HOPTON & STANTON SURGERIES

PREMISES OPTION APPRAISAL

JUNE 2016

30 June 2016

Final

Contents

INTRODUCTION

This document summarises the option appraisal undertaken by the Hopton & Stanton Surgeries to determine its preferred way forward for the configuration of practice premises in Hopton and Stanton, in West Suffolk. It draws upon past experience and recent discussions with both NHS West Suffolk CCG and NHS England, and sets the context for the practice's application for financial support from the primary care infrastructure fund in 2015/16.

STRATEGIC CASE

This section summarises the context within which the investment proposals have been developed – both the context for the commissioners and existing arrangements within the practice.

Context

Following the publication of the five year forward view, and subsequent planning guidance, NHS England has established a structured approach to delivery of a programme of investments in primary care premises and investment.

The focus of this investment will be to meet the NHS England strategic aims, which are to:

- Maximise use of premises.
- Ensure value for money.
- Support seven day working across the NHS.
- Facilitate merger/collocation of primary care services.

These investments should be consistent with the CCG local estates strategy. However, at the time of writing this document, the NHS West Suffolk CCG local estates strategy is not complete, but CCG support for the practice to take measures to negotiate or ameliorate changes in service delivery does exist (see letter from Ed Garrett, dated 27 March 2014, in Appendix A).

Existing premises

The Hopton and Stanton practice serves a network of rural villages between Thetford, Bury St Edmunds and Diss. Other practices that operate nearby include Ixworth, Botesdale, Mendelsham, Woolpit and East Harling.

Hopton is the location of the original practice premises, an extension of a now retired partner's private residence. The landlord has served notice on the practice, and the amount of space available to the practice reduced to a single clinical room and part of the reception desk area in December 2015. The remaining room will no longer be available from January 2017. At present there is no lease in place for the reduced footprint in use by the practice. The services available on site are also limited – with a selection of nurse-led interventions for two whole days and three part days each week. While originally the main surgery, this is being switched to the Stanton surgery.

The GP surgery at Stanton is 3.9 miles from Hopton. It is larger than Hopton, self-contained and purpose built in 1992. It is owned by the practice and subject to notional rent. The net internal area is 268sqm. In addition to containing two consult/exam rooms, one treatment room and a dispensary it is also the practice's administrative base. The surgery is open every week day from 8am until 6:30 or 7:00pm.

Within close proximity to the Stanton Surgery is Stanton Health Centre. Owned by NHS Property Services, the health centre has a net internal area of 177sqm. It contains two clinical rooms, which are used by a range of community services (midwives, podiatry, foot care and continence) and (on a sessional basis) as a branch for the Ixworth GP practice. In addition, health visitors, school nurses and midwives use the health centre as an administrative base.

Previous investment proposals

In June 2014 an unsuccessful PID was submitted suggesting the creation of a stand-alone surgery in Hopton similar in size to the existing Stanton surgery.

In 2015 the practice submitted a successful grant application, proposing an extension to the Stanton surgery. Unfortunately, this did not proceed, as the local planning authorities indicated that the extension would not be approved due to the lack of car parking on the site.

In January 2016, NHS England approved a revised project initiation document for a new surgery in Hopton, built by NHS Property Services Ltd. The approval was contingent upon the practice including within the OBC that followed an assessment of additional housing developments and the likely impact on its patient list. Before the practice proceeded to OBC, it became clear that the limited opening hours proposed for Hopton would lead to a financially unviable solution, and this scheme did not proceed any further, despite significant local support for the retention of a facility in the village.

Patient list

The patient population for the entire practice in March 2016 was 4,920. The patients live in Hopton and Stanton and other outlying villages (e.g. Barningham, Garboldisham, Coney Weston – see Appendix B). The list is expected to grow over coming months and years (indeed, at the end of June 2016 it has risen to 4,982), with local housing growth. The impact of these key developments in Hopton and Stanton are as follows:

List as at March 2016			**4,920**
Housing developments	No. patients	Practice share	
Bury Road, Hopton	100	100%	100
Upthorpe Road, Stanton	202	50%	101
Generic growth 1.3% per year over five years			320
Projected list			**5,441**

Staffing profile

The staff profile of the practice in March 2016 is described in the table below.

Staff profile in March 2016	Headcount	Whole time equivalent
GPs	4	2.30
Practice nurses (see note)	3	1.14
Healthcare assistant	1	0.70
Phlebotomist/Summariser	1	0.60
Dispensary staff	6	5.30
Reception staff	5	3.20
Admin team	3	2.50
Medical secretaries	2	1.40
Practice manager	1	1.00
Total	**26**	**18.14**

Note: these totals include a part time practice nurse, who starts work in August 2016.

As its list increases, the practice will explore a range of approaches to ensuring that its patients' needs are met. This will include up-skilling existing staff and developing new staff through apprenticeships (in which the practice has very positive past experience) and other training and mentoring, in addition to recruitment.

Training

The practice is working towards engagement in training. Although the GP partners are not yet fully qualified to train, there are plans to provide training, initially for two undergraduate students, but eventually to undertake Registrar training. There have been preliminary discussions with the Deanery to take this forward.

One partner has part completed the training required to be a Registrar trainer. Another has previously taught undergraduates and is part-qualified in higher education academy (associate fellow).

Service profile

In addition to a core GP consulting and home visits primary care service, the practice also provides the following from its Stanton surgery:

Minor operations	Contraceptive services (coil/implant/depo/pill)	NHS Health checks
Wound care management (PN)	Leg ulcer (PN)	Phlebotomy (practice-led – HCA)
Deep vein thrombosis	Child immunisations (PN)	Adult routine vaccinations (PN)
Influenza vaccinations	Learning disability health checks	Six week baby checks
24 hour Blood pressure checks	Asthma reviews (PN)	Audiogram
COPD reviews (PN)	Coronary heart disease checks	Diabetes annual reviews (PN)
Specialist diabetic nurse clinic (with West Suffolk Hospital)	Doppler (PN)	Cervical screening
Diet/activity/weight loss advice	Smoking cessation	Ear syringing (PN)
24 ECG (PN)	Medicals	Spirometry (PN)
Stitch removal (PN)	Tele-dermatology	Travel vaccinations (PN)
Mental health reviews	Care planning – to avoid unplanned admissions	MDT (Multi-disciplinary team) 6-weekly meetings
Dispensary	Post natal checks	Hypertension reviews (PN)
Gonadorelin injections	Palliative care	Dementia screening

The practice also provides all other areas of QOF.

From December 2015, Hopton services include the Practice Nurse (PN) treatments listed above, except injectable procedures requiring refrigerated items and/or GP supervision (i.e. vaccinations); Health care Assistant (HCA) procedures, as above, and Phlebotomy.

Outreach services currently provided at Stanton include:

- Hospital phlebotomists
- Ad-hoc visits from the specialist nurse for diabetes

In addition, the practice would like to:

- Make the specialist diabetes nurse a more regular feature.
- Accommodate a dietician outreach clinic.
- Enable ad-hoc visits from the Suffolk Family Carer advisor.
- Facilitate closer working with community teams (i.e. health visiting, physiotherapist and podiatry).

ECONOMIC CASE

This section considers the potential solutions available and identifies which option might best meet the practice's needs

Scope of the development

Given the current and projected patient list, core opening hours and range of services, initial work suggests that the practice requires a facility containing at least three C/E rooms and one treatment room – with a net internal area of c.331 sqm, in accordance with HBN 11 (see Appendix C). This assessment includes estimates of the level of demand, which practice systems are now beginning to track in more detail and will inform further refinement of demand for appointments and how these will be managed by the practice. The scope of the new facility would also need to be adapted to reflect the additional requirements arising from training (for example, one larger C/E room for undergraduate training and additional C/E rooms for registrars) and any visiting practitioners.

Given the scope of the facility required to meet the needs of local patients now and in the foreseeable future, the practice has considered a range of options, which reflect variations in:

- Location of the surgery premises.
- Extent of collocation of other services (e.g. community services, social care providers, other primary care services).
- Ownership arrangements.
- Responsibility for funding and managing the development.
- Ongoing management arrangements.

Option - Long list

The long-list of options identified was as follows:

Option A - Do nothing – Retain both existing premises (Hopton and Stanton).

Option B - Do minimum – re-provide the Hopton surgery within Hopton and retain the current Stanton premises. This option envisages the creation of a self-contained suite of two clinical rooms with ancillary spaces – reception, waiting, dispensary, toilets etc, in Hopton.

Option C – Multi-agency re-provision – as for option B, but in collaboration with other health and social care providers, to encourage closer working relationships and better utilisation of the facility.

Option D - Consolidation - Extend the existing surgery at Stanton to provide facilities for patients who previously used the Hopton surgery.

Option E - New build (primary care only) – replacing both the Hopton and Stanton premises with a single new build, on a different site, central to the practice catchment area.

Option F – New build (multi-agency) – as Option E, but providing facilities for other health and social care providers, to develop closer working relationships. This might include provision for the patients registered at the Stanton branch of the Ixworth practice, currently located at Stanton Health Centre. Discussions with the Ixworth practice on linked-working and potential collocation have begun, with the support of NHS West Suffolk CCG.

Options – Short list

This long-list was reduced to a shortlist by eliminating options that were not viable, or where other, retained, options were better able to deliver very similar outcomes. This led to the elimination of the following options:

Option A – Do nothing - This not a viable option as the landlord has indicated that Hopton will no longer be available, and extensive discussions have indicated that there is no flexibility.

Option C – Multi-agency re-provision in Hopton. There are limited site options available in the village and the population of Hopton alone is too small to justify such a development of this nature, and the potential for joined-up working is better illustrated by Option F.

Option D – Consolidation. This is essentially equivalent to the approved grant funded scheme, which could not be implemented, as the planning authorities considered the site too small, with insufficient scope for car parking.

The remaining shortlist was therefore:

Option B – Do minimum, which will be retained as the baseline comparator option.

Option E – new build (primary care only).

Option F – new build (multi-agency).

Option appraisal

The three shortlisted option have been appraised against the following criteria, which have been identified by NHS England as core for bids against the Primary Care Transformation Fund from 2016 to 2019):

- Improving access to effective care.
- Increased capacity for primary care services out of hospital.
- Commitment to a wider range of services, as described in CCG commissioning intentions, to reduce unplanned admissions to hospital.
- Increased training capacity.

And also considers the relative performance of each option against the estates specific criteria:

- Patient involvement and engagement across the health economy.
- Consistent with local estates strategies.
- Clear identified need.
- Deliverable within financial years April 2016 to March 2019.
- Sustainable in the long term.
- Flexible to changing healthcare delivery patterns.

The results of this appraisal are summarised in the table below:

	Criteria weighting	Option B Do minimum		Option E New build - primary care only		Option F New build - multi-agency	
		Raw score	Weighted score	Raw score	Weighted score	Raw score	Weighted score
Generic criteria							
Improved primary care access	10	4	40	8	80	8	80
Increased capacity for primary care and out of hospital	10	0	0	7	70	9	90
Wider range of services/reduced unplanned hospital admissions	10	0	0	7	70	9	90
Increased capacity for training	10	0	0	9	90	9	90
Estates criteria							
Facilitates patient engagement	10	8	80	7	70	9	90
Consistent with local estates strategies	10	2	20	8	80	8	80
Clear identified need	10	8	80	8	80	6	60
Deliverable - 04.2016 to 03.2019	10	2	20	9	90	4	40
Long term sustainability	10	2	20	8	80	8	80
Flexible to changing healthcare delivery patterns	10	2	20	6	60	9	90
Total	**100**	**28**	**280**	**77**	**770**	**79**	**790**

Each option is scored between 0 and 9 against each criteria, where 0 means the criteria is not achieved, and 9 that it is fully achieved. The reasons for the scores given to each option are as follows:

Access to primary care – Do minimum would maintain access for residents of Hopton, but retain the existing problems for patients from other out-lying villages wanting to use the surgery at Stanton. A new build could be designed to accommodate adequate parking for all patients, and located near public transport links. A consolidated facility would also allow the practice to make best use of its clinical staff, as no time would be lost travelling between sites or staffing underutilised clinics.

Increased capacity for primary and out of hospital care – Do minimum does not increase capacity from the existing baseline. The new build options have this potential, and score much better. Option F scores particularly well, because it recognises the contribution of community services in the maintenance of patients out of hospital.

Wider range of services – Do minimum does not facilitate any significant change in services, due to the continued fragmentation in service delivery and limited scope to change facilities or increase utilisation at Stanton. Option F scores more highly than Option E because collocation with community services should enable much closer working and more scope to innovate.

Training capacity – Do minimum would stretch clinical staff across two sites, making it difficult to make resources available for training. Only the new build options would include scope for training facilities, which is reflected in their scores.

Patient engagement – Do minimum scores quite well here, as it maintains the configuration with which patients are familiar. Option E is slightly lower, because the sites are consolidated. Option F scores better, as it allows greater engagement with users on services beyond core primary care.

Consistent with estates strategies – the local strategy has not yet been published, but the general trend is away from small isolated premises towards greater collocation, and this is reflected in the option scores.

Identified need – This is similar for do nothing and Option E, as the existing Hopton surgery is clearly time-constrained. It is slightly less strong for Option F, as community services have a base at Stanton Health Centre, which is currently reasonably fit for purpose.

Deliverability – Do minimum scores poorly on deliverability, as there is no clear route for the capital and revenue funding of a stand-alone facility in Hopton. Option E scores well, as the proposed timescale fits within the deliverability window. There is more of a risk regarding the deliverability of Option F, as the number of parties involved is greater, and the future of Stanton Health Centre will need to be resolved as part of the planning.

Long term sustainability – Do minimum is unlikely to be sustainable in the longer term, as the size of the population base in Hopton, although growing, will remain below the level required to support a viable full-time medical facility, even a very small one. This is likely to lead to problems with staffing and funding, which will undermine the service in time. Both of the new build options score much better against this criteria, because they involve creating premises to support a practice of a viable size.

Flexibility – the new build options are better able to accommodate changes in delivery, as they are larger developments. Option F is the best of the two new build options, because community services are integral to the development from the outset, and therefore scores highest, with Option E just behind.

For the purpose of this appraisal, each criterion is treated as equally important, with a common weighting of 10. It is possible to vary these weights, but this is unlikely to change the relative strength of the two new build options against do minimum, as they deliver more and therefore score more highly against almost all criteria.

Option F is marginally the better option, on the basis of benefits scores alone. However, the deliverability of this configuration within a relatively short timescale is a risk. The practice would therefore wish to follow a two-strand process, retaining the collocation of community services within the project scope unless and until it becomes clear that this is not feasible, or is not deliverable within the timescale, for whatever reason.

Preferred way forward

The preferred way forward in benefit terms is therefore a new build, to accommodate core primary care and dispensing premises for the entire practice (replacing both the Hopton and Stanton premises) – introducing training activities, core outreach services and (if feasible) collocating services from the Stanton Health Centre. In doing so, it will create a focus for primary and community care, with wider range of services available to patients in a single location, and greatly enhanced potential for closer working to support people outside of an acute setting.

The disadvantage to Hopton residents of losing their local practice premises would be ameliorated wherever possible, continuing the practices existing plans to deliver prescriptions (in collaboration with the Botesdale practice) and collect repeat requests, introduce volunteer transport to Stanton and provide telephone support where possible.

A potential site has been identified, on a part of what was the playing field of the former Blackbourne Middle School, and the practice is in early discussions regarding the scale of the development that may be feasible, the terms of any acquisition and any conditions of planning that may arise.

COMMERCIAL CASE

This section will describe the arrangements for the funding of the preferred option, although these are currently work in progress.

Initial plans are for the practice to purchase the site and fund the design and construction of the new facility. Appropriate elements of the building would then be subject to a notional rent agreement with NHS England and others will be covered by leases to third party organisations (primarily the providers of community services).

However, these issues will be explored in further detail as the plans are confirmed.

FINANCIAL CASE

Identifying the financial implications of the development is integral to confirming its viability. The preferred way forward is not sufficiently well defined for it to be entirely completed, but an outline, including the available costs, is included.

The financial implications of the development affect a series of organisations:

- NHS England, to the extent that they reimburse any relevant costs.
- The practice, which will need to meet those revenue costs incurred that are not recovered elsewhere.
- NHS West Suffolk CCG, both directly (to the extent that the CCG commissions any services from the practice) and indirectly (through any changes in contract values with other providers).
- NHS Property Services Ltd, as the scheme proposes changes in the use of one of the company's freehold properties.

At this stage, the preferred way forward has not been fully specified or costed, but the costs of the current configuration have been identified as a baseline. These are as follows:

	Year ended April 2015			2016/17 budget
	Practice total	**Hopton**	**Stanton**	**Stanton HC**
Notional rent	27,500	-	27,500	-
Actual rent (estimate - see note)	8,000	8,000	-	19,470
Business rates	11,817	-	11,817	5,929
Water rates	1,241	-	1,241	-
Trade refuse	1,247	517	730	727
Reimbursed costs	**49,805**	**8,517**	**41,288**	
Property repairs and maintenance	7,735	2,613	5,122	13,261
Electricity and oil	6,640	1,266	5,374	2,619
Cleaning and laundry (incl employment)	13,515	4,745	8,770	105
Telephone	3,742	-	3,742	12
Insurance	805	-	805	18
Equipment repairs and replacements	228	-	228	-
Other	-	-	-	4,421
Total - property costs	**82,470**	**17,141**	**65,329**	**46,562**

Note: there is currently no lease in place for the reduced footprint at Hopton, without which it is not possible for NHS England's professional valuer to identify a current market rent (CMR) for the premises. The £8,000, included above, reflects the previous notional rent valuation.

The revenue costs or replacement premises are not yet known and will remain uncertain until further design work is completed and the terms of any leases known. Using existing premises as a benchmark, suggests a cost of £110 per sqm of net internal area (NIA) for rent and £41.50 per sqm for other costs treated as reimbursable within the premises directions. The revenue costs that would fall to the practice are equivalent to £40.50 per sqm of NIA.

MANAGEMENT CASE

Project management arrangements

The practice will be responsible for the delivery of the scheme. It will employ an experienced project manager (a qualified and experienced quantity surveyor) to ensure the delivery of the scheme from initial approval by NHS England through to commissioning. This will include completion of the detailed design and engineering work and the procurement of the main contractor.

Regular updates will be provided to NHS England, or its technical representative, throughout the process – to ensure that the completed building is entirely consistent with the commissioner's expectations – in both size and quality.

The practice will also work with NHS West Suffolk CCG to explore a range of approaches for engaging with and updating other key stakeholders, including regular briefings for Suffolk Healthwatch, the Patient Participation Group and local councillors.

Timescales

Milestone	**Timing**
Option appraisal agreed	July 2016
Engagement with partner organisations to inform scope and finalise design	July/August 2016
Planning application submitted	August 2016
Project manager appointed	August 2016
Public consultation launched	October 2016
Business case approved	October 2016
Planning consent obtained	November/December 2016
Hopton surgery closes	January 2017
Design work completed	March 2017
Tender process commences	February 2017
Land acquired	May 2017
Main contractor appointed	June 2017
Construction commences	July/August 2017
Completion of construction	March - July 2017
Commissioning completed	April - August 2018
Building operational	April - August 2018
Existing buildings decommissioned	August 2018 onwards

Interim arrangements

Given the timescale for the main development, and the constraint on the availability of the remaining facilities at Hopton, the practice has explored a range of interim arrangements, specifically:

- The utilisation of available sessions at Stanton Health Centre; or,
- The delivery and installation of a modular building adjacent to the existing Stanton or Hopton surgery.

Of these, the use of the existing Health Centre capacity is the preferred way forward, as it makes best use of available resources, does not add to the costs in the local health economy and is less complex to implement. The practice and NHS West Suffolk CCG have been exploring the potential for this with NHS Property Services Ltd, which owns the property.

APPENDICES

Appendix A – Letter of support from West Suffolk CCG (March 2014)

integrated working

NHS
West Suffolk
Clinical Commissioning Group

St Andrews Castle
St Andrews Street South
Bury St Edmunds
Suffolk IP33 3PH
Tel: 01284 774794
Fax: 01284 760529
www.westsuffolkccg.nhs.uk

Our ref: EG/AH/ejw/270314
Direct Dial: 01284 774805
Email: ed.garratt@westsuffolkccg.nhs.uk
Date: 27 March 2014

Dr Andrew Hassan
Avicenna,
High Street
Hopton
Diss
IP22 2QX

Dear Andrew

Thank you for sharing your project initiation document for the Primary Care premises planned for Hopton. As you know the capital and revenue processes for Primary Care sit with the Area Team of NHS England and CCGs have no role in the approval process.

West Suffolk CCG is committed to ensure that patient care is delivered close to people's homes, especially given the rural geography of our patch. Therefore the removal of a Primary Care base at Hopton would be considered by the CCG to be a negative change. The CCG would wish to support as far as is within its remit any measures which negate or ameliorate that change. If it is helpful please include this letter in your communications with NHS England.

I would be very interested in receiving updates on the project.

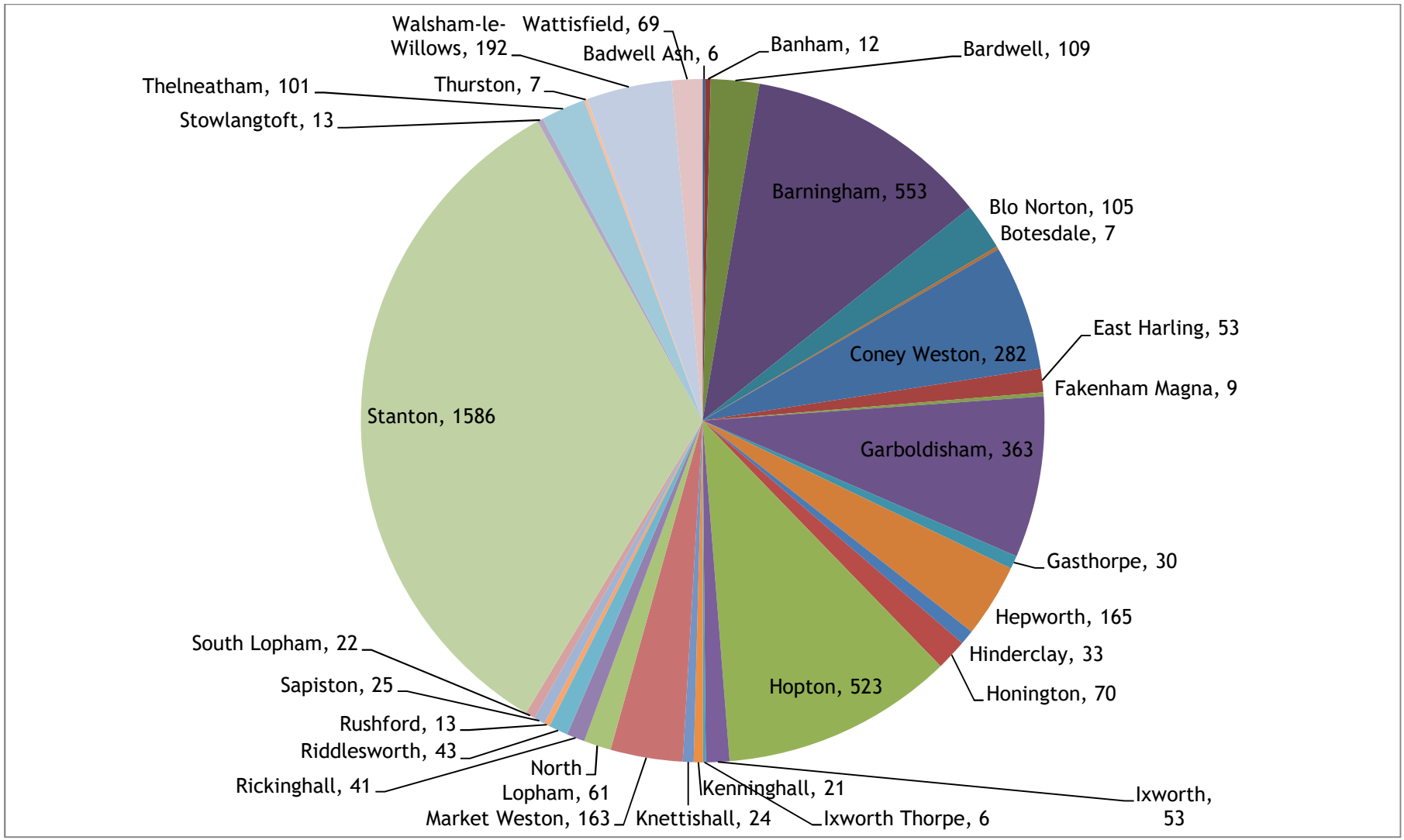
Yours sincerely

Ed Garratt

Ed Garratt
Chief Operating Officer

THE BEST OF HEALTH FOR WEST SUFFOLK

Appendix B - Patients registered, by locality (April 2016)



Appendix C – PID space estimator (April 2016)

Primary Care Consulting and Examination Room and associated Treatment Room estimator
Based on Department of Health requirements / guidance HBN 11-01
Version: May 2016

Project title	Avicenna - Hopton and Stanton, Suffolk
Provider Contact	Rob Freeman
Commissioner contact	Lois Wreathall

When inserting time remember to use colon :

Completing this table is optional

Day	Commissioning Strategy Optimum Times		
	Open hr : min	Close hr : min	Hours
Example	8 : 00	18: 30	10:30
Monday	8:00	19:00	11:00
Tuesday	8:00	18:30	10:30
Wednesday	8:00	19:00	11:00
Thursday	8:00	18:30	10:30
Friday	8:00	18:30	10:30
Saturday	00:00	00:00	00:00
Sunday	00:00	00:00	00:00
HOURS PER WEEK			53

Complete this table for line 'K' total

Day	Normal Opening Times		
	Open hr : min	Close hr : min	Hours
Example	8 : 00	18: 30	10:30
Monday	08:00	19:00	11:00
Tuesday	08:00	18:30	10:30
Wednesday	08:00	19:00	11:00
Thursday	08:00	18:30	10:30
Friday	08:00	18:30	10:30
Saturday	00:00	00:00	00:00
Sunday	00:00	00:00	00:00
HOURS PER WEEK			53

Insert your own local data in the unshaded cells to produce your space estimate for this project

① Estimating the number of consulting/examination rooms required for general medical services

Ref	Heading	Value	Strategy Option	Your notes
A	Catchment area / population		-	
B	Estimated list size (of 'A') for this proposal	5,500	5,500	
C	Anticipated average annual contacts per patient per year	6	6	
D	Total anticipated annual contacts (BxC)	33,000	33,000	
E	Estimated % patients using C&E rooms	80%	80%	
F	Estimated attendances (D x E)	26,400	26,400	
G	Building opened (weeks a year)	50	50	
H	Number attendances per week (F/G)	528	528	
I	Appointment duration minutes	12	12	
J	Patient appointment time (hours per week) (Hx I / 60)	106	106	
K	Building operational hours per week (total from Opening Times table)	54	53	
L	**C/E room utilisation % :** If the building opens 50 hours per week e.g. 8.00 to 18.00 M to F but C/E rooms only used part of that time insert the average % operational e.g. x 50 hours pw available but only 30 hours pw utilised = 60%	75%		
M	Rooms available hours per week (Kx L)	40	0	
	Number of C&E rooms required (I/L)	2.6	#DIV/0!	Rounded up / down as appropriate

② Estimating the number of treatment rooms required for general medical services:

Ref	Heading	Value	Strategy Option	Your notes
A	Catchment population	-	-	As 1A above
B	Access rate	5,500	5,500	As 1B above
C	Anticipated average annual contacts per patient per year	6	6	As 1C above
D	Total anticipated annual contacts (BxC)	33,000	33,000	
E	Estimated % patients using Treatment Room	20%	20%	
F	Estimated Treatment Room attendances (D x E)	6,600	6,600	
G	Building opened (weeks a year)	50	50	As 1G above
H	Number attendances per week (F/G)	132	132	
I	Treatment time (minutes)	20	20	
J	Patient treatment time (hours per week) (Hx I / 60)	44	44	
K	Building operational hours per week	53.5	53	As 1K above
L	**Treatment room utilisation % :** If the building opens 50 hours per week e.g. 8.00 to 18.00 M to F but C/E rooms only used part of that time insert the average % operational e.g. x 50 hours pw available but only 30 hours pw utilised = 60%	80%		
M	Rooms available hours per week (Kx L)	42.8	0	
	Treatment Rooms required for above (I/L)	1.0	#DIV/0!	Rounded up / down as appropriate

③ Estimating the Total GIAm2

#	Accommodation	Estimated GIAm2	Strategy Estimate GIAm2	Your notes
1	Consulting/Examination /Treatment space (as above)	64	#DIV/0!	
2	Public space / waiting areas	149	#DIV/0!	
Subtotal		213	#DIV/0!	
3	Planning allowance	64	#DIV/0!	
4	Engineering allowance	21	#DIV/0!	
5	Circulation allowance	32	#DIV/0!	
TOTAL ESTIMATED GIAm2		331	#DIV/0!	