mins	Up to 40 mins	Up to 50 mins	Up to 60 mins	Up to 120 mins
Cherry Knowle	3%	8% (11%)	22% (33%)	22% (55%)	19% (74%)	8% (82%)	18% (100%)
Hylton Lane	6%	5% (11%)	15% (26%)	38% (64%)	21% (85%)	10% (95%)	5% (100%)
Downhill	8%	4% (12%)	28% (40%)	31% (71%)	18% (89%)	7% (96%)	4% (100%)
Glebe	9%	10% (19%)	5% (24%)	14% (38%)	25% (63%)	29% (92%)	8% (100%)
Carley Hill	11%	23% (34%)	16% (50%)	13% (63%)	16% (79%)	12% (91%)	9% (100%)

() Cumulative

8.8 AEDET Analysis

DH INFORMATION READER BOX	
Policy	Estates
HR / Workforce Management	Commissioning
Planning / Clinical	IM & T
	Finance
	Social Care / Partnership Working
Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 9276
Title	Achieving Excellence Design Evaluation Toolkit documentation
Author	DH Estates and Facilities
Publication Date	10 Jan 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Estates and Facilities Directors
Circulation List	
Description	AEDET Evolution toolkit is part of a benchmarking toolkit to assist trusts in measuring and managing the design quality of their healthcare facilities (new and existing).
Cross Ref	AEDET Evolution documentation; AEDET/ ASPECT Evidence Layer
Superseded Docs	AEDET Evolution toolkit (NHS Estates site)
Action Required	N/A
Timing	N/A
Contact Details	Brian Coapes Design and Costing (GREFD) 3N10 Quarry House LEEDS LS2 7UE 0113 25 45696

Project details:	Title
	St Benedict's Hospice, Ryhope, Sunderland

Workshop details:	Location	Date (dd.mm.yy)
	Pemberton House, Sunderland	31 August 2011

Completed by:	First name	Last name	Organisation	Job title	Email address
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IMPACT: Character and innovation

Average score: 4.1

The four IMPACT sections deal with the extent to which the building creates a sense of place and contributes positively to the lives of those who use it and are its neighbours.

Section A deals with the overall feeling of the building. It asks whether the building has clarity of design intention, and whether this is appropriate to its purpose. A building that scores well under this heading is likely to lift the spirits and to be seen as an exemplar of good architecture of its kind.

ID	Description	Weighting	Score	Notes
A.01	There are clear ideas behind the design of the building	High (2)	Strong agreement (5)	
	<i>The design should embody a clear and coherent vision confidently communicating its function and aspirations through its physical elements.</i>			
A.02	The building is interesting to look at and move around in	High (2)	Fair agreement (4)	
	<i>The design should have sufficient variety to create interest both in terms of the overall form and massing externally and the spaces internally. This should be achieved without losing the clear vision (see A.1) or becoming confusing. Art should be incorporated into the building both internally and externally.</i>			
A.03	The building projects a caring and reassuring atmosphere	High (2)	Fair agreement (4)	
	<i>Primarily a healthcare building should be about the people who it is there to care for. A civic presence may be appropriate for a healthcare building but an institutional or corporate image is unlikely to be appropriate. The detail of the image will need to depend both on the type of building and the location.</i>			
A.04	The building appropriately expresses the values of the NHS	High (2)	Fair agreement (4)	
	<i>The design of the building overall should lift the spirits of those who work in it and are being treated in it as well as those who visit. It should communicate a strong positive image of the NHS.</i>			
A.05	The building is likely to influence future designs	Normal (1)	Little agreement (3)	More information is required to allow panel to make an informed decision.
	<i>The design should be of its time. It should use and express the current best practice in terms of form and technology. The building should clearly reflect new and appropriate models of healthcare provision. It should be a building that clients, developers and designers would wish to visit to learn from when working on future projects.</i>			

◀ Project workshop setup

▶▶ Results summary

Form and materials ▶

IMPACT: Form and materials

Average score: 3.8

Section B deals with the nature of the building in terms of its overall form and materials. It is primarily concerned with how the building presents itself to the outside world in terms of its appearance and organisation. Although it deals with the materials from which the building is constructed it is not concerned with these in a technical sense but rather the way they will appear and feel throughout the life of the building.

ID	Description	Weighting	Score	Notes
B.01	The building has a human scale and feels welcoming	High (2)	Little agreement (3)	Early indications would suggest 'yes' but more information is required following further design development.
	<i>However large or small the building it should appear welcoming to staff, patients and visitors. The scale should be appropriate to a caring image. Scale is the result not just of the size of the building but of the way certain features are expressed. Windows, floor to floor heights and, in particular, doors and entrances all contribute significantly to our sense of the scale of a building.</i>			
B.02	The design takes advantage of available sunlight and provides shelter from prevailing winds	High (2)	Strong agreement (5)	
	<i>The building should be designed in relation to its orientation on the site. In particular it should be designed to capture sunlight appropriately. It should shelter people approaching it from the prevailing winds and poor weather. The way the building is orientated may also contribute to the potential for views out of the building.</i>			
B.03	Entrances are obvious and logically positioned in relation to likely points of arrival on site	High (2)	Strong agreement (5)	
	<i>Consider using double weighting. This item may be particularly important where there are likely to be large numbers of visitors on a daily basis, where there may be more than one entrance or where there may be several routes onto the site. The form of the building should invite approach and entry and make the places where the public enter apparent, even without signs. The design should respond to the major expected points of arrival. The entrances should be obvious from these angles.</i>			
B.04	The external materials and detailing appear to be of high quality	High (2)	Little agreement (3)	More information is required to allow panel to make an informed decision.
	<i>Materials should be chosen to enhance the building as a whole. The form and materials should be well detailed. The building should be one that will age gracefully rather than show unsightly staining or weathering.</i>			
B.05	The external colours and textures seem appropriate and attractive	High (2)	Little agreement (3)	More information is required to allow panel to make an informed decision.
	<i>Colours and textures should articulate and enrich the building's form and enhance its enjoyment. As with interior colour schemes what feels appropriate will to some extent depend on the type of building. However in the case of the exterior, colours and textures should also be chosen to relate positively to adjacent buildings and other aspects of the setting.</i>			

IMPACT: Staff and patient environment

Average score: 4.4

Section C deals with how well an environment complies with best practice as indicated by the research evidence.

ID	Description	Weighting	Score	Notes
C.61	The building respects the dignity of patients and allows for appropriate levels of privacy and dignity	High (2)	Strong agreement (5)	
	<p><i>Consider using double weighting. This item may be particularly important for space where patients spend significant amounts of time, or where sensitive consultations, treatments or discussions may take place. Both company and privacy are highly valued by patients and staff and the building should facilitate both. The spaces where patients are likely to be for lengthy periods should provide places where they can have both visual and acoustic privacy. Patients should be able to have private conversations and to be alone if they wish. However, it should also be easy for patients to find company and to be with others. Patients' dignity should be respected by the design. When being treated or examined they must be shielded from the gaze of others and should not be overheard. Toilets and bathrooms should be nearby but located discreetly without being in full view of others.</i></p>			
C.62	There are good views inside and out of the building	High (2)	Strong agreement (5)	
	<p><i>Consider using double weighting. This item may be particularly important for space where patients and/or staff spend significant amounts of time. Rooms where patients or staff spend significant amounts of time should have windows which afford good, pleasant and interesting views. This might be particularly important where patients may be in bed for long periods or having to wait. Preferably patients should be able to see the ground and the sky. In cases where patients may be concerned or under stress the view should be calming. The restorative effects of views of nature are proven.</i></p>			
C.63	Patients and staff have good access to outdoors	High (2)	Strong agreement (5)	
	<p><i>Patients should be able to go outside easily and have access to well landscaped gardens. Both staff and patients should be able to see nature especially vegetation. This might be in the form of interior planting or a formal garden. Restorative green spaces are shown to be helpful to those recovering from short-term treatments, to comfort visitors and provide respite for harried staff. Being able to walk or sit in such places can reduce blood pressure, relieve stress, encourage healing and restore hope.</i></p>			
C.64	There are high levels of both comfort and control of comfort	High (2)	Little agreement (3)	More information is required to allow panel to make an informed decision.
	<p><i>Consider using double weighting. This item may be particularly important for space where patients and/or staff spend significant amounts of time. Patients and staff should be comfortable. The temperature should be comfortable all year round and be capable of easy local control. Patients and staff should be able to exclude sunlight and dark on spaces when patients wish to sleep. Artificial light should be easily controllable offering patterns suitable for day and night and for winter and summer. Patients and staff should be able to open windows and doors easily for fresh air. The places where staff work or patients spend time should be quiet and free from unwanted levels of background noise. Stress and heart rates have been proved to rise in noisy hospitals.</i></p>			
C.65	The building is clearly understandable	High (2)	Fair agreement (4)	Early indications would suggest 'yes' but more information is required following further design development.
	<p><i>Consider using double weighting. This item may be particularly important for large or complex buildings or collections of buildings. The whole building should be easily understandable allowing for easy way-finding. The entrance should be obvious on arrival and the way out should also be clear. There should be a logical hierarchy of spaces in the building with varying scales appropriately indicating the public and private domain. It should be clear which are staff only areas and patients and visitors should easily be able to tell where to find a member of staff. Different parts of the building should have different characters in order to avoid an overall feeling of being nowhere. Distinctive landmarks, familiar artefacts from the past, self-contained looping paths are techniques for maximising legibility and orientation.</i></p>			
C.66	The interior of the building is attractive in appearance	High (2)	Little agreement (3)	Unable to score at the moment due to levels of information available.
	<p><i>The interior should feel light and airy. Spaces where patients spend significant amounts of time should be made as homely as possible. There should be a stimulating variety of appropriate colours and textures. The interior should look tidy and well cared for as well as being clean. Ceilings should look interesting especially where patients are likely to be on beds or trolley for any length of time. Patients should be able to store and display their own personal items.</i></p>			
C.67	There are good bath/toilet and other facilities for patients	High (2)	Strong agreement (5)	
	<p><i>Bath and toilet facilities are known to be important to patients: ideally there should be a choice of bath or shower. These areas should have non-slip flooring, seats, handrails and shelves within easy reach so that patients are not 'disabled' by the design. Places for religious observance and live performances are also important. Having the option of a relative/friend being able to stay overnight very close by can make a big difference to patients. In their own spaces, patients should have access to a range of suitable furniture including comfortable seating and a table or desk. Patients who are able should have facilities to make drinks and snacks and vending machines should be conveniently available.</i></p>			
C.68	There are good facilities for staff, including convenient places to work and relax without being on demand	High (2)	Strong agreement (5)	
	<p><i>These facilities particularly impact on staff. It may be very important to be able to change into working clothes, to shower and to store clothes and belongings safely. Staff need to be able to get away from demand sometimes when working in order to concentrate, and also when taking a break. Places for this should be provided nearby. Staff who move around, should have easy access to IT. It is important to provide staff with basic banking and shopping facilities.</i></p>			

Form and materials

Results summary

Urban and social integration

IMPACT: Urban and social integration

Average score: 3.8

Section D deals with the way the building relates to its surroundings. It asks whether the building plays a positive role in the neighbourhood whether that is urban, suburban or rural. A building that scores well is likely to improve its neighbourhood rather than detract from it.

ID	Description	Weighting	Score	Notes
D.01	The height, volume and skyline of the building relate well to the surrounding environment	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>Consider using double weighting. This item may be particularly important where the building is in either a tight urban environment or a very rural environment. The profile and skyline of the building as it is approached should fit in well with nearby buildings and landscape.</i></p>				
D.02	The building contributes positively to its locality	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
<p><i>Ideally the locality should be enhanced by the addition of the building. This might be through the way it opens up vistas, closes and contains urban space, or perhaps provides a landmark. The design should be sensitive to the setting, whether urban or rural, and sit comfortably within it. The building should feel as if it 'belongs' in this place. The spaces immediately outside the building should be pleasant. The relationship of interior and exterior space should be well thought out with appropriate connections between the levels of the building and landscape.</i></p>				
D.03	The hard and soft landscape around the building contribute positively to the locality	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>The hard and soft landscape around the building should be appropriately therapeutic in their qualities. They must be designed to last and to minimise maintenance and be sustainable and not deteriorate. Ground materials and changes of levels should be safe and clear. Hard landscape should be provided where pedestrian routes are likely but this does not need to be in the form of straight edged paths, but should be composed into the landscape as a whole.</i></p>				
D.04	The building is sensitive to neighbours and passers-by	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>Consider using double weighting. This item may be particularly important where the building or group of buildings are largely in the public domain for example in a town and many people may be passing by or through the site on a daily basis. The building should be a 'good neighbour'. Those approaching the building or passing by should feel safe as they do so. Neighbours may see the building every day and it should be designed to look attractive to them and not just for those who visit occasionally.</i></p>				

BUILD QUALITY: Performance

Average score: 3.0

The three BUILD QUALITY sections deal with the physical components of the building rather than the spaces. This is therefore what might be thought of as the more technical and engineering aspects of the building. It asks whether the building is soundly built, will be reliable and easy to operate, last well and is sustainable. It is also concerned with the actual process of construction and the extent to which any disruption caused is minimised.

Section E is concerned with the technical performance of the building during its lifetime. It asks whether the components of the building are of high quality and fit for their purpose. However we are not concerned here with how well the building functions in relation to the human use of it which belongs in another section.

ID	Description	Weighting	Score	Notes
E.01	The building is easy to operate	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
<p>The general organisation of the building makes the management of the facility as straightforward as possible.</p>				
E.02	The building is easy to clean	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
<p>The arrangement of the building and the materials make it easy to clean. Surfaces should have finishes that enable simple and quick methods of cleaning especially those that require to be clean for clinical reasons. Access to windows for cleaning both externally and internally should be as easy as possible given the nature of the building. In some cases this may require the provision of cradles or other specialised methods of access.</p>				
E.03	The building has appropriately durable finishes	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
<p>The materials both externally and internally should be able to last for their predicted lifespans. These lifespans should be as long as possible. Where for some reason this may be shorter than the predicted lifespan of the building overall then statement G.04 may be even more important.</p>				
E.04	The building will weather and age well	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
<p>The building should be able to age gracefully. The nature of the design, choice of materials and detailing of junctions all affect this together with the ease of maintenance and access as discussed in other Headings. Some materials such as stone often look better as they get older whereas some may quickly look dirty and uncared for. Junctions between materials (especially external horizontal ones) can cause staining unless carefully detailed.</p>				

[◀ Urban and social integration](#)
[▶▶ Results summary](#)
[Engineering ▶](#)

BUILD QUALITY: Engineering

Average score: 3.0

Section F is concerned with those parts of the building that are engineering systems as opposed to the main architectural features. It asks whether the engineering systems are of high quality and fit for their purpose, will be easy to operate and if they are efficient and sustainable.

ID	Description	Weighting	Score	Notes
F.01	The engineering systems are well designed, flexible and efficient in use	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
	<i>Engineering systems should be effective and flexible. Local controls should be provided for use by staff and patients. Engineering systems should operate quietly and respond rapidly. These systems should operate satisfactorily through all seasons of the year and be capable of adapting to reconfiguring of the building in future.</i>			
F.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
	<i>Standardisation is not good in its own right but may often be helpful not only during construction but in operating and maintaining a building. Unnecessary variation can be expensive. Again prefabrication is certainly not good in itself but may offer better value for money and may help to ensure easier and speedier construction which may cause less disruption on site and later maintenance.</i>			
F.03	The engineering systems are energy efficient	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
	<i>The engineering systems should be designed to be efficient and economic in use and to meet or exceed all mandatory NHS targets.</i>			
F.04	There are emergency backup systems that are designed to minimise disruption	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
	<i>The design should meet the emergency backup requirements of the brief and to meet any clinical requirements of the brief. In particular coverage should be considered for medical gases, emergency generators, batteries, nurse call systems, heating, theatre and other lighting, hot water, cold water storage, telephones. Clearly a judgment must be made as to which of these are vital depending on the kind of building.</i>			
F.05	During construction disruption to essential services is minimised	Zero (0) ▼	Select... ▼	Not applicable
	<i>The continuity of essential services in many healthcare buildings is vital. It may be necessary because of the design to modify or relocate some parts of existing essential services. Under these circumstances the potential for danger and serious harm may be considerable. Ideally existing services should be left untouched while they are in operation, however where some modifications or relocation is necessary the design should clearly show an assessment of risk and ways of counteracting all identified risks.</i>			

◀ Performance

▶▶ Results summary

Construction ▶

BUILD QUALITY: Construction

● Average score: 3.0

Section G is concerned with the technical issues of actually constructing the building and with the performance of the main components. A building that scores well is likely to be constructed as quickly and easily as possible under the circumstances of the site and to offer a robust and easily maintained solution.

ID	Description	Weighting	Score	Notes
G.01	<p>If phased planning and construction are necessary the various stages are well organised</p> <p><i>Consider using double weighting. This item may be particularly important if it is necessary to phase the project either for financial reasons or to keep existing facilities operating while the construction is in progress. If the project needs to be built in phases this is made as easy as possible by the design. In gaining access to future phases, minimal disruption to any open facilities and neighbours should be minimised. Ideally each phase should be self-contained. Any future demolition should be clearly thought through. However it should be remembered that the construction phase is a very short one in the total lifespan of the building and it is therefore generally undesirable to allow considerations of phasing to dominate the design.</i></p>	Zero (0) ▼	Select... ▼	Not applicable
G.02	<p>Temporary construction work is minimised</p> <p><i>In order to satisfy the needs of phasing it may be necessary to construct some facilities which will then later be demolished or removed. This is obviously additional expenditure for which there is no long term benefit and yet further short-term potential disruption. This should be minimised. In particular the temporary provision of services may present risks to discontinuities in operation which may be expensive and hazardous. As with G.01 it is important to note that achieved quality of the long term permanent building is the most important consideration and on some occasions constructing temporary buildings may be the best way of achieving this.</i></p>	Zero (0) ▼	Select... ▼	Not applicable
G.03	<p>The impact of the building process on continuing healthcare provision is minimised</p> <p><i>Ideally the site works should be laid out so that contractor's areas are entirely separate from operational areas. This may not always be possible but overlaps should be avoided if possible and minimised where not. Crossing points where contractors' site traffic crosses routes used by other traffic and pedestrians should be minimised.</i></p>	Zero (0) ▼	Select... ▼	Not applicable
G.04	<p>The building can be readily maintained</p> <p><i>Components in the construction should be designed to require minimal maintenance. The life-cycles of components should be known and thought through. Access to components that are most likely to need maintenance or replacement is easiest. In particular access to items that may need attention is available without disrupting the lives of patients and staff.</i></p>	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
G.05	<p>The construction is robust</p> <p><i>Junctions between materials and components should be well detailed. Components and finishes should have sufficient strength and integrity for their functions and locations.</i></p>	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
G.06	<p>The construction allows easy access to engineering systems for maintenance, replacement and expansion</p> <p><i>The design of the construction should be integrated with the design of the engineering systems. Access to engineering components that are most likely to need maintenance or replacement is easiest. In particular access to items which may need attention is available without disrupting the lives of patients and staff. Some items require more attention than others and disruption can be minimised by designing access routes, hatches and removal panels etc to enable this. (e.g. cisterns in en-suite bathrooms may be maintained without accessing the bedroom).</i></p>	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.
G.07	<p>The construction exploits any benefits from standardisation and prefabrication where relevant</p> <p><i>Standardisation is not good in its own right but may often be helpful not only during construction but in operating and maintaining a building. Unnecessary variation can be expensive. Again prefabrication is certainly not good in itself but may offer better value for money and may help to ensure easier and speedier construction which may cause less disruption on site and later maintenance.</i></p>	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.

◀ Engineering

▶▶ Results summary

Use ▶

FUNCTIONALITY: Use

Average score: 4.0

The three FUNCTIONALITY sections deal with all those issues to do with the primary purpose or function of the building. It deals with how well the building serves these primary purposes and the extent to which it facilitates or inhibits the activities of the people who carry out the functions inside and around the building.

Section H is concerned with the way the building enables the users to perform their duties and operate the healthcare systems and facilities housed in the building. To get a good score the building will be highly functional and efficient, enabling people to have enough space for their activities and to move around economically and easily in a way that relates well to the policies and objective of the Trust. A high scoring building is also likely to have some flexibility in use.

ID	Description	Weighting	Score	Notes
H.01	<p>The prime functional requirements of the brief are satisfied</p> <p><i>The whole design must meet the needs of the core purposes which it serves. Clearly this is one of the most central and important considerations.</i></p>	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
H.02	<p>The design facilitates the care model of the Trust</p> <p><i>The design should express and facilitate the healthcare philosophy of the Trust. Design inevitably involves trade-offs, so the relative values in terms of efficiency of healthcare delivery that are in the care model should be reflected in the design.</i></p>	High (2) ▼	Strong agreement (5) ▼	
H.03	<p>Overall the building is capable of handling the projected throughput</p> <p><i>The sizes of spaces, circulation and access must be adequate to meet the demands made at peak times and feel comfortable throughout the operating period.</i></p>	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
H.04	<p>Work flows and logistics are arranged optimally</p> <p><i>All the appropriate adjacencies for human circulation and the flow of activities and services are arranged in order to minimise distances travelled and lines crossed.</i></p>	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
H.05	<p>The building is sufficiently adaptable to respond to change and to enable expansion</p> <p><i>Consider using double weighting. This item may be particularly important where forecasts already suggest future expansion that is not funded as part of the current project. The design should be adaptable where possible. The building is likely to last longer than the current models of care and patterns of treatment. Where changes or expansion can be predicted the design should show how it can be adapted to meet these. Therapeutic, technological, organisational innovations will take place and the building should be able to accommodate these without losing its coherence.</i></p>	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
H.06	<p>Where possible spaces are standardised and flexible in use patterns</p> <p><i>Some spaces are so technically demanding that they must be very tightly designed on a functional basis. However it is highly likely that throughout the life of the building the pattern of use will change. Where possible similar kinds of spaces should be the same size and shape and be capable of changing their use as needs change. Over precise design can lead to an inflexibility that in the life of the building can cost considerably more than some small addition of initial floor area to enable future changes. It can often be the case that relatively small additions of floor space can be the most economical way of creating valuable flexibility.</i></p>	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
H.07	<p>The layout facilitates both security and supervision</p> <p><i>Consider using double weighting. This item may be particularly important if the site is in an area with historically high crime rates. The layout should include suitable supervision and control points. Entrances and departments should be designed to enable ready supervision and security. The layout should maximise passive supervision and overlooking so that all parts of the building internally and the site externally feel supervised and safe.</i></p>	High (2) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.

◀ Construction

▶▶ Results summary

Access ▶

FUNCTIONALITY: Access

Average score: 3.9

Section 1 focuses on the way the users of the building can come and go. It asks whether people can easily and efficiently get onto and off the site using a variety of means of transport and whether they can logically, easily and safely get into and out of the building.

ID	Description	Weighting	Score	Notes
I.01	There is good access from available public transport including any on-site roads <i>Access requirements for staff, patients and visitors arriving at the building using public transport should be thought through. Any on-site roads should be adequate and sensitively designed. Road widths and turning circles should be safe and convenient. Consideration should be given to bringing public transport onto the site where possible and appropriate. Pedestrian routes from public transport points should be clear, safe and sensitively designed. Cars and other vehicles should not dominate the external public areas.</i>	High (2) ▼	Little agreement (3) ▼	It is anticipated that improvements to the public transport system will be implemented before occupation of the scheme.
I.02	There is adequate parking for visitors and staff cars with appropriate provision for disabled people <i>In particular the design should accommodate the forecast demand in terms of staff, patients and visitors' cars. Consideration should be given to the extra demand at major staff shift handover periods. Any points of access to the existing road system should be able to cope with peak demand. Drop off points for less able people should be provided appropriately near entrances.</i>	High (2) ▼	Strong agreement (5) ▼	
I.03	The approach and access for ambulances is appropriately provided <i>Adequate segregation and demarcation of ambulance access and drop off points should be clear. Alternative routes should be considered for emergencies.</i>	High (2) ▼	Strong agreement (5) ▼	
I.04	Goods and waste disposal vehicle circulation is good and segregated from public and staff access where appropriate <i>Particular attention should be given to ensure unsightly, large or noisy vehicles are kept away from pedestrian areas.</i>	High (2) ▼	Strong agreement (5) ▼	
I.05	Pedestrian access routes are obvious, pleasant and suitable for wheelchair users and people with other disabilities / impaired sight <i>The major and minor routes should be obvious with continuity of line and materials. They should be well signposted. They should be safe from vehicles and with safe crossings where they cross roads or other vehicular access. They should be free from obstacles and changes of levels. In particular isolated steps should be avoided and appropriately shallow ramps provided where changes of level are necessary.</i>	High (2) ▼	Little agreement (3) ▼	Early indications would suggest 'yes' but more information is required following further design development.
I.06	Outdoor spaces are provided with appropriate and safe lighting indicating paths, ramps and steps <i>They should be pleasantly landscaped and well lit at night. Safe lighting is of course a requirement of Health and Safety regulations. Compliance with legislation is not generally the main purpose of this AEDET evaluation.</i>	High (2) ▼	Little agreement (3) ▼	Early indications would suggest 'yes' but more information is required following further design development.
I.07	The fire planning strategy allows for ready access and egress <i>The fire planning strategy should be integrated with the design in order to allow easy access and egress in emergency as well as in normal use. The design must comply with Firecode and have provision for safe horizontal escape routes. These must be easy, direct, free and unhindered access for fire fighting appliances to the whole of the building perimeter. The same comments about compliance with legislation apply as those found in I.06.</i>	Normal (1) ▼	Little agreement (3) ▼	More information is required to allow panel to make an informed decision.

◀ Use

▶▶ Results summary

Space ▶

FUNCTIONALITY: Space

Average score: 3.9

Section J concentrates on the amount of space in the building in relation to its purpose. It asks if this space is well located and efficient and whether people can move around in it efficiently and with dignity.

ID	Description	Weighting	Score	Notes
J.01	The design achieves appropriate space standards	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>In addition to the technical spaces, all general spaces must be adequate to meet normal demand comfortably and peak demand at least adequately. In particular entrance areas should be uncluttered and spacious as must all circulation and social spaces. Provision for special areas for children should be considered. Space for external franchises and other add-ons should be thought about. The design must clearly follow and at least satisfy all the minimum requirements of the relevant HBNs and HTNs. A good design strategy will have listed all the relevant specific notes and shown how the design meets these as opposed to making general statements.</i></p>				
J.02	The ratio of usable space to the total area is good	Normal (1) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>The net to gross ratios should be calculated and show high figures. Where possible spaces should be capable of being shared to maximise utilisation. The design strategy and the brief should see space as a resource not personal territory. Dual use of circulation space should be exploited where this can be effective. For example to create informal social and gathering spaces. The overall proportion of space devoted exclusively to circulation should be kept to a minimum.</i></p>				
J.03	The circulation distances travelled by staff, patients and visitors are minimised by the layout	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>Consider using double weighting. This item may be particularly important where emergency treatments are common. It is also likely to be particularly important for those groups of staff who need to move around as a normal part of their job. Clinical adjacencies as determined by the care model are minimised. Patients and visitors are faced with journeys that are as logical and short as possible.</i></p>				
J.04	Any necessary isolation and segregation of spaces is achieved	High (2) ▼	Fair agreement (4) ▼	Early indications would suggest 'yes' but more information is required following further design development.
<p><i>Any required clinical isolation should be achieved. In addition inherently noisy areas should be kept away from quiet ones. Similarly inherently messy or unpleasant visual areas should be isolated. Inappropriate adjacencies that might offend sensibilities should be avoided. The design should naturally isolate and screen areas, which patients and visitors may not wish to see.</i></p>				
J.05	The design makes appropriate provision for gender segregation	Normal (1) ▼	Strong agreement (5) ▼	
<p><i>Consider using double weighting. This item may be particularly important where there are in-patients. The care model should be clear about the location and extent of desired gender segregation. The design should reflect and provide this. Areas where the boundaries between genders may need to change in use should be clearly identified and solutions for providing this made apparent.</i></p>				
J.06	There is adequate storage space	High (2) ▼	Little agreement (3) ▼	More detailed analysis of storage requirements will be completed as part of the design development process.
<p><i>It is very easy to underestimate the amount of storage space required. This frequently leads to other major failures in the use of buildings. Common results are to see materials stored in public areas causing restrictions, and giving a sense of clutter. In particular storage needs to be adjacent to places where it will be needed to ensure items are appropriately stored in actual use. The design should avoid creating storage spaces which can easily be eliminated. Storage may be required at several stages in the various supply/use/disposal systems.</i></p>				

◀ Access

▶▶ Results summary

Achieving Excellence Design Evaluation Toolkit (AEDET Evolution)



Project details: Title
St Benedict's Hospice, Ryhope, Sunderland

Workshop details: Location
Pemberton House, Sunderland

Date
31 August 2011

Results summary:

A:	▶ Character and innovation				■			● 4.1	9 of 5 scored
B:	▶ Form and materials				■			● 3.8	10 of 5 scored
C:	▶ Staff and patient environment					■		● 4.4	16 of 8 scored
D:	▶ Urban and social integration				■			● 3.8	5 of 4 scored
E:	▶ Performance			■				● 3.0	8 of 4 scored
F:	▶ Engineering			■				● 3.0	4 of 5 scored
G:	▶ Construction			■				● 3.0	6 of 7 scored
H:	▶ Use					■		● 4.0	12 of 7 scored
I:	▶ Access					■		● 3.9	13 of 7 scored
J:	▶ Space					■		● 3.9	9 of 6 scored
		1	2	3	4	5	6		

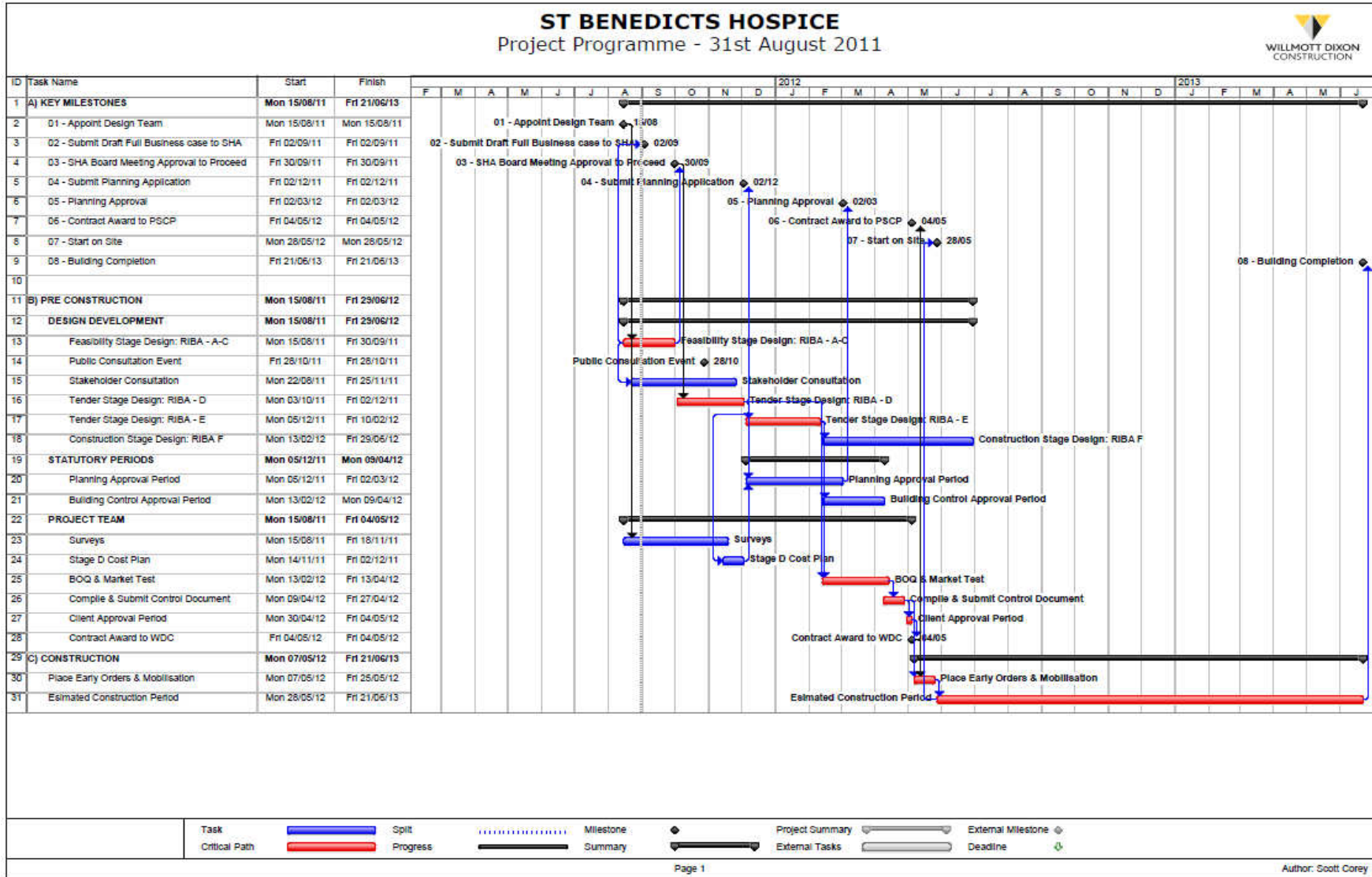
NOTE: A filled traffic light dot [●] in the table above indicates a valid average score, a hollow dot [○] indicates that one or more statements have been marked as 'unable to score'.

8.9 Traffic impact assessment and travel plan (Attached as a separate document)

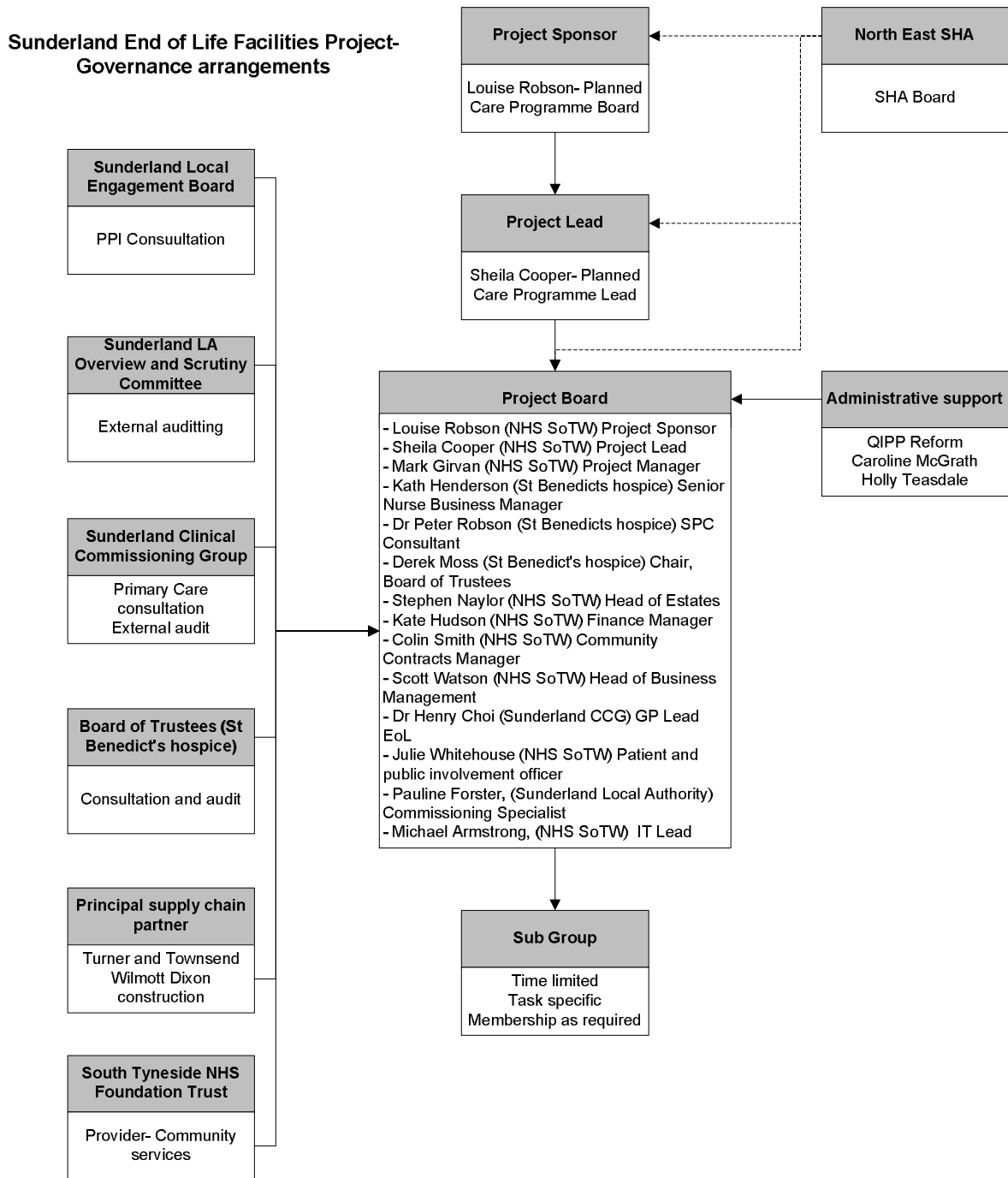
8.10 Extended phase 1 habitat survey
Due Friday 9th Sept

8.11 Noise survey and assessment
Due Friday 9th Sept

8.12 Construction Programme



8.13 Project Management Structure



8.14 Project Boards- roles and responsibility

Project Sponsor (NHS SoTW Integrated Board)

The project sponsor will be the TPCT Board being advised by their delegated representative on the Project Board (Louse Robson, Chief Operating Officer). The key responsibilities for the TPCT Board will be to:

- Act as investment decision maker with ultimate responsibility for the delivery of the project within the agreed cost envelope
- Commits financial resources to the project
- Ensure the submitted business case is viable. Ensuring that the revenue consequences are clearly identified and
- Ensure that appropriate management arrangements are in place for the successful delivery of the project from inception to completion.

Project Lead (Sheila Cooper)

The project lead is responsible to the project sponsor. The project lead's key responsibilities will be to:

- Ensure that the project is successfully delivered to time, cost and quality
- Appointment of the contractor and associated design team
- Appointment of a project team
- Provide regular progress reports to the TPCT Board, identifying cost, time and quality performance and
- Is responsible for ensuring that linkages are maintained between the project and the organisations strategic direction
- Appraises the project sponsor and make recommendations for future action
- Arrange the post-project evaluation of the scheme.

Project Manager (Mark Girvan)

Responsible to the project lead and Project Board. The project manager's key responsibilities will be to:

- Establish a multi-disciplinary Project Board
- Establish task specific sub-groups as and when required. e.g. clinical and operational, to identify, schedule and carry out tasks to effect the development of the proposed build
- Manage communication and transfer of information between the Project Board, sub-groups, project lead and sponsor
- Set up reporting and communication procedures for the Project Board
- Co-ordinate and facilitate the work of the project team
- Monitor and review progress of activities and
- Provide regular progress reports to Project lead and sponsor

Project Board

The Project Board was established to steer and oversee the development of the most appropriate accommodation and facilities for end of life care service provision in Sunderland. The board is overseen by the Planned Care Programme Board as well as the project sponsor. Key responsibilities include;

- Ensure patient safety and service provisions are maintained
- Ensure a project plan is developed and delivered to plan
- Develop an option appraisal for future accommodation/facilities for Sunderland taking into account the impact of all End of Life services provided out of Sunderland
- Develop a business case
- Oversee the development of the hospice in accordance with the business case
- To ensure recommendations have agreement of all group members and their respective organisations.
- Ensure the project remains on track throughout its development and concentrated on achieving its agreed objectives
- Monitors and controls the project through its reporting and planning arrangements
- Refers problems/issues to the project sponsor as appropriate
- Proactively manage the risks as identified by the project manager

Membership:

- Louise Robson, Chief Operating Officer, (NHS SoTW) Project Sponsor
- Sheila Cooper, Commissioning lead Planned Care (NHS SoTW) Project Lead
- Mark Girvan, Project manager (NHS SoTW) Project Manager
- Kath Henderson, Senior Nurse Business Manager (St Benedict's hospice)
- Dr Peter Robson, SPC Consultant (St Benedict's hospice)
- Derek Moss, Chair, Board of Trustees (St Benedict's hospice)
- Stephen Naylor, Head of Estates (NHS SoTW)
- Kate Hudson, Finance Manager (NHS SoTW)
- Dr Henry Choi, GP Lead EoL (Sunderland CCG)
- Julie Whitehouse, Patient and public involvement officer (NHS SoTW)
- Pauline Foster (Sunderland Local Authority)
- Scott Watson, Head of Business Management, (NHS SoTW)
- Colin Smith, Community Services Business Manager, (NHS SoTW)
- Michael Armstrong, IT Lead, (NHS SoT)

Key relationships:

- Project Sponsor
- Project Lead
- Sunderland Clinical Commissioning Group
- Sunderland Local Authority
- City Hospitals Sunderland NHS Foundation Trust
- St Benedict's hospice
- North East SHA

Work areas:

- Development of business cases
- Risk management (identify, monitor and manage)
- Work plans for each stage of the project, identifying objectives, deliverables, activities and resources required.

Estates (Lead- Stephen Naylor)

The lead for estates is the interface between the PSCP and the Project Board. Responsibilities include:

- Day-to-day management of the construction of the project
- Management of the contractor and associated design team in partnership with the Project Manager
- Contract control and performance;
- Advises the Project Board of construction risks, that are likely to affect the projects objectives or timescales
- Ensures the building design supports its clinical functionality incorporating the facility and environmental requirements of the hospice
- Ensure the building is constructed in accordance with the health care specification
- Organises site visits as and when required
- Completes the 'snags' list

Key relationships:

- Project Board
- PSCP
- Local Authority

Work areas

- Design development
- Planning application
- Construction phase design development
- Liaison with external suppliers in relation to specification and instillation of medical equipment
- Construction phase
- Identify security requirements following the commissioning of the building from the contractor

8.15 Post project evaluation plan

Objective	Task	Activities	Outcome	Completion date	Responsibility
Complete an evaluation of the project following completion of the construction phase	To evaluate the processes put in place to deliver this project, including project management, procurement and design	Collect information: <ul style="list-style-type: none"> • Review project documentation (business case/project documentation/minutes of meetings) • Review risk register • Distribute questionnaire to project team/design champions 	Written report outlining <ul style="list-style-type: none"> • What went well • Lessons learnt How to improve current and future performance	Summer 2013	Project Lead
Post construction-complete an evaluation of the building including review of AEDET and BREEAM	To evaluate the procurement process and the performance of Willmott Dixon	Collect information (face to face interviews/questionnaires/meetings) to review the construction phase: <ul style="list-style-type: none"> • assess Willmott Dixon's performance against programme • review relationship with Willmott Dixon' team assigned to project • review quality of build and materials • evaluate responsiveness to views of TPCT during construction phase • Review snagging issues • Review the design – positive issues of the design/ areas of innovation and the benefits and outcomes • Collect patient/staff feed back on the design and layout of the building (questionnaire/face to face interview) 	Written report outlining <ul style="list-style-type: none"> • What went well • Lessons learnt • How to improve current and future performance 	Summer 2013	Estates lead

		<ul style="list-style-type: none"> • Lessons learned and best practice • Review challenges during the construction phase and responses 			
Evaluate the commissioning of the building	To evaluate the process of preparing the building for occupation and service delivery	<p>Review Willmott Dixon performance by examining a number of areas, e.g. delivered on time/number of snagging issues/compliance with TPCT guidance in terms of quality of materials and construction</p> <p>Collect information to assess the effectiveness of internal processes to prepare building for occupation:</p> <ul style="list-style-type: none"> • Feed back from service providers • Review of performance against planned programme • Internal review of contractors (installation of specialist equipment/IT/telecommunications) 	<p>Written report outlining</p> <ul style="list-style-type: none"> • What went well • Lessons learnt • How to improve current and future performance 	Summer 2013	Project lead
12 month post completion evaluation to assess the success of the project against the stipulate aims within the business case	To assess to what extent the original objectives have been achieved	<ul style="list-style-type: none"> • Identify the kinds of data to be collected, the teams responsible currently for collecting this data and internal constraints • Agree timing of this evaluation • Collect feed back from patients 	Evidence which demonstrates the extent to which the expected benefits and objectives of the project were met in relation to patient experience and the wider health economy	Summer 2014	TBC

8.16 Risk evaluation

REF	CATEGORY	RISK DESCRIPTION	RISK MANAGEMENT	CURRENT STATUS
1	Planning	Planning department and the statutory consultees unhappy with the proposed use of the site or proposed design	Early and frequent meetings with the planning department and the statutory consultees to establish requirements	Live
2	Building Regulations	Building Regulations conditions with potential impact on cost	Early liaison with Building Control and produce a Building Regs approval discharge matrix to be produced to manage process	Live
3	Client Sign-off	Approval by Client/User of the layout, aesthetical appearances throughout the building (areas of fabric repair, ceiling downstands, material selection and colours, etc.).	Frequent meetings diarised with the end users and Client to develop the design collaboratively	Live
4	Obstructions	Obstructions in the ground including services and old culverts, may affect construction.	Site required and design developed to mitigate findings in most cost effective manor	Live
5	Existing Buildings	Construction may cause damage to adjacent existing structures due to vibrations, collisions or by undermining the structures.	Site to be established, design and construction methods to be developed to mitigate impact	Live
6	Existing Services	There is a risk that unidentified services could be damaged or could become obstructions, thus increasing the cost of the project.	Full CAT scan required to establish what services will need diverting or considering.	Live
7	Mining Areas	There is a risk that old mine workings are more extensive than envisaged, as mining records are not definitive.	Site required and design developed to mitigate findings in most cost effective manor	Live
8	Contamination / Gas / Groundwater	There is a possibility that gas and contaminated ground may be present on site together with adverse ground water levels. This may lead to additional costs as protection measures may be required.	Site to include gas monitoring, ground water measurements and contamination tests.	Live
9	Migration of Contaminants	There is a risk that the migration of contaminants may occur.	Site to establish risk and mitigation measures put in place	Live
10	Water and Drainage	Potential that the water board may ask us to attenuate drainage on site leading to an increased cost.	Early application made once outline discharge rates are known	Live
11	Public Utility Quotes	There is a risk that quotations for services may be high.	Early applications made to establish outline budgets and network conditions.	Live
12	Northumbrian Water Quotes	Detailed quotations for new connections have not been received from NWL. It would be prudent to include a contingency cost of approximately £1500 per building to include for the new connections and meters.	Costs may increase due to traffic management which may be required to make the connection.	Live
13	Planning	Restrictive conditions imposed by the Local Authority when granting planning permission	Early engagement with LA, who have confirmed no anticipated problems with approval	Live
14	Commercial	Unaffordable scheme, growth in revenue costs to fund uplift in running costs	Revenue stream calculation carried out and finance engaged	Live
15	Commercial	Unaffordable scheme; growth in build cost	Clear specifications within design brief and transfer of risk through contracting arrangements	Live

8.17 Contribution to the NHS North East Vision and Aims

Local Health Economy Aims	The proposed developments contribution
<p>No barrier to health and well-being</p> <p>No inequality</p>	<ul style="list-style-type: none"> • In line with the End of Life Strategy, there will be no barrier to services at the end of life. This space will provide a future proofed facility with an environment which is appropriate for this specific patient group. • The move to single bed units will significantly improve patient experience, equity of access in dignity at the end of life. • To support the delivery of the integrated model of care for end of life patients, services will be collocated.
<p>No avoidable deaths, injury or illness</p>	<ul style="list-style-type: none"> • Provision of a range of services in the right setting meaning that people get seen by the right person, at the right time and in the right place • Provision of a safe, therapeutic facility
<p>No unnecessary waiting or delays</p> <p>No avoidable suffering or pain</p>	<ul style="list-style-type: none"> • Provision of a range of services for assessment and treatment in the community. • Choice during the end of life provides opportunities; <ul style="list-style-type: none"> - Avoid hospital admission. - Reduce length of stay • Respite beds help avoid delay in discharge from acute bed to an appropriate care setting • Services to cater for a complex range of needs including pain management and carer support
<p>No helplessness</p>	<ul style="list-style-type: none"> • Public, Users, Carers and Patients involved and engaged in the development and implementation of the new service model contributing to the improvement in services / provision of services that meet their needs • Opportunities for people to take control of their end of life care through integrated model of care and advance care planning.
<p>No waste</p>	<ul style="list-style-type: none"> • Full Business Case developed by TPCT in partnership with local authority colleagues, Clinical Commissioning Group. • Collocation of facilities with other 24 hour health providers creates economies of scale; <ul style="list-style-type: none"> - Design - Build - Utilities

8.18 Letter of support- Sunderland TCPT

*Chair and Chief Executive's Office
Pemberton House
Colima Avenue
Sunderland Enterprise Park
Sunderland
SR5 3XB*

*Susan Winfield
Chairman
Tel: 0191 5297008
Fax: 0191 5297396
Email: sue.winfield@sotw.nhs.uk*

7-Sep-11

Mr Tim Watkinson
Head of Capital Investment
c/o North East SHA
Riverside House
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne, NE15 8NY

Dear Tim

Re: End of Life Care facilities, Sunderland

I am writing to endorse the submission of the Full Business Case for a new purpose built hospice facility in Sunderland. I understand that the case is being submitted for consideration by the North East SHA Board at its September meeting.

I am happy to take 'Chairs Action' in the endorsement of this document and will take my decision to the next NHS South of Tyne and Wear Integrated Board meeting on 14 September for ratification. Due to the tight timescales for this development it has not been possible to submit this business case to the Board prior to this stage however the Board has been given a verbal update prior to agreement to take 'Chairs Action'.

The provision of a purpose built hospice facility has been part of Sunderland Teaching Primary Care Trust's estate strategy for a number of years and the Board wants to ensure that we deliver this last piece of the jigsaw as our legacy commitment to the people of Sunderland. Non Executive Directors have been regularly briefed on the progress of the proposed facility and we all strongly support the submission.

I am happy to confirm that Sunderland TPCT considers the proposal outlined in the business case as beneficial and affordable.

I would strongly recommend this business case to you.

Yours sincerely



**Sue Winfield
Board Chair**

8.19 Letter of support- Sunderland Clinical Commissioning Group

SUNDERLAND CLINICAL COMMISSIONING GROUP

Sunderland Clinical Commissioning Group
GP Commissioning
Sunderland Teaching Primary Care Trust
Pemberton House
Colima Avenue
Sunderland Enterprise Park
Sunderland
SR5 3XB

Our Ref: IP/MA
Your Ref:
Contact: Michael Anderson
Direct Dial: 0191 529 7135
Email: michael.anderson@sotw.nhs.uk
Consortia Email: SCC@sotw.nhs.uk

2.8.11

RE: End of Life Facilities; Sunderland

Dear Sheila,

I am writing in my role as Chair of the Sunderland Clinical Commissioning Group. Following your attendance at our recent board meeting I would like to offer the groups formal support for the proposed development of end of life facilities in Sunderland.

The group agreed that the development of a new purpose built facility represented an opportunity to ensure the provision of sustainable palliative care services for the residents of Sunderland.

We look forward to working with you closely throughout the ongoing development of this project.

Best Wishes



Ian Pattison
Chair Sunderland Clinical Commissioning Group

8.20 Letter of Support Lead GP

Mr. Mark Girvan
Project Manager
End of Life Facilitators-Sunderland
Sunderland TPCT
Loftus House
Colima Avenue
Sunderland

8.8.2011

Dear Mark,

I am writing in my capacity of Sunderland Primary Care Cancer Lead to support the Relocation of St. Benedict Hospice.

The focus of palliative care has shifted from secondary care to community based service and the scope of palliative care has extended from cancer to non cancer in the past few years. There is a better recognition of the condition in Primary Care as practices are actively promoting end of life care such as Liverpool care pathway and Advanced Care Planning. We anticipate the demand for Specialist Palliative Care mainly delivered from the hospice will increase. We need modern facilities with adequate capacity to take us thorough the next 10 or 20yrs as the growth for palliative care service will rise. The uncertainty of current site creates anxiety among GPs.

I hope our concerns can be shared with the Project Board and I look forward to hearing the decision about the relocation of St. Benedict Hospice Project.

Yours sincerely,

Dr. H. Choi
Primary Care Cancer Lead

8.21 Letter of Support Board of Trustees, St Benedict's hospice

11 August 2011



St. Benedict's
HOSPICE

Registered Charity 1019410

Registered office
St. Benedict's Hospice
Monkwearmouth Hospital
Newcastle Road
Sunderland, SR5 1NB
Telephone: 0191 5690194
Facsimile: 0191 5690253
www.hospice.co.uk

Dear Sheila,

RE: St Benedicts Hospice

I'm delighted to be able to offer the full support of The Board of Trustees for St Benedict's hospice to the proposed redevelopment in Ryhope.

The Board feels that this location is in line with our visions for the future delivery of care and is pleased to have had full involvement in the decision making process.

We look forward to working in collaboration with the project steering group to take this development forward into the next phase.

Yours Sincerely,

Derek Moss
Chair- St Benedicts Board of Trustees



The Queen's Award
for Voluntary Service
REGISTERED CHARITY

Chairman:
Derek Moss JP

Patron:
The Duchess of
Northumberland

President:
Denise Robertson



Sunderland NHS
Teaching Primary Care Trust

St. Benedict's Hospice, Sunderland is a private company limited by guarantee. Registered in England and Wales Company Reg. No. 02803974

8.22 Letter of support, South Tyneside NHS Foundation Trust

Preliminary support has been provided in principle by South Tyneside NHS Foundation Trust. A formal letter of support is pending the Trusts Board meeting on 27th September.

8.23 4 Tests

In May 2010, the Secretary of State for Health set out four tests against which substantial NHS reconfigurations are to be assessed. The tests are designed to build confidence within the service, with patients and communities. The tests require reconfiguration proposals to demonstrate:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice.

Further guidance developed by the Department of Health in July 2010 states that the goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way. The guidance is not prescriptive but requires commissioners to design and lead a local process to gather evidence and formally review the level of support for any proposed changes.

The table below outlines where the evidence is included within this report which demonstrates all four tests have been considered and met.

Test		FBC Section
1) Support from GP commissioners	<ul style="list-style-type: none"> • Letter of support from Sunderland Clinical Commissioning Group • Letter of support from GP Cancer lead • GP Questionnaire distributed electronically to every GP in Sunderland designed to identify future service requirements. • Lead GP for end of life care sits on Project Board 	<p>8.14</p> <p>8.15</p> <p>2.5</p> <p>8.8</p>
2) Strengthened public and patient engagement	<ul style="list-style-type: none"> • Focus group with existing service users (Patients and families) to identify what their priorities would be when considering the selection of the new hospice site. Information collated was used to determine questions for consideration in the options appraisal and their weighting scores. • Staff, patients and carers from the hospice inpatient unit were asked to list their 'vision' for a new hospice build. They were specifically asked to include the non tangible; their thoughts and feelings of what the hospice would represent • 2 patient 'design champions' were included in the sub group who reviewed the selection of architect. • A paper has been submitted to the Sunderland Local Engagement Board with 	<p>2.5</p> <p>2.5</p> <p>2.5</p> <p>2.4</p>

	<p>an agreement to attend their next meeting to present a progress update.</p> <ul style="list-style-type: none"> • A detailed programme of consultation exercises has been developed in collaboration with the TPCTs engagement officer. • Attendance at an opening event of Houghton Primary Care Centre provides an opportunity to carry out significant public consultation and engagement • Confirmation of support from Sunderland Local Authorities Overview and Scrutiny Committee 	
3) Clarity on the clinical evidence base	<ul style="list-style-type: none"> • End of Life Care Strategy 2008 • NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer • Department of Health's Building on the Best: end of life care initiative (2004) • The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2007) • The Preferred Priorities for Care, NHS End of Life Programme, December 2007 • Gold Standards Framework www.goldstandardsframework.nhs.uk • Department of Health Transforming Community services (2009) • Palliative and End of Life Care Quality Markers 2009 	3.1
4) Consistency with current and prospective patient choice.	<ul style="list-style-type: none"> • Provision of specialist community based services which will help to sustain care at home, reducing the need for admission to acute care. • Provision of services which align with the integrated model for specialist palliative care services 	3.2 3.2

8.24 Equality impact assessment

NHS South of Tyne and Wear

serving Gateshead Primary Care Trust, South Tyneside Primary Care Trust and
Sunderland Teaching Primary Care Trust

When deciding if your function/plan/strategy/service/policy has a high or low impact, you will have to make a judgement about the potential risk to each of the equality groups. Background data will help to identify these potential risks. If there is no data available then you cannot assume that there is no risk. In these circumstances you may need to carry out some further investigations before you can carry out the Equality Impact Assessment.

1. Name of function/plan/strategy/service/policy:	St Benedict's Hospice Business case	
2. Aim of function/plan/strategy/service/policy:	To outline the aims and objectives of a new purpose built development for hospice care in Ryhope. To outline the business model to support the development and the progress made so far.	
3. Directorate:	Commissioning and Reform	
4. Manager(s) completing assessment:	Mark Girvan and Sheila Cooper	
5. Date:	9 th August 2011	
6. Does this function/plan/strategy/service have direct impact on service users/public or staff? Yes or No	Yes – the re-location of the hospice and its allied services will have an impact on staff, service users and the public.	
7. Patients, Community or staff groups by equality strands	High or Low Risk	If high, please list some examples of evidence, e.g. PALS, low uptake by minority group, If low, please list some positive examples of how patients/public/staff can access your service.
Race What is the risk that Black, Asian or Minority Ethnic communities would have problems accessing your service or function/plan/strategy?	Low	The facility outlined in the business case would be open to all communities. All communities have been engaged in the development of the design of the facility and have contributed to the development of the service content. The communications strategy for the project outlines measures to ensure that Black, Asian or Minority Ethnic Groups have access to accessible information about the hospice and its services.
Disability What is the risk that patients/public/staff with	Low	Due to the nature of the services provided and the intended service users, the building has been

<p>a disability would have problems accessing your service or function/plan/strategy</p>		<p>designed to accommodate best practice in terms of a physical environment that is accessible to people with a range of disabilities. Disabled parking provision has been made near to the building. Attention is being paid to the external environment to make it a stimulating space for people with sensory impairment.</p>
<p>Gender What is the risk that people of different genders would have problems accessing your function/plan/strategy/service? (This will also include transgender)</p>	<p>Low</p>	<p>The building has been designed to accommodate single, en suite bedrooms in the inpatient unit to ensure that people of different genders feel that their privacy and dignity is respected. The communal spaces have also been designed in a way that allows people to find a private space.</p>
<p>Age What is the risk that older people or younger people would have problems in accessing your service, function/plan or strategy?</p>	<p>Low</p>	<p>It is anticipated that the majority of service users will be aged 65 or over. However families and carers of all ages will access the facility. Following engagement with staff and service users, careful consideration is being given to making the site feel safe and secure for older people. Access by public transport has also been considered. For families with children, there will be specific facilities for included.</p>
<p>Religion and belief What is the risk that people practicing different religions or beliefs would have problems in accessing your service, function/plan or strategy?</p>	<p>Low</p>	<p>It is anticipated that people from all beliefs and religions will access the centre. As there are inpatient facilities, a multi faith room has been added to the design to create opportunities for spiritual reflection. Within the development consideration will be given to ensure all appropriate facilities are included, for example for prayers during Ramadan, which includes the need for people to cleanse themselves before praying.</p>
<p>Sexual orientation What is the risk that people who are lesbian, gay or bisexual would have problems in accessing your service, function/plan or strategy?</p>	<p>Low</p>	<p>It is anticipated that people who are lesbian, gay or bisexual will attend the centre. No specific barriers to the facility have been identified.</p>
<p>Health equity ** What is the risk that your service, function/plan or strategy will be less easy to access by people from vulnerable groups with particular health needs? E.g. homeless people, people with mental ill health, people living in poverty, people with an offending past, and people with differing immigration status. In other words, is the service, function/plan or strategy more accessible to people with fewer health needs?</p> <p>** Health equity ** can be described as <i>distributing services and resources relative to the health needs of different groups and</i></p>	<p>Low</p>	<p>The facility itself will be very accessible within the Ryhope area. The building will be built to be welcoming and unthreatening. It will have as least clinical feel as possible there will be a number of areas such as the communal outside space which will provide access to non-health related service. The health need of the local area and the entire Sunderland region has been assessed and the decision to place the hospice in Ryhope was determined by this information.</p> <p>The engagement work that has been done to date with service users has included many groups of people with particular health needs or those who are considered to be more vulnerable</p>

<i>areas, rather than an equal distribution.</i>		(and their representatives)
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8.25 Review of SCAPE

SUNDERLAND TEACHING PRIMARY CARE TRUST PROCUREMENT USING THE SCAPE FRAMEWORK PROCUREMENT ADVICE

Instructions

1. We have been instructed by Sunderland Teaching Primary Care Trust (the "PCT") to review the Scape National Framework 2010 (the "Framework") and the associated OJEU Contract Notice in order to ascertain if the PCT may utilise the Framework for the construction of a hospice in Sunderland instead of the PCT procuring the construction works through an independent procurement process.
2. This advice has been written by the PCT and may not be relied upon by any third party.

Introduction

3. For the purposes of this advice, we have reviewed the following documents only:
 - 3.1 The Contract Notice for construction works that advertised the single supplier Framework (2009/S 176-253640) and was dispatched to the Official Journal of the European Union ("OJEU") by Scape System Build Limited ("Scape") on 10 September 2009 (the "Contract Notice");
 - 3.2 The Scape National Framework 2010 between Scape and Willmott Dixon Capital Works Limited dated 23 April 2010.
4. In order for us to consider if the PCT may utilise the Framework for the construction of a hospice in Sunderland instead of procuring the works through its own procurement process, we must consider whether:
 - 4.1 Scape have the authority to procure the works required by the PCT as a central purchasing body;
 - 4.2 the PCT are adequately defined in the Contract Notice as a potential user of the Framework to be able to utilise the Framework procured by Scape; and
 - 4.3 the Contract Notice and the Framework covers the type of construction works required by the PCT.

Our advice

5. **Do Scape have the authority to procure the works required by the PCT?**

- 5.1 The PCT are subject to the Public Contracts Regulations 2006 (the "Regulations") which means that they must procure contracts for works, goods and services valued above a set financial threshold, in accordance with specific rules set out in the Regulations.
- 5.2 We assume for the purposes of this note that the works contract that the PCT intend to procure via the Framework is valued in excess of the current financial works threshold of £3,927,260.
- 5.3 There is a provision under the Regulations that allows a contracting authority (such as the PCT) to satisfy the requirements of the Regulations by purchasing works from or through a central purchasing body instead of procuring works via an independent PCT run process. However, the Regulations are clear that when relying upon a central purchasing body, the PCT will have only complied with the Regulations to the extent that the central purchasing body has complied with them.
- 5.4 A central purchasing body is defined in the Regulations as "*a contracting authority which:*
- a) acquires goods or services intended for one or more contracting authorities;*
 - b) awards public contracts intended for one or more contracting authorities; or*
 - c) concludes framework agreements for work, works goods or services intended for one or more contracting authorities."*
- 5.5 Therefore Scape can only be classified as a central purchasing body if they are a contracting authority in their own right.
- 5.6 Under the Regulations, a contracting authority includes "*a corporation... for the specific purpose of meeting needs in the general interest, not having industrial or commercial character and:*
- 5.6.1 *financed wholly or mainly by another contracting authority; or*
 - 5.6.2 *subject to management supervision by another contracting authority; or*
 - 5.6.3 *more than half of the board of directors or members of which... are appointed by another contracting authority."*
- 5.7 The Contract Notice states that Scape is "*a company entirely owned and controlled by 6 English Local Authorities*" but it gives no further indication as to whether or not it is a contracting authority for the purposes of the Regulations. Scape's website would indicate that they have been set up to meet needs in the general interest and that they do not have an industrial or commercial character which would support the fact that they are indeed a contracting authority but the PCT should confirm this directly with Scape. If Scape are a contracting authority then they will have the authority to procure the construction works on behalf of the PCT.

6. **Is the scope of the Contract Notice precise enough to allow the PCT to be able to utilise the Framework procured by Scape?**

6.1 The PCT may only use the Framework if they are adequately identified in the Contract Notice as a contracting authority who may, in addition to Scape, utilise the Framework. If the PCT are not adequately identified in this way, the PCT can not use the Framework without being at risk of legal challenge under the Regulations.

6.2 Guidance from the Office of Government Commerce ("OGC")¹ states that a class of users may be used in a contract notice to describe those contracting authorities who may utilise a framework agreement but *"it must be sufficiently well defined and precise that a contracting authority can be immediately identified as a member (or not) of that class."*

6.3 The Scape Contract Notice states that call off contracts under the Framework may be entered into by (amongst others) *"Primary Care Trusts"* and the location of the works includes the *"North East of England"*. Therefore, although the PCT are not mentioned specifically, the PCT fall under a clearly defined class of users.

7. **Does the Framework cover the type of works required by the PCT?**

7.1 The PCT wish to use the Framework to procure construction works for the build of a hospice in Sunderland. The Contract Notice describes the scope of the works under the Framework as including *"new build and refurbishment of the following building types... Health,...Day Care...Elderly Homes..."* and the CPV codes in the Contract Notice used to describe the subject of the contract include *"construction work, site preparation work and architectural services"*. Although a hospice building is not mentioned specifically in the Contract Notice, it does fall within the "Health" category of building types. Also, it is a similar building to a day care building and elderly homes which would further indicate that it falls within the intended scope of the Framework.

7.2 The overall spend under the Framework (for all users) listed in the Contract Notice is £250 - £350 million with an annual estimated spend of £62.5 million - £87.5 million and an average project value of approximately £7 million. If the PCTs project is materially outside the above value ranges, there is the possibility that the PCT could be legally challenged for using the Framework. Therefore the PCT should check with Scape that the current spend under the Framework (by other contracting authorities who have utilised the Framework) has not materially exceeded the levels set out above.

7.3 Although the Framework does refer to it being entered into as the result of a tender process commenced by the publication of the Contract Notice, it does not specify in detail the works to be carried out by Willmott Dixon as these are to be detailed within each call-off contract (Project Agreement) that is entered into under the Framework. Therefore, the PCT should make sure that when specifying works under a call off contract they do not exceed the scope of works identified in the Contract Notice.

¹ Procurement Policy Note 16/10, 8 September 2010

- 7.4 The only potential issue with the Framework scope that we have noticed is that it refers to Wilmott Dixon carrying out "services" under the Framework as opposed to works. However, we assume that this is an oversight as the definition of services under the Framework includes "*construction services*" and "*construction, testing, commissioning and completion of premises (including any temporary works)*" and further to this, the model Project Agreement which is used by users of the Framework when they call off a contract, clearly refers to works.

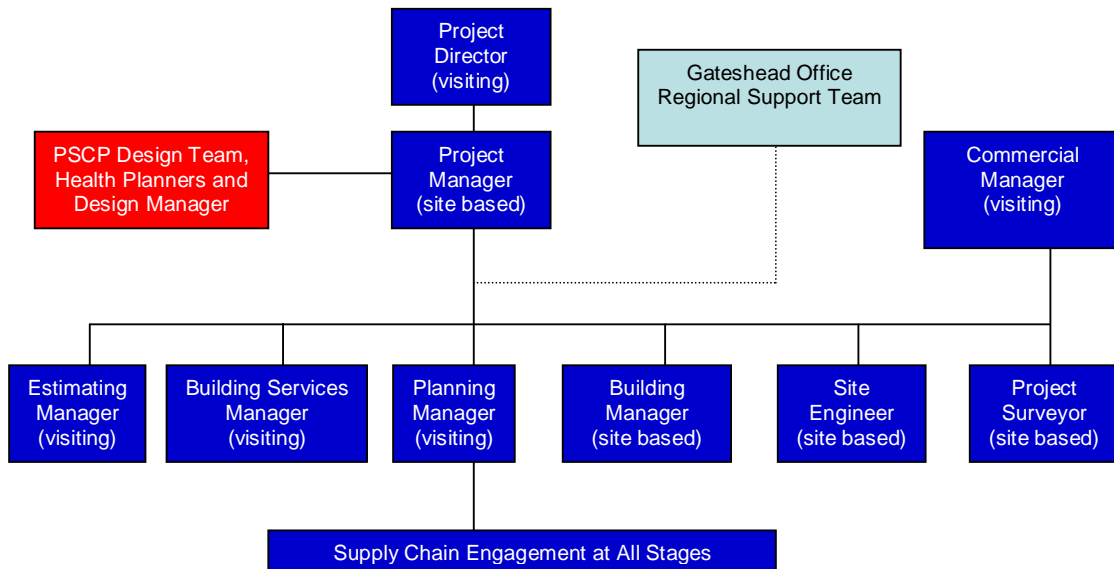
Summary

8. Subject to the PCT checking with Scape that Scape are a contracting authority in their own right and that the spend under the Framework is materially within the anticipated financial range set out in the Contract Notice, the PCT may utilise the Framework for the procurement of construction works for the build of a hospice and do not need to procure the design and construction of the hospice independently under a PCT run procurement process. The PCT should ensure however that they call off any contract under the Framework in accordance with the instructions set out in the Framework document and scope of works in the Contract Notice.
9. As referred to in paragraph 5.3 above, the PCT will have only complied with the Regulations to the extent that Scape has complied with them. Although we have no details of the compliance of the procurement process carried out by Scape, the fact the Framework was entered into on 23 April 2010 would indicate that no legal challenge was made to Scape's procurement process that would have an effect on the validity of the Framework.

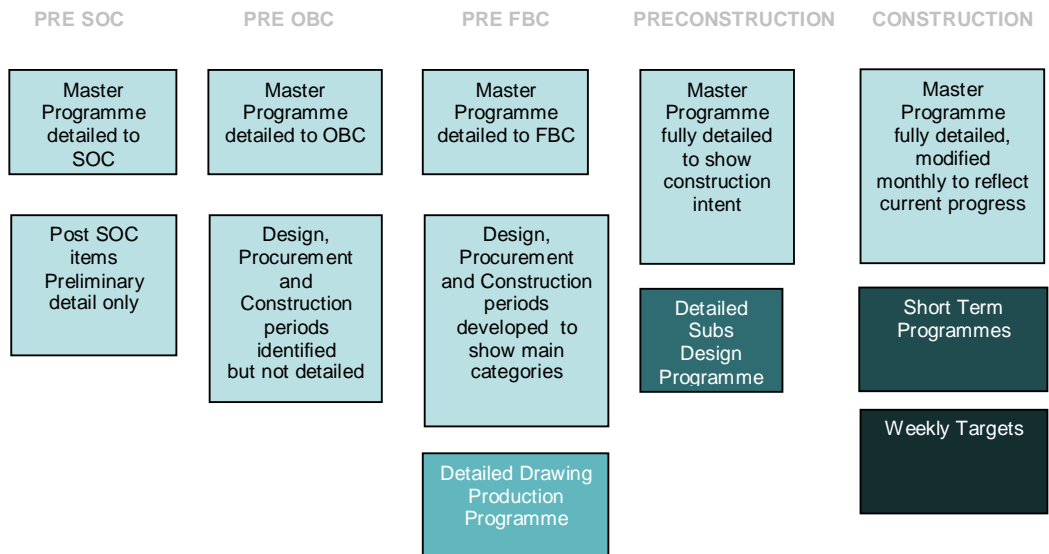
Eversheds LLP
24 August 2011

8.26 PSCP Management Structure and Monitoring Control Processes

Principal Supply Chain Partner Structure



Monitoring and Control Processes



MEALS AT HOME SERVICE**REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING AND ADULT SERVICES AND EXECUTIVE DIRECTOR OF CITY SERVICES****1. PURPOSE OF REPORT**

- 1.1 To provide Members of Health and Wellbeing Scrutiny Committee with an update on the Meals At Home service.

2. BACKGROUND

- 2.1 The purpose of providing Meals at Home is one way to meet the assessed nutritional needs of service users and help them maintain a healthy diet. These needs can be met in a variety of ways, and increasingly people are finding alternate solutions that best suit their personal circumstances.

The Meals At Home service provided by the Council was to deliver hot meals at lunchtime. The service was delivered by City Services having transferred from Health, Housing and Adults service in 2006.

- 2.2 The service was provided through a Service Level Agreement between City Services and HHAS. In those cases where people choose to have their nutritional needs met by Meals at Home Services, these are offered by a range of providers in communities across Sunderland. Individual customers have not usually received the service every day of the week as they made other arrangements on certain days according to their circumstances. In order for the Council's service to be financially viable within the terms of the agreement that was in place the service needed to deliver 300 meals per day. The cost of running the service became uneconomic as fewer people were using the service. The charge to the customer has been unchanged for some time at £2.60, to cover the cost of the food content which in itself is not a social care need, while the cost of the service to the council rose to £5.79.
- 2.3 The previous customer base fell to approximately 100 meals per day. This was due to customers' needs changing and preferences changing with many newly assessed customers using community based providers. Also the fact that people with a Direct Payment are legally required to buy the service from external providers.
- 2.4 The key aims for social care are to support people to live independently in the community, and in doing so ensure services are personalised to

individuals in a way that gives them maximum choice and control in how their services are delivered.

3 POLICY CONTEXT

- 3.1 The implementation of personalised services means that people who have eligible social care needs receive a personal budget which they can take as a Direct Payment, or as a budget which the Council can manage on their behalf but which can be spent to meet their outcomes in the way that they want. This approach increases the choice and control for people over the support they receive.
- 3.2 By 2013, it is expected that all people with eligible social care need to be directing their own support through a personal budget with the majority taking their budget as a Direct Payment. The laws relating to local authorities and 'trading' mean people cannot buy services direct from the council using their direct payments; therefore over the next few years people would be unable to buy the in-house service.
- 3.3 Where a person is assessed as needing support to maintain a healthy diet a sum of money, in line with their level of need, is included in their Personal Budget. A financial assessment is carried out and where people have the means to contribute to the cost of their care they do so for part or all of the cost. They are supported to design a plan to meet that need, and this includes being signposted to service providers in their local community. A range of providers exist including the establishment of meals at home services from Beckwiths – the community interest company which provides the catering in the city's first three Extra Care Schemes. The prices of services, including meals at home services, vary across the city.
- 3.4 This approach is also flexible enough to enable the individual to change the pattern of the meals they eat as and when they wish to do so, for example going out with family and friends, getting help to cook for themselves or having food delivered.

4. CURRENT SITUATION – PROCESS OF REVIEW

- 4.1 As part of the requirement to review the needs of customers HHAS has completed a process of reviewing the individual needs of the customers of the Meals At Home service. All customers were informed of the intention via a letter to review their nutritional needs and how these could be met.
- 4.2 The process was as follows:
 - All customers were reviewed to provide an up to date picture of their circumstances and needs

- If their needs had changed and they needed less support, this was confirmed with them and they were advised where they can access the support they needed
 - If they were assessed as eligible for support they were allocated a personal budget, and advised as to the amount and helped to develop a support plan to achieve the outcomes they need.
 - A support plan has been put in place to help the customer organise their support, and they have received a financial assessment determining how much they can afford to contribute towards the personal budget
- 4.3 Reviews were undertaken on an area basis and were concluded on the 30th September 2010.
- 4.4 There is no change to the eligibility criteria for support, and therefore if a customer is reassessed as still having an eligible need in relation to accessing a healthy diet they will be supported to help decide how to best meet that need, which may include use of their personal budget and own resources.

5. CURRENT SITUATION – OUTCOMES OF REVIEWS

- 5.1 The process described in section 4 had clear implications for the viability of City Services' Meals At Home service. Additionally, in order to break even City Services needed a guaranteed customer base of 300 individuals per day wanting to use their personal budget (at a cost of £5.79 per meal) to buy meals from the Council. The level of demand for the service was, as previously stated, 100 meals per day.
- 5.2 Following the reviews of individual needs:
- 171 People were signposted to a range of alternative services that would provide access to food to meet any nutritional needs identified – many of these individuals were supported to set up alternative arrangements
 - A small number of people (28) are independently preparing their meals or are being supported by their family
 - 14 people have had their nutritional needs built into their existing care package
- 5.3 The exercise has been quite complex. There have been a small number of cases where the transition has not been as smooth as we would have hoped and we have worked to resolve these on a case by case basis. In these cases follow ups have been initiated and continue to be monitored to ensure arrangements are satisfactory.
- 5.4 Reviews of all individuals continue to take place to ensure people's needs continue to be met; this will be an ongoing process, with any action being carried out on an individual basis if required.

6. RECOMMENDATION

6.1 It is recommended that Members receive this report for information

BARMSTON MEDICAL CENTRE PROCUREMENT

REPORT OF THE SUNDERLAND TEACHING PRIMARY CARE TRUST

1. Purpose of Report

- 1.1 The purpose of this report is to provide members with information relating to the process for procuring a long term contract for the delivery of primary medical care services for patients registered with the Barmston Medical Centre in Washington.
- 1.2 Peter Berry and Carol Robb, GP Contract Managers from the North East Primary Care Services Agency (Working on behalf of Sunderland TPCT) will be present at the meeting to provide information to the Scrutiny Committee.

2. Background

- 2.1 Barmston Medical Centre provides primary medical services from two sites in Washington – Barmston Medical Centre, Westerhope Road, Barmston and The Galleries Health Centre, Washington.
- 2.2 Following on-going concerns, in February 2009, Sunderland PCT took the decision to remove the previous contract holders from the Performers List and terminate their primary care contract with effect from the end of April 2009. In line with Department of Health Regulations and following a procurement process, a temporary contract was awarded to Intrahealth Limited with effect from 1st May 2009. At that point, the intention was to allow a full consultation with patients and partners leading to an open procurement for the service.
- 2.3 A full patient and public consultation took place from 9th November 2009 to 5 February 2010. However, publication of this was placed on hold due to the General Election and subsequent re-organisation of the NHS introduced by the coalition government resulted in a delay to the procurement.
- 2.4 Sunderland PCT is now in a position to progress with the procurement of a contract (minimum 5 years). This report sets out the timescales and processes for engagement with patients on the outcome of the consultation and the procurement process.

3. Patient Engagement

- 3.1 The PCT intend to engage with the practice patient groups to

- feedback the results of the earlier consultation.
- advise on how patient suggestions will be incorporated into the new contract
- provide an explanation for any which cannot be incorporated
- explain the procurement process and timetable as well as how the successful bidder will be identified
- provide assurance that staff at the practice will have the opportunity to transfer over to the new provider
- identify any further issues that could impact on the development

4. Procurement Process

4.1 The PCT's desired timescales for this procurement process are

September 2011	Patient Engagement
October 2011	Full service review and specification completed
November 2011	Procurement process commenced
July 2012	Contract commencement by successful bidder

5. Conclusion

5.1 Members are requested to note and provide feedback on the procurement process.

POLICY REVIEW: HOSPITAL DISCHARGE – EVIDENCE FROM COMMUNITY HEALTH SERVICES**REPORT OF THE CHIEF EXECUTIVE****1. Purpose of Report**

- 1.1 At its meeting on 8th June 2011 the Scrutiny Committee agreed to pursue a review of Rehabilitation and Early Supported Discharge from Hospital.
- 1.2 The purpose of this report is to advise members of evidence to be presented at the meeting about how Community Health Services support hospital discharge services. Bev Atkinson, Managing Director of Community Health Services for NHS South of Tyne and Wear will be at the meeting to provide information to the Scrutiny Committee.

2. Background

- 2.1 The aim of the review is to establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings.
- 2.2 Members will recall the Scrutiny Committee has at previous meetings received briefings about the Transforming Community Services (TCS) programme which required that all PCTs should increase the separation between the commissioning and providing parts of the organisation. South Tyneside NHS Foundation Trust was the chosen management partner for the Transforming Community Services process.

3. Current Position

- 3.1 Transforming Community Services is a new model of care and partnership working across South of Tyne & Wear.
- 3.2 The services under the TCS umbrella include:
 - district nursing
 - health visiting
 - specialist nursing care supporting patients with diabetes
 - respiratory disease and heart disease
 - school nursing
 - community matrons
 - palliative care
 - community dentistry
 - substance misuse and sexual health

- speech and language therapy
- audiology
- podiatry

4. Conclusion

- 4.1 The Committee is asked to receive the evidence from the service provider at the meeting to support the ongoing policy review.

5. Background Papers

Policy Review reports to Health & Well-Being Scrutiny Committee: – 6 June 2011 - Work Programme and Policy Review; 19 July 2011 – Scope of Review; 6 September 2011 – Setting the Scene.

Contact Officer: Karen Brown, Scrutiny Officer
Tel: 0191 561 1004

POLICY REVIEW: HOSPITAL DISCHARGE - ISSUES HIGHLIGHTED BY THE 2010 SURVEY OF PATIENTS ON LEAVING HOSPITAL**REPORT OF THE CHIEF EXECUTIVE****1. Purpose of Report**

- 1.1 To provide the Scrutiny Committee with the key findings from national patient surveys which are relevant to leaving hospital services in support of the evidence for the policy review of hospital discharge.

2. Background

- 2.1 At its meeting on 6 June 2011 the Scrutiny Committee agreed to carry out a policy review with the following aim: To establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings.
- 2.2 At the Scrutiny Committee on 6th September 2011, the Committee received a comprehensive report setting the scene for the policy review. This report included information about the discharge planning process, services that support discharge, and statistics for delayed discharges.

3. Introduction

- 3.1 The Care Quality Commission (CQC) survey was carried out between September 2010 and January 2011, and gathered the views of patients who were discharged between June and August 2010. Nationally, over 66,000 patients from 161 acute and specialist NHS trusts in England responded to the survey, a response rate of 50%.
- 3.2 The results from the survey are primarily intended for use by NHS trusts to help improve patient experience and their performance.

4. Leaving Hospital – National In-Patient Services

- 4.1 There were no statistically significant changes from the 2009 survey in the proportion of participants feeling involved in decisions about their discharge from hospital. Fifty-four percent said they 'definitely' felt they were involved and 30% felt this was the case 'to some extent'. Sixteen percent said that they did not feel involved in decisions about their discharge from hospital.
- 4.2 Waiting for discharge from hospital - Two fifths of respondents (40%) said that their discharge from hospital was delayed, no change from

2009. For those who were delayed, the most commonly cited reason was to wait for new medicines (61%) followed by; waiting to see the doctor (16%), waiting for an ambulance (9%) and 'something else' (14%).

- 4.3 There were no statistically significant changes in the reported length of the delay from the 2009 survey. Sixteen percent of those who experienced a delay to discharge from hospital said that it was 'up to one hour', 28% said they were delayed between one and two hours, 33% between two and four hours and 23% longer than four hours.
- 4.4 Medication - Of those who had medication to take home with them, three quarters (75%) said that a staff member 'completely' explained the purpose of the medicine in a way they could understand, no change from 2009 though a decrease from 79% in 2002. Seventeen percent said that they received an explanation 'to some extent', with almost a tenth (9%) saying that a member of staff did not explain the purpose of medicines they were to take home with them.
- 4.5 Thirty seven of respondents said that a member of staff 'completely' told them about medication side effects to watch out for after they went home which, while not being statistically significantly different to 2009, is a decrease from 39% in 2002. Almost a fifth (19%) said that medication side-effects were explained 'to some extent', not a statistically significant change from 2009 but an increase from 16% in 2002. This leaves 44% who said that they were not told what medication side-effects to watch out for after they went home, though this is an improvement from 45% in 2009.
- 4.6 Three quarters (75%) of respondents said they were 'definitely' told how to take their medication in a way they could understand, 15% said they were 'to some extent' and 10% said they were not told in a way they could understand.
- 4.7 About two thirds (67%) of respondents who took medicines home responded 'yes, completely' when asked if they were given clear written or printed information about their medicine. Sixteen percent responded 'yes, to some extent' and 17% 'no'.
- 4.8 Information at discharge - Sixty-five percent of respondents said that they were given written or printed information about what they should or should not do after leaving hospital, an improvement from 63% in 2009. The remainder (35%) said that they did not get this information (37% in 2009).
- 4.9 Respondents were asked if a member of staff told them about any danger signals they should watch for after they went home. Forty one percent responded 'yes, completely', an increase from 39% in 2009. There was a corresponding decline in the proportion responding 'no'

(38%, an improvement from 40% in 2009.) The remaining 21% answered 'yes, to some extent'.

- 4.10 The proportion of respondents who reported that hospital staff told them who to contact if they were worried about their condition or treatment after leaving hospital increased from 75% in 2009 to 76% in 2010, while the proportion of those saying 'no' decreased correspondingly from 25% in 2009 to 24% in 2010.
- 4.11 Forty-four percent of respondents said that doctors or nurses 'definitely' gave their family or someone else close to them all the information they needed to help care for them, with 23% responding 'yes, to some extent'. Just under a third of respondents (32%) said that a doctor or nurse did not give their family or someone else close to them all the information they needed to help care for them.
- 4.12 Copies of letters - Department of Health guidance states that patients should receive copies of letters sent between the hospital and the patient's family doctor. For the first time since the question was first asked in 2005 the majority of respondents (53%) reported that they did receive copies of these letters, an increase from 47% in 2009.
- 4.13 Respondents who did receive these letters were asked if the letters were written in a way they could understand. Seventy four percent reported that they 'definitely' were, an improvement from 73% in 2009. There was a corresponding decrease in the proportions responding that the letters were 'to some extent' written in a way they could understand (23% in 2010 and 24% in 2009) and those responding that the letters were not written in a way they could understand (3% in 2010 and 4% in 2009).

5. City Hospitals Sunderland NHS Foundation Trust

- 5.1 At the end of 2009, a questionnaire was sent to 850 recent inpatients. Responses were received from 429 patients at City Hospitals Sunderland NHS Foundation Trust.

	Based on patients' responses to the survey, this trust scored:	How this score compares with other Trusts
Being involved in decisions about their discharge from hospital, if they wanted to be	7.1/10	About the same
Not being delayed on the day they were discharged from hospital	8.6/10	Better
Whether they were given written or printed information about what they should or should not do after leaving hospital	6.9/10	About the same
Having the purpose of medicines explained to them in a way they could understand, when given medicines to take home	8.7/10	About the same
Being told about the side effects to watch out for,	5.2/10	About the same

when given medicines to take home		
Being told how to take medication in a way they could understand, when given medicines to take home	8.9/10	Better
Being given clear written or printed information about their medicines, when given medicines to take home	8/10	About the same
Being told about any danger signals to watch for after going home	5.9/10	About the same
Information for family and friends for information being given to their family, or someone close, about how to help care for them	5.8/10	About the same
Being told who to contact if they were worried about their condition or treatment after leaving hospital	7.8/10	About the same
Receiving copies of letters sent between hospital doctors and their GP	5.7/10	About the same
Letters between the hospital doctors and family GP being written in a way they could understand	8.7/10	About the same

6. National Mental Health Services

- 6.1 The 2009 CQC survey of people who had recently had an inpatient stay for acute mental health problems was the first of its kind and collected responses from over 7,500 people. The survey asked people all about their experiences of acute inpatient mental health services along the pathway from admission to leaving hospital, including the care and treatment they received, day-to-day activities, and relationships with staff.
- 6.2 Respondents were asked a series of questions about their discharge from hospital. The majority (74%) of people said that they were given enough notice about their discharge from hospital, meaning that 26% were not. Just under a quarter (22%) said that their discharge date had been delayed, the main reason being that they had to wait to see the doctor or nurse in charge of the ward (cited by 34%). Other reasons cited were 'having to wait for suitable accommodation' (9%), and 'having to wait for community services to become available' (7%), 'having to wait for financial help' (1%). Another unspecified reason was given by 49%, and we would encourage trusts to explore the reasons for these delays. Respondents were asked whether hospital staff took their home situation into account when planning their discharge from hospital. Just under half (49%) answered 'yes, completely', 31% answered 'yes, to some extent' and 21% said no.

7. Northumberland, Tyne and Wear NHS Foundation Trust

- 7.1 At the start of 2009, a questionnaire was sent to people who had recently had an inpatient stay for acute mental health problems. Responses were received from 77 service users at Northumberland, Tyne and Wear NHS Foundation Trust.

	Based on patients' responses to the survey, this trust scored:	How this score compares with other Trusts
Being given enough notice of discharge from hospital	7.6/10	About the same
Not being delayed on the day they were discharged from hospital	8.2/10	About the same
Staff taking their family and home situation into account when planning discharge	6.4/10	About the same
Having a contact number for someone from their local mental health services to phone out of office hours	7.2/10	About the same
Being given information about how to get help in a crisis before leaving hospital	7.5/10	About the same
Being contacted by a member of the mental health team after discharge from hospital	6.6/10	About the same

8. Conclusion & Recommendations

- 8.1 The Committee is asked to receive this report in relation to patient information about leaving hospital as part of the evidence gathering for the policy review.

9. Background Papers

Care Quality Commission National in-patient survey results 2010

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ANNUAL WORK PROGRAMME 2011-12

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

- 1.1 For the Committee to receive an updated work programme for 2011-12.

2. Background

- 2.1 The Scrutiny Committee is responsible for setting its own work programme within the following remit:

Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Citizenship (Adults); and External inspections (Adult Services)

- 2.2 The work programme can be amended during the year and any Member of the Committee can add an item of business.

3. Current Position

- 3.1 In addition to the items taken at the scheduled meetings the following activities have taken place since the last meeting.

1. Children's Heart Services

The Scrutiny Committee has been kept informed about the ongoing the consultation on the reconfiguration of children's heart services in England.

The consultation follows the national 'Safe and sustainable review' which is proposing four options to reduce the number of hospitals providing children's heart surgery from 11 to either six or seven. No decisions about the future of any of the centres under review will be made until after the consultation. A decision on the proposals is expected in November 2011.

Overview and Scrutiny services have been given one further opportunity to comment on the proposals before a final decision is reached. The North East Regional Joint Health Scrutiny Committee has submitted a further response on behalf of all of the health scrutiny committees in the region which reiterates the earlier submission. This was in support of Option A which would provide for seven surgical centres including the Freeman Hospital, Newcastle.

2. Veterans Review

Delivery of the action plan following the Veterans Review is ongoing. All 12 local authorities in the region have submitted their first progress reports on

delivery of the recommendations. Key actions achieved by all local authorities at the early stages of delivery are, including reference to veterans in the Joint Strategic Needs Assessment, the identification of veterans at the point of accessing services and the establishment of champions or coordinators across the region to oversee the implementation of recommendations in each local area.

3. Any Qualified Provider (AQP)

The Committee has received a briefing on extending patient choice of provider in the South of Tyne and Wear which is intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice.

By October 2011, NHS South of Tyne and Wear must identify three or more services to be opened up to the wider healthcare provider market to create better choice for patients. In selecting services consideration needs to be given to local priorities. Stakeholder views have been sought on which services currently offered by NHS South of Tyne and Wear should be prioritised for the AQP process and on that basis, the initial recommendations for services to be considered for procurement via this first phase of AQP are:

- Adult Hearing Services in the Community;
- Diagnostics closer to home – possibly ultrasound scans (not for pregnancy)
- Podiatry

4. Conclusion & Recommendation

4.1 That Members note the updated work programme.

5. Background Papers

None

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE WORK PROGRAMME 2011-12

Appendix A

	JUNE 08.06.11	JULY 19.07.11	SEPTEMBER 6.09.11	OCTOBER 19.10.11	23 NOVEMBER	DECEMBER 07.12.11	JANUARY 11.01.12	FEBRUARY TBC	FEBRUARY 22.02.12	APRIL 4.04.12
Cabinet Referrals & Responses			Cabinet Response to 2010/11 Hospital Food & Veterans Policy Reviews		Policy Review: Evidence Gathering Day			Policy Review: Community Event		
Policy Review	Work Programme & Policy Review – Hospital Discharge & Reablement (KB)	Scope of Policy Review (KJB)	Endorse co-opted representation Setting the Scene – Delayed Discharge (JC/AN) Monitoring Action Plans: Dementia, Home Care, Health Inequalities	Community Services (BA)		Evidence Gathering	Evidence Gathering		Draft Report	Final Report
Performance			Q1 Performance Report (SL)			Q2 Performance (SL)				Q3 Performance (SL)
Scrutiny	Safe and Sustainable: Consultation (KB) Integrated Strategic & Operational Plan (STPCT) Health & Well-Being Board (NR)	Campus Completion Programme (PCT/NTW) Training Standards Care Homes (GK)	Procurement of social care for adults with a learning disability – progress report (PF)	Meals at Home Service (PC) Barmston Medical Centre Procurement (PCT)		Safe and Sustainable outcome of consultation JSNA Consultation (NC)	Quality Standards Care Homes (SL) Health Strategy consultation (NC)			Annual Commissioning Plan (STPCT)
CCfA/Members items/Petitions		Request to attend conferences Feedback visit to Wearmouth View								Draft Annual Report (KB)

At every meeting:

Forward Plan items within the remit of this committee / Work Programme update

**FORWARD PLAN – KEY DECISIONS FOR THE
PERIOD 1 OCTOBER – 31 JANUARY 2012**

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of the Report

- 1.1 To provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 October – 31 January 2012.

2. Background Information

- 2.1 The Council's Forward Plan contains matters which are likely to be the subject of a key decision to be taken by the Executive. The Plan covers a four month period and is prepared and updated on a monthly basis.
- 2.2 Holding the Executive to account is one of the main functions of scrutiny. One of the ways that this can be achieved is by considering the forthcoming decisions of the Executive (as outlined in the Forward Plan) and deciding whether scrutiny can add value in advance of the decision being made. This does not negate Non-Executive Members ability to call-in a decision after it has been made.
- 2.3 In considering the Forward Plan, members are asked to consider only those issues which are under the remit of the Scrutiny Committee. These are as follows:-

General Scope: To consider issues relating to health and adult social care services

Remit: Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Citizenship (Adults); and External inspections (Adult Services)

3. Current Position

- 3.1 The relevant extract from the Forward Plan is attached.
- 3.2 In the event of members having any queries that cannot be dealt with directly in the meeting, a response will be sought from the relevant Directorate.

4. Recommendations

- 4.1 To consider the Executive's Forward Plan for the current period.

5. Background Papers

Forward Plan 1 October – 31 January 2012

**Forward Plan -
Key Decisions for
the period
01/Oct/2011 to
31/Jan/2012**



**E Waugh,
Head of Law and Governance,
Commercial and Corporate Services,
Sunderland City Council.**

14th September 2011

Forward Plan: Key Decisions from - 01/Oct/2011 to 31/Jan/2012

No.	Description of Decision	Decision Taker	Anticipated Date of Decision	Principal Consultees	Means of Consultation	When and how to make representations and appropriate Scrutiny Committee	Documents to be considered	Contact Officer	Tel No
01438	To agree the Social Care Contributions Policy for Personalisation	Cabinet	05/Oct/2011	Cabinet, Service Users and Ward Members, Portfolio Holders	Briefings and/or meetings with interested parties	via the Contact Officer by 19 September - Health and Wellbeing Scrutiny Committee	Report	Neil Revely	5661880
01515	To agree Procurement for First Tier Welfare Rights Service and to award contract from April 2012.	Cabinet	05/Oct/2011	Cabinet, Service Users and Ward Members, Portfolio Holders.	Briefings and/or meetings with interested parties	Via the Contact Officer by 20 September 2011 - Health and Wellbeing Scrutiny Committee.	Report and supporting papers	Graham King	5661894