NHS

NHS
Coventry and Rugby
Clinical Commissioning Group

FULL BUSINESS CASE

FOLESHILL PRIMARY CARE DEVELOPMENT

NHS England & NHS Improvement and Coventry and Rugby CCG

JUNE 2020

Version control

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GLOSSARY

Acronym	Meaning	Acronym	Meaning
3PD	Third Party Development	HPCG	Healthcare Premises Cost Guide
AEP	Arden Estates Partnership	HBN	Health Building Note
APMS	Alternative Provider of Medical Services	HTM	Health Technical Memorandum
BIM	Building Information Modelling	IM&T	Information Management and Technology
BRE	Building Research Establishment	JSNA	Joint Strategic Need Assessment
BREEAM	Building Research Establishment Environmental Assessment Method	LIFT	Local Improvement Finance Trust
BRP	Benefits Realisation Plan	LPA	Lease Plus Agreement
CCC	Coventry City Council	MCP	Multispeciality Community Providers
CCG	Clinical Commissioning Group	NHSE/I	NHS England & NHS Improvement
CHP	Community Health Partnerships	NHSPS	NHS Property Services
CIAMS	Commissioners Investment and Asset Management Strategy	NIA	Net Internal Area
CoCHC	City of Coventry Health Centre	NPC	Net Present Cost
CQC	Care Quality Commission	NPV	Net Present Value
CRCCG	Coventry and Rugby Clinical Commissioning Group	OBC	Outline Business Case
CSU	Commissioning Support Unit	P21+	Procure 21+ Framework (procurement method)
CWMIND	Coventry and Warwickshire MIND	PACS	Primary and Acute (Care Systems)
DDA	Disability Discrimination Act	PCN	Primary Care Network
DHSC	Department of Health and Social Care	PCT	Primary Care Trust
DQI	Design Quality Indicator	ETTF	Estates and Technology Transformation Fund

DV	District Valuer	PFI	Private Finance Initiative
EAC	Equivalent Annual Cost	PMO	Project Management Office
ERM	Equipment Responsibility Matrix	PPE	Post Project Evaluation
ESA	European System of National and Regional Accounts	PSC	Public Sector Comparator
FBC	Full Business Case	QIPP	Quality, Innovation Productivity and Prevention
FIAC	Finance and Investment Advisory Committee	RPA	Risk Potential Assessment
FM	Facilities Management	SDLT	Stamp Duty Land Tax
FRI	Full Repairing & Insuring (lease)	SOA	Super Output Areas
FUNDCO	The development vehicle used by Arden Estate Partnerships to fund and manage the scheme for Foleshill	SoA	Schedule of Accommodation
GAAP	Generally Accepted Accounting Practice	STP	Sustainability and Transformation Partnership
GCC	Good Corporate Citizen	SWCCG	South Warwickshire Clinical Commissioning Group
GEM	Generic Economic Model	TUPE	Transfer of Undertakings (Protection of Employment)
GIA	Gross Internal Area	VOA	Valuation Office Agency
GSL	Government Soft Landings	WNCCG	Warwickshire North Clinical Commissioning Group

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APPENDICES

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2	OBC approvals
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4	Decision Note- Confirmation of Extension to Planning Application for demountable
5	DQI report and attendance list
6	Letter from CCG to CHP confirming that they will commission services from the building and underwrite the costs for the duration of the lease
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8	Schedule of accommodation
9	DQI design stage February 2017 and mid stage November 2018
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11	1:50 drawings
12	VOAQ April 2016
13	VOAQ April 2019
14	Difference between VOAQ 1 (date) and VOAQ 2 (April 2019)
15	RPA report
16	Coventry & Rugby CCG Equality, Inclusion and Human Rights Strategy
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1 Executive Summary

1.1 Introduction and Background

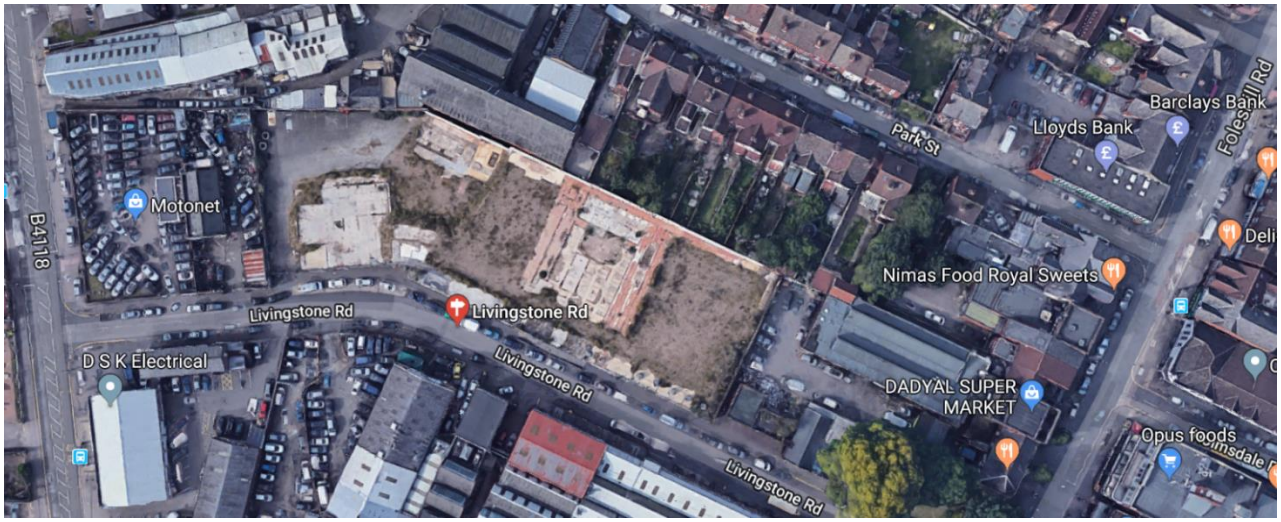
The purpose of this Full Business Case (FBC) is to seek approval from NHS England & NHS Improvement (NHSE/I), Community Health Partnerships (CHP) and Coventry and Rugby CCG for investment in a primary care development in Foleshill, Coventry. The Foleshill scheme will replace an existing primary care temporary facility that only has short term planning permission and will look to meet demand for up to c10,000 patients. The new facility will significantly enhance the service provision and help to meet the objectives of the NHS Long Term Plan and enable the delivery of the 2019 GP contract in the catchment area.

The centre will offer a number of benefits to patients including close, accessible care in new, clean and safe facilities. In addition to primary care services, it will provide the opportunity for a wider range of services to be delivered under one roof. These benefits are discussed in later sections of the FBC.

The location of the proposed development is the former leisure centre site at Livingstone Road, Coventry. Figures 1 and 2 show the proposed site.

Figure 1: Location of proposed site

Figure 2: Location of proposed site – Google Earth



This FBC follows the successful approval of the OBC in December 2016 and an Addendum agreed in August 2018 (Appendices 1 and 2). The development is fully supported by local commissioners, local authorities, and the general public.

The Foleshill OBC was jointly produced with a development in Brownsover, Rugby, as the two schemes are of similar size and, at the outset, had similar requirements. It was thought that efficiencies could be achieved through a joined-up approach.

However, although, efficiencies and economies of scale have been sought, the different locations, circumstances and timings of the two projects has meant that many of the expected synergies have not been realised. The opportunities for sharing resources across the projects have been limited in practice and the passage of time has compounded the need for a different approach to Foleshill.

In addition, there have been a number of other changes to the Foleshill scheme since this OBC,that now differentiate it from Brownsover:

- Rather than using a third-party developer, Arden Estates Partnerships (AEP), the scheme is now being delivered by Community Health Partnerships (CHP)
- Procurement of the design and construction is taking place through the NHS Shared Business Services (SBS) modular framework
- The scheme will meet the required NHS technical specifications and with Passive House certification, a voluntary standard for energy efficiency in a building, which reduces the building's ecological footprint and results in an ultra-low energy building solution that requires little energy for space heating or cooling, thus improving user comfort and sustainability

In respect of value for money, discussions first took place between Community Health Partnerships and the District Valuer (DV) in July 2018 when it was concluded that the scheme represented value for money. Given the changes since the original plans, the case was reappraised by the DV in February 2019.

Having reviewed the updated case, the DV continues to view the scheme as value for money (Appendix 3).

1.2 Strategic Case

1.2.1 The National View

The NHS is facing a number of challenges:

- Life expectancy is increasing
- More people are living with long term conditions
- Pressures to stay within budget and to cut costs remain high (despite new funding coming into the services)
- Ongoing statutory and regulatory requirements around sustainability and energy consumption remain priorities, despite an estate that is often not fit for purpose and expensive to run.

There is pressure nationally and locally to explore new ways of working and alternative models of service provision to meet these challenges, whilst also strengthening relationships with patients, carers and the local community and actively promoting health and wellbeing.

Some of the changes needed can be brought about by the NHS itself whilst others require partnerships with local communities, local authorities and employers.

The Foleshill development will support the delivery of national requirements by:

- Providing the opportunity for patients to receive care closer to home and reducing admissions to local acute hospitals.
- Promoting wellness and preventing ill health within the community.

- Being designed to meet the latest standards for health care buildings, with the flexibility to meet the changing demands of the local population

1.2.2 The Regional View

The three Clinical Commissioning Groups in Coventry and Warwickshire (the CCGs) have agreed to work together to achieve the common aim of becoming a larger unit of planning and utilising resources more efficiently. Particular challenges for the CCGs are:

- Continued growth in population- Coventry and Rugby CCG has seen an increase in the population of 7,993 (ONS, 2017 mid-year estimates).
- An aging population- 19% of the population are over 60.
- A more ethnically diverse population
- A significant life expectancy gap between more and less affluent households in the area.

The strategic and operational plans (2014/2015 – 2018/2019) of the CCGs (developed with local communities, the third sector and voluntary organisations) set out a number of risks, including:

- Financial targets
- QIPP delivery
- A&E Performance

To address these challenges and risks, the CCGs have agreed to focus on the transformation of services, based on the following principles:

- Delivering care closer to home
- Ensuring parity of esteem for mental disorders (treating them with the same priority as physical disorders).
- Providing specialist care in the right place, at the right time
- Enabling patients to live the lives they choose
- Supporting clinicians from across health and social care to work together
- Encouraging the use of innovative practice and technology to deliver care
- Strengthening the financial sustainability of the system

Delivery of the Foleshill scheme will support the CCG to address these needs by:

- Creating a local, accessible primary care spoke (linked to a hub), where services relevant to patient's needs are delivered
- Optimising the use of space, improving efficiency and encouraging better use of resources
- Providing a building flexibly designed for current and future service delivery- it will be a light, modern space to promote wellbeing for both patients and staff.

1.2.3 The Local View

The objective of this business case is to set out the rationale for an integrated health centre to meet the growing population of the Foleshill area. The building must be flexible enough to accommodate growth in the area (due to new housing) and an expected list size of up to 10,000 patients as well as offering space that enables the delivery of a wider service offering.

A Stage 1 LIFT approval was received by the then Midlands and East Strategic Health Authority in September 2011 for a new development in Foleshill. At the time, the Local Authority, Coventry City Council

(CCC), asked health colleagues to postpone development of the scheme on a planned and commercially available site and to wait for the Livingstone Road Leisure centre site, owned by CCC, to become available (following relocation of the leisure facilities in 2014). After five years, this site is now available as a brownfield site following the demolition of the leisure centre.

GP services are currently delivered in Foleshill through an APMS contract, provided from a demountable building located on the back of a pub car park in Station Street West, under temporary planning permission. This planning permission was extended in 2012, again in May 2016 and in October 2018 (please see appendix 4 for Decision Note). Following the last application for an extension, it will now run until November 2020.

The lease for the land expired in December 2015. However, the lease was not 'contracted out' which means that the lease will continue until brought to an end by a notice period of not less than six months.

Since autumn 2014, when it was determined that the site should be held exclusively for health, local commissioners have been keen to deliver the new GP facility.

1.3 Economic Case

A robust option appraisal on the possible solutions for a new primary care centre in Foleshill is included as part of the economic case. It includes a non-financial and financial assessment which, when combined, identifies the preferred option for the scheme.

1.3.1 Non-financial option appraisal

On 26 April 2016, a non-financial option appraisal workshop was held for both the Foleshill and Brownsover schemes. The event included key stakeholders, including representation from service providers, the CCG, NHS England & NHS Improvement and patients (Appendix 5 for DQI report).

Discussions took place around possible alternatives and resulted in the creation of a long list of options. The strengths and weaknesses of each were discussed and a consensus was reached on which to take forward to a shortlist. The long list of options can be referred to in Appendix 51.

The key benefits of each were weighted by importance and a raw score of 1 – 10 used as a multiplier. The options were then scored, and the preferred option identified.

The outcome of this qualitative appraisal was the identification of the following as the preferred option:

- New build development on the Livingstone Road site.

1.3.2 Quantitative benefits- economic appraisal

A quantitative appraisal was also carried out on the shortlisted options. This included a detailed overview of the costs and benefits associated with each of the options which enabled the calculation of the option providing the greatest net economic benefit.

The outcome of this exercise identified the following as the preferred option:

- Do minimum, remain in the existing temporary location for the short term

Whilst possible in the short term, a longer-term solution was required as the temporary solution was only viable for a maximum of 2 -3 years.

1.3.3 Identification of the preferred option

Following a subsequent cost benefit analysis, the most favourable, sustainable, option was to provide a new build development on the Livingstone Road site.

The option appraisal exercise has been reviewed and it has been confirmed that there have been no fundamental changes that would impact on the outcome of the appraisal.

A new building on the Livingstone road site remains the preferred option.

1.4 Commercial Case

This section sets out the commercial arrangements for the project, including the proposed procurement strategy. It covers the approach to acquisition of equipment and IM&T and the key risks (including how these can be best managed).

1.4.1 Procurement route

Although Foleshill is in a LIFT area, due to the scale of this development, the standard Lease Plus Agreement (LPA) has been discounted due to high costs on fixed items such as legal, financial, maintenance and lifecycle factors. It has, therefore, been determined that the facility will be procured through CHP, using NHS Shared Business Services. This represents a change from the original planned procurement route set out in the OBC, when it was expected that Arden Estate Partnerships (AEP) would procure the facility.

CHP will provide a formal lease for the whole building to the practice for the period of the APMS contract. However, the CCG will underwrite the cost for the 25 year period (Appendix 6).

Coventry and Warwickshire MIND (CWMIND) own the land the new development will be built on at Livingstone Road. As the site is significantly larger than that required purely for the development of a new practice, CWMIND have developed an inpatient unit on their plot. However, 0.38 acres of the site have been set aside for other health service use, at a cost of £125,000. CHP exercised the option to purchase the land on 31 May 2019.

1.4.2 Planning consent

Planning consent for the new building was originally granted on 14 April 2016. CHP have made an amendment to this consent and the revised application was approved on 16 January 2019. (See Appendix 7).

1.4.3 Equipment

As the contract for the project will only be for the design and build of the new health centre, the CCG and tenants will be responsible for procurement of the medical fixtures and fittings, loose furniture and any Group 3 or 4 equipment. The cost of equipment has been included in the estimated capital costs for the scheme.

CHP will work with the CCG to determine the most appropriate procurement and funding route for other equipment. The preferred option is for the CCG to fund and purchase individual items.

Where practical, equipment will be transferred from the existing facility to the new healthcare building. Where this is not practical, equipment will be procured, purchased, supplied, installed and commissioned, as set out in the Equipment Responsibility Matrix – see section 5.8.1 and the costed equipment schedule for Group 3 and 4 items can be found in Appendix 24.

1.4.4 Schedule of Accommodation

The schedule of accommodation developed at OBC stage to accommodate a list size of up to 10,000 patients has been reviewed and updated. A summary of the comparison of the OBC schedule of accommodation and the final version is shown in table 25 with a detailed spreadsheet at Appendix 8.

It is based on the need for flexible room usage, full utilisation of space in core hours and the potential to offer extended hours.

1.4.5 Design Principles

A number of design considerations had been outlined in the commercial chapter of the OBC, these include the need to:

- Reference the set of drawings, based on the schedule of accommodation
- Include flexibility and show a clear understanding of adjacencies and patient flow
- Ensure building measurements and capacity are shown and include GIA

- Ensure that BREEAM and BIM form part of the design

These remain core to the FBC and have not changed.

1.4.6 DQI

The Design Quality Indicator is a toolkit to measure, evaluate and improve the design quality of buildings. The first DQI event for Foleshill was held with key stakeholders on 22 April 2016. The team wanted to test:

- the strength of the existing brief;
- assess functionality; and
- to revisit the potential of the site.

Discussion concentrated on function, impact and build quality. It was confirmed that these would be aspirations rather than an assessment of what was presented, given that no formal design was available to assess, at this stage.

The DQI attendance list and report can be seen at Appendix 5

Two further DQI events took place, in February 2017 and November 2018. The list of those attending is included in the DQI reports which can be viewed at Appendix 9.

1.4.7 Drawings

A set of 1:200 scale drawings and 1:50 scale drawings have been developed based on the schedule of accommodation and considers good design principles, these can be found at Appendices 10 and 11.

1.4.8 Valuation Office Agency (VOA)

A Valuation Office questionnaire was completed for the OBC and has been refreshed for the FBC (Appendices 12 and 13). A comparison of the two has been completed and is appended to clearly illustrate the changes that have been made since the project was initially planned (Appendix 14).

The development will be compliant with the expectations of the VOA.

1.5 Finance Case

An affordability analysis has been undertaken for the Foleshill scheme. Coventry & Rugby CCG have evaluated the additional rent reimbursement and associated costs payable to the GP Practice under the Primary Care Premises Costs Directions.

Following advice from the District Valuer, they have concluded the additional costs to be appropriate for the proposed new facilities.

In addition to the recurring costs associated with the new facility, a provision has been made for the non-recurrent costs of the lease transaction (legal and Stamp Duty Land Tax (SDLT)) these are anticipated to be in the region of £46,500. This cost will be met by the CCG.

Key financial information for the scheme is shown in table 1

Table 1: Key financial information for the scheme

Key Financial Information	Total
Capital Cost (excl VAT)	£3,270,123
Affordability Envelope set by DV for rent on new building (619.4m^2) GIA	£127,255
Lease cost (619.4m^2) GIA	£119,000
Non-recurrent costs (SDLT)	£46,500
Project development costs	£320,000

1.6 Management Case

This section explains how the Foleshill scheme will be governed, setting out the delegated authority required to ensure its successful delivery in accordance with best practice. This governance will be implemented on approval of the FBC and will stay in place until the new facilities are opened.

This section provides assurance that:

- The Foleshill scheme has a robust project and reporting structure.
- A detailed project programme has been developed for the scheme which shows an operation date of November 2020.
- A summary of project costs has been included. It is anticipated that a cost of £320,000 will be required for the delivery of the FBC.
- A Benefits Realisation Plan is in place. These benefits will be monitored at regular intervals during the delivery and operation of the projects. The main benefits are that the new scheme will:
  - Better meet the needs of the local population
  - Address "legacy" estates issues to provide a safe patient environment
  - Ensure access to the facility remains "all inclusive", removing barriers to access and ensuring patients feel comfortable with their surroundings
  - Support the independence and self-care for those with special needs and disabilities.
  - Improve facilities for staff and patients
  - Improve patient experience
  - Provide a place that the local community can identify with and have a sense of ownership
  - Contribute to effective care, delivered by well trained staff
  - Deliver the appropriate capacity and service requirements within necessary timescales and the cost estimates
- A risk register has been developed which identifies the key risks for the project. A mitigation plan and, where possible, estimated financial impact has been assessed for the high risks and this will be reviewed on a regular basis. These include:
  - Business case approval refused
  - Inability to negotiate appropriate terms with current landowners
  - Poor site/building conditions
  - Interdependencies with other services not achieved
  - Unable to secure a suitable APMS provider

  - Project costs incorrectly estimated
  - Proposal does not achieve Value for Money
  - Increased Construction Costs due to unforeseen circumstances
  - S106 contribution draw down not received in time to support project.
- There is clear guidance for evaluation of the project during and after its lifecycle has been developed. This includes undertaking reviews at regular intervals during the operation of the new facilities. The Post Project Evaluation will include the use of BIM, DQI and monitoring against the Valuation Office Agency checklist.
- A Risk Potential Assessment (RPA) was completed for the scheme at OBC stage and this scored an overall result of 'medium'. This has been reviewed as part of the FBC and it has been confirmed that this score is still relevant. Further detail can be found in section 7.13 and the full assessments in Appendix 15.

2 Introduction

2.1 Introduction

The purpose of this Full Business Case (FBC) is to seek approval from NHS England & NHS Improvement, CHP and Coventry and Rugby CCG for investment in a primary care development in Foleshill, Coventry.

The service provider for Foleshill currently operates from a demountable building located at the back of a pub car park in Station Street West. It is under temporary planning permission which has recently been extended to 2020 (see Decision Note, Appendix 4), along with a land lease from the pub which expired in December 2015.

This FBC justifies the requirement for capital and revenue investment to construct modern healthcare facilities for General Practice (GP) services provided in the Foleshill locality. It has been produced using the agreed standards and Five Case model format for business cases.

The following chapters address:

- **The Strategic Case –** setting out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
- **The Economic Case** – covering the option appraisal process followed at OBC stage and confirming that the selected choice for investment best meets the existing and future needs of services and optimises value for money.
- **The Commercial Case –** outlining the content and structure of the commercial aspects of the project.
- **The Financial Case –** assessing the affordability and proposing funding arrangements for the preferred option.
- **The Management Case** – explaining processes and procedures that have been put in place which will enable the scheme to be delivered successfully in terms of quality, cost and time.

2.2 Background

A Stage 1 LIFT approval was received by the then Midlands and East Strategic Health Authority in September 2011. At the time, the Local Authority, Coventry City Council (CCC), asked for the postponement of the development on the planned, available site and to wait for the Livingstone Road Leisure Centre site, owned by CCC, to become available, following the relocation of the leisure facilities. This site is now available and has been held exclusively for health development since 2014 when the existing leisure centre was demolished.

The OBC preceding this document was approved in December 2016 (Appendix 21) for the OBC. Evidence of approvals can be viewed at Appendix 2. The OBC was jointly produced with a development in Brownsover in Rugby. The two schemes are of similar size, with very similar requirements and it was thought that efficiencies could be achieved through a joined-up approach.

However, although, efficiencies and economies of scale have been sought, the different locations, circumstances and timings of the two projects has meant that many of the expected synergies have not been realised. The opportunities for sharing resources across the projects have been limited in practice and the passage of time has compounded the need for a different approach to Foleshill.

In addition, there have been a number of other changes to the Foleshill scheme since this OBC,that now differentiate it from Brownsover:

- Rather than using a third-party developer, Arden Estates Partnerships (AEP), the scheme is now being delivered by Community Health Partnerships (CHP)
- Procurement of the design and construction is taking place through the NHS Shared Business Services (SBS) modular framework
- The scheme will meet the required NHS technical specifications and with Passive House certification, a voluntary standard for energy efficiency in a building, which reduces the building's ecological footprint

and results in an ultra-low energy building solution that requires little energy for space heating or cooling, thus improving user comfort and sustainability

2.3 Project scope

The scope of this project is to build a health centre to meet the needs of the growing population within the area. The building must be flexible enough to accommodate growth in respect of new housing estates and an expected list size of up to 10,000 patients.

The land identified for this development in Foleshill is at Livingstone Road. At the time of the OBC, the land was owned by Coventry City Council but has subsequently been purchased by Coventry and Warwickshire MIND (CWMIND). An area of 0.38 ha has been set aside for the purposes of the GP premises which CHP will purchase for this purpose. The final sale of this land will be completed once this business case is approved.

Planning consent for the building was granted in April 2016. However, CHP submitted an amendment to this consent that takes into account the new requirements for the modular building. Planning permission for the revised plans was granted on 16 January 2019.

2.4 Wider Stakeholders

The key project stakeholders are:

- Coventry and Rugby CCG
- NHS England & NHS Improvement
- The current local primary care service provider, Malling Health (APMS Contract Provider)

All the key organisations have confirmed their support for the project. Support has also been demonstrated by clinical and non-clinical stakeholders in the development of the scheme proposals.

2.5 Approvals Required

A process of review and subsequent approval for the FBC has been agreed. The scheme will require approval from the following:

- Coventry and Rugby CCG
- NHS England & NHS Improvement Midlands Regional Director of Finance
- CHP Board (Finance and Investment Advisory Committee)
- NHS England & NHS Improvement Chief Financial Officer

The project timeline for this case has ensured that all approvals are scheduled into the workplan for the coming months.

3 The Strategic Case

This section presents the context and strategic case for a new health centre in Foleshill. It commences with a summary of national imperatives and political priorities before considering the local aspirations and vision for change.

With this established, it goes on to review the current estate (within Coventry and within Foleshill) and the extent to which it is fit for purpose, in terms of meeting the national and local transformation agenda. This informs the case for change, which follows.

The section concludes with the outcome of stakeholder consultation and the proposed way forward for Foleshill.

The scheme is clearly aligned to national and local priorities and will act as an enabler for the delivery of better healthcare.

3.1 National Strategic Context

The NHS is facing a number of challenges, as people live longer and with more long-term conditions. Funding for health is not keeping pace with demand, resulting in the need to provide services more efficiently. Health and social care budgets have been under unprecedented pressure and future years will be even more challenging, creating an even greater need for new ways of working and new models of care.

In addition, there are a number of statutory, regulatory and policy requirements, specifically concerned with sustainable development, including requirements to reduce energy consumption, the carbon footprint and waste.

Within this context, the main policy documents directing healthcare developments currently are the NHS Long Term Plan (2019), the new GP contract (2019) and the Five Year Forward View (2014). The Five Year Forward View triggered much of the transformation work currently in train and the Long Term Plan and new GP contract builds upon it, reinforcing the necessity of better out of hospital care and support for older people.

Table 2: Summary of Key National Plans

National Plan	Summary
The Five Year Forward View (FYFV)	Setting out how the health service needed to change, the FYFV presented the need for greater engagement with patients, carers and citizens to promote wellbeing and prevent ill-health. It set out a future vision where: • Patients are empowered and prevention is pivotal to healthcare • Care is delivered in, and with, engaged local communities • Care is delivered through new models, including Multispecialty Community Providers (expanding the leadership of primary care), Primary and Acute Care Systems (to better integrate care) and urgent and emergency care networks, enabling the transition to a more sustainable model • Smaller hospitals play a key role and specialised care can be delivered when needed.
The NHS Long Term Plan	Building upon the FYFV, it emphasises the need for a model of care focused on out of hospital support, reducing pressure on emergency services. It also continues to stress the necessity of giving people more control over their health. The centrality of quality to patient care is emphasised, along with the need to improve health outcomes. It sets out how the additional £20.5 billion awarded to the NHS will be spent over the next five years, focusing on the following objectives: • enabling everyone to get the best start in life • helping communities to live well • helping people to age well • improve out-of-hospital care

2019 GP Contract	Published in January 2019, the new GP contract reflects the themes of the Long Term Plan and the investment needed in out of hospital solutions to meet the current health and social care challenges. £1.8bn is committed to the development of Primary Care Networks (PCN) to make better use of the expertise available within this part of the system. Investment is also identified to build multidisciplinary teams to work alongside GPs. New technology will be pivotal, to improve the options through which patients can access support. An additional 22,000 staff are expected to be in post by 2023/24. This will mean approximately 3 extra staff working with every practice in England. This will be in addition to the space required for the administration of the PCN. All will require space to work, even if many roles are peripatetic.

Existing commitments in the Five Year Forward View and national strategies for cancer, mental health, learning disability, general practice and maternity will all continue to be implemented in 2019/20 and 2020/21. 2019/20 will be a transition year, with every NHS trust, foundation trust and CCG expected to agree single year organisational operating plans and contribute to a single year local health system-level plan.

3.2 Local Strategic Context: Organisational Overview

3.2.1 The CCG

Coventry and Rugby Clinical Commissioning Group (Coventry & Rugby CCG) was licensed in April 2013 under provisions enacted in the Health & Social Care Act 2012 and was fully authorised in January 2014. Since then, it has been responsible for planning and buying healthcare services across Coventry and Rugby. This includes hospital services, mental health services and community services such as district nurses and physiotherapists.

It comprises 68 member practices working in three locality groups, with a registered population of 431,000, including some of the most deprived areas in the country. Coventry & Rugby CCG works closely with other healthcare organisations within the local health economy – NHS Warwickshire North CCG (WNCCG) and South Warwickshire CCG (SWCCG), Arden/Greater East Midlands Commissioning Support Service, NHSE/I regional teams and local authorities in Coventry and Warwickshire.

Coventry & Rugby CCG has strong links with local communities, the third sector and voluntary organisations allowing it to reach many different community sectors and involve them in its work. Coventry & Rugby CCGs commissioning intentions were developed in partnership with provider Trusts, GPs, local authorities and council organisations, voluntary sector organisations and members of the public, to ensure that the right services for the population are commissioned.

The vision of the CCG is:

- To improve the health and wellbeing of the community
- To provide the best possible patient experience
- To ensure choice, value for money and high-quality care

It will achieve this by:

- Ensuring the population receives fair and timely access to a choice of services which are safe, clinically effective and patient centred
- Focusing on health and wellbeing, preventing ill health and reducing health inequalities
- Delivering services as close to people's homes as possible
- Using resources effectively and efficiently, investing in services that deliver quality and best value for money
- Being responsive and listening to the community, practices and partner organisations
- Enabling and empowering the workforce and members to be the best they can.

The overriding priority of Coventry & Rugby CCG is quality- working together with patients, hospitals, communities and local authorities to make positive and sustainable changes for the future of the people of Coventry and Rugby. It has signed up to be a Good Corporate Citizen (GCC) and is looking at how it can act

and commission services sustainably. Sustainability objectives have been developed and these have been reflected in an action plan based on the GCC guidance.

The Coventry & Rugby CCG has collaborated on a number of initiatives to improve communication and involve the public in making decisions about the services it provides.

3.2.2 Partnership Working

With the geographical footprint of Coventry & Rugby CCG covering two local authority areas, Coventry & Rugby CCG works closely with Coventry and Warwickshire Health and Wellbeing Boards. The work of the two Health and Wellbeing Boards, along with the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, inform CCG priorities which are reflected in key CCG planning documents, including the two-year operating plan, the five-year strategic plan and Equality Delivery System Action Plan.

3.2.3 Equality and Diversity

Coventry & Rugby CCG is committed to promoting equality, diversity and human rights for the population it serves and for its staff. Regardless of the pressures currently faced by health economies across the country, the goal is for every employee of Coventry & Rugby CCG CCG to feel pride in the organisation and for every patient to feel confident that they have been offered the best possible service. To enable this to happen, the Coventry & Rugby CCG strives for fairness and consistency in managing the needs of staff, partners, and service users.

Coventry & Rugby CCG have produced an Equality, Inclusion and Human Rights Strategy (Appendix 16).

3.3 Local Strategic Context: The Overarching Framework

Within Coventry and Warwickshire, the over-arching, strategic framework for health and social care services is provided by the Sustainability and Transformation Partnership (STP) plan, the CCG Strategic Plan and the Primary Care Strategy. These inform the CCG's commissioning intentions and directions for service providers.

3.3.1 Coventry and Warwickshire Sustainability & Transformation Partnership (STP) Plan

Sustainability and Transformation Partnerships are driving plans to achieve the improvement goals set out in the Five Year Forward View. In December 2016, the Coventry & Warwickshire Sustainability & Transformation Partnership Plan (STP) was produced, setting out the way forward for the local system, focused on:

- Achieving clinically and financially sustainable services
- Reducing the amount of people needing hospital care
- System and service changes

Within the plan, workstreams direct service redesign, focusing on:

- **Proactive and preventative care –** ensuring people have better general health regardless of where they live, requiring fewer visits to hospital, and shorter stays if they need inpatient care. Making more services available closer to people's homes.
- **Urgent and emergency care** – ensuring urgent and emergency care is easy to use with one point of access, and that all stroke patients receive initial care in a specialist unit.
- **Planned care** – reducing the number of times patients have to go to hospital before and after hospital treatment.
- **Maternity and paediatrics** – offering increased choice around where to give birth.
- **Productivity and efficiency** – making organisations more financially secure, which would make services more secure. Spending less money on expensive agency staff – improving quality and releasing money to spend on patient care.

- **Mental health** – focusing on improving access to high-quality inpatient and community mental health services for adults and children.

These are supported by a number of enabling workstreams covering:

- Workforce (staffing)
- Estates (buildings and land)
- IM&T (use of technology)
- Communications & Engagement

The Foleshill scheme will contribute to the plans to improve the wider estate and enable the deliver of better care, closer to home.

3.3.2 CCG Strategic Plan 2014 - 2019

Each of the three CCGs has individual plans setting out how they will deliver healthcare for their respective populations. However, they have all agreed to work collaboratively, where appropriate, to achieve common aims only possible through being larger unit.

Health and social care are delivered in a variety of ways, as demonstrated by figure 3. The aim is to make sure the best use of resource available to address needs.

Specific health challenges for Coventry and Warwickshire:

- **Population growth:** The population is expected to continue to grow between now and 2021, with the greatest percentage growth to be seen in Coventry (15%), closely followed by Rugby Borough (11.1%) and Stratford upon Avon District (9.5%).
- **An aging population:** In Warwickshire, the challenge relates to an aging population, with more people living for longer with long term medical conditions. Warwickshire currently has approximately 13,356 people aged over 85, and by 2021 this group is expected to be 18,965
- **Managing the needs of the urban and rural populations:** Warwickshire's rural population is generally older than the urban population. The proportion of people aged 65 or over in rural areas is 21%, whilst in urban areas it is 17%.
- **Ethnic diversity:** In Coventry, there is an ethnically diverse population, with 33% of the city's residents coming from minority ethnic communities compared to 20% for England as a whole.
- **Life expectancy:** There is a large gap in life expectancy between the richest and poorest areas of both Coventry and the county of Warwickshire.

Figure 3 Coventry and Warwickshire Health and Social Care services

The growing and aging population means increasing financial and service delivery pressures on health and social care services, and this is expected to continue. Flexible and responsive services will need to be commissioned and provided closer to the patients' homes.

The acute sector also has its own challenges, resulting in a need to adapt the way in which hospital services are provided, to ensure financial sustainability. Given this, changes are taking place to:

- **Care pathways**- which are being redesigned to enable more support to be provided out of hospital.
- **The workforce-** which is aging. Many local clinicians are approaching retirement over the next few years and there are not enough new doctors and nurses to take their place. New roles and opportunities are being created to make the NHS a more attractive place to work.
- **Technology**- where it is used well, it offers the scope for safer and high-quality patient care, at a lower cost.

In summary, in common with many other areas, the approach to transformation is focused on delivering:

- Care closer to home
- Specialist care in the right place, at the right time
- Enabling patients to live the lives they choose
- Clinicians from across health and social care working together
- Use of innovative practice and technology to deliver care
- Care delivered within a financially sustainable system
- Treating mental disorders on par with physical disorders.

3.3.3 **Primary Care Strategy 2015 – 2019**

Within the CCG area, there are 68 GP practices of varying sizes. The GP practices are grouped into three localities - two in Coventry and one in Rugby. The map in figure 4 shows the location of GP practices across the three localities. The annual spend on primary care in Coventry and Rugby is approximately £57 million.

Primary care services are currently delivered from a variety of settings across Coventry and Rugby including GP practices, pharmacies, NHS LIFT or similar buildings and secondary care provider and local authority premises, which incur a total of £44 million in estates costs.

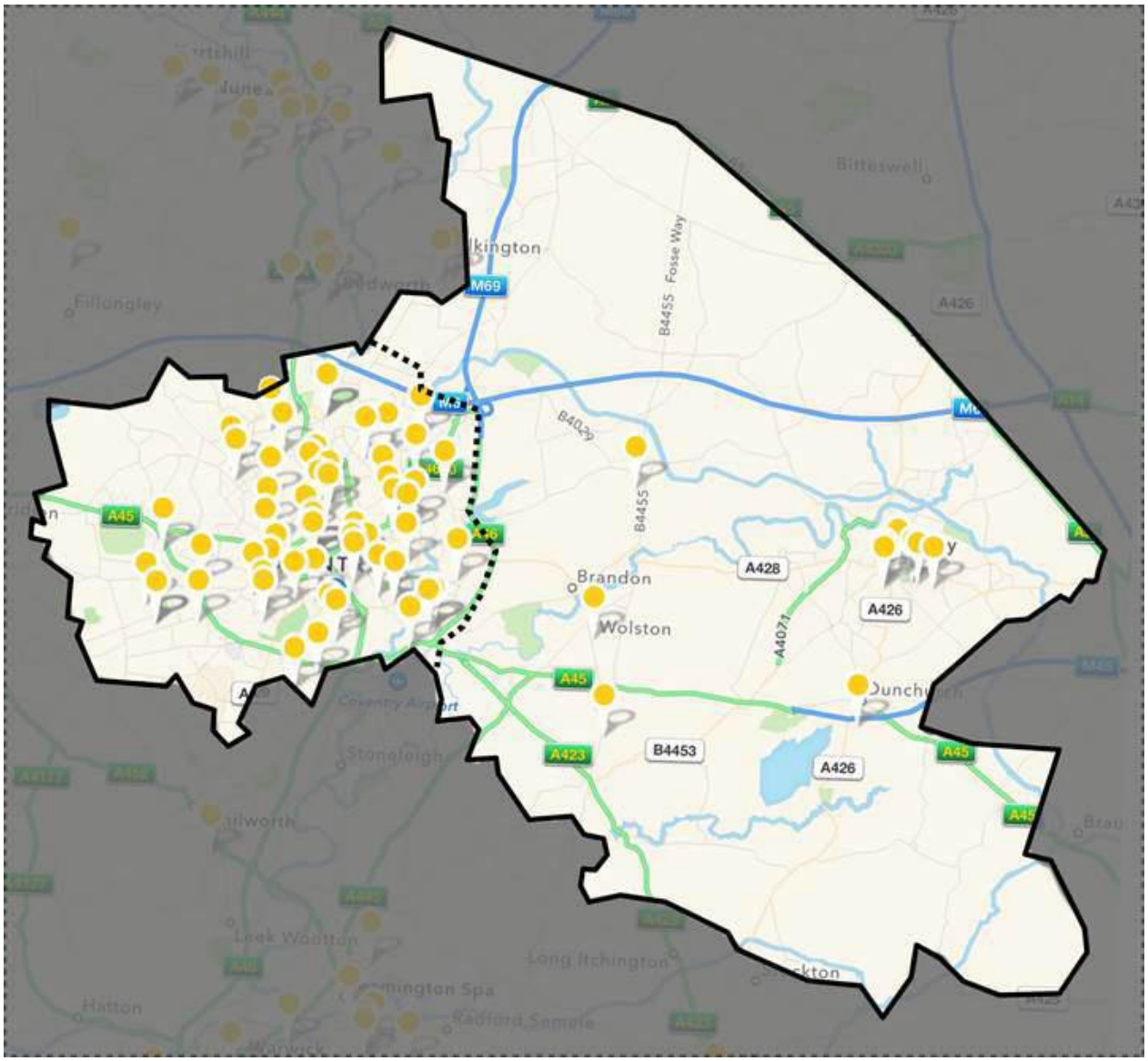
The original Commissioners Investment and Asset Management Strategy (CIAMS) for Coventry, developed in 2010, envisaged a 'Hub and Spoke' service delivery model with a city centre hub, four neighbourhood hubs and a number of primary care spokes.

Over the intervening period, significant elements of this model have been realised with the completion of the city centre health centre and NHS LIFT (or similar) premises built or in development around the city. The Coventry premises model is to be refreshed to ensure its relevance within the primary care strategy and work undertaken in Rugby to develop an appropriate model for the future. Local authorities in Coventry and Warwickshire and provider NHS Trusts have also reviewed their estate plans and these will need to be considered in aspiring to make best use of the health and care estate.

The Foleshill scheme is referenced in the CCG's Strategy Estates Plan (January 2016).

The STP submitted an updated estates strategy in July 2018, reflecting an ambition to develop primary care networks, which practices must work within from July 2019. STP support for the scheme can be found in Appendix 47.

Figure 4 GP Practices across 3 localities



Primary care networks will build further on the core current primary care services and enable greater provision of proactive, personalised, coordinated and integrated health and social care. Where emerging primary care networks are in place in parts of the country, there are clear benefits for patients and clinicians.

Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. They are intended to be small enough to provide the personal care valued by both patients

and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. See figure 5 for Coventry PCNs.

Mirroring the national agenda, in early 2015, the Coventry Health and Wellbeing Board with the Local Medical Committee (LMC) coordinated a visioning workshop, involving patient representative groups, general practice, pharmacists, the local authority, NHS England & NHS Improvement and the CCG to explore and develop a five-year vision for primary care. This was followed up in September 2015 with a further workshop to test and further define the key agreed themes. This resulted in a vision statement:

“Primary care in Coventry and Rugby will be provided as close to home as possible, reducing the dependence on secondary care, in appropriately equipped facilities and adequately resourced”.

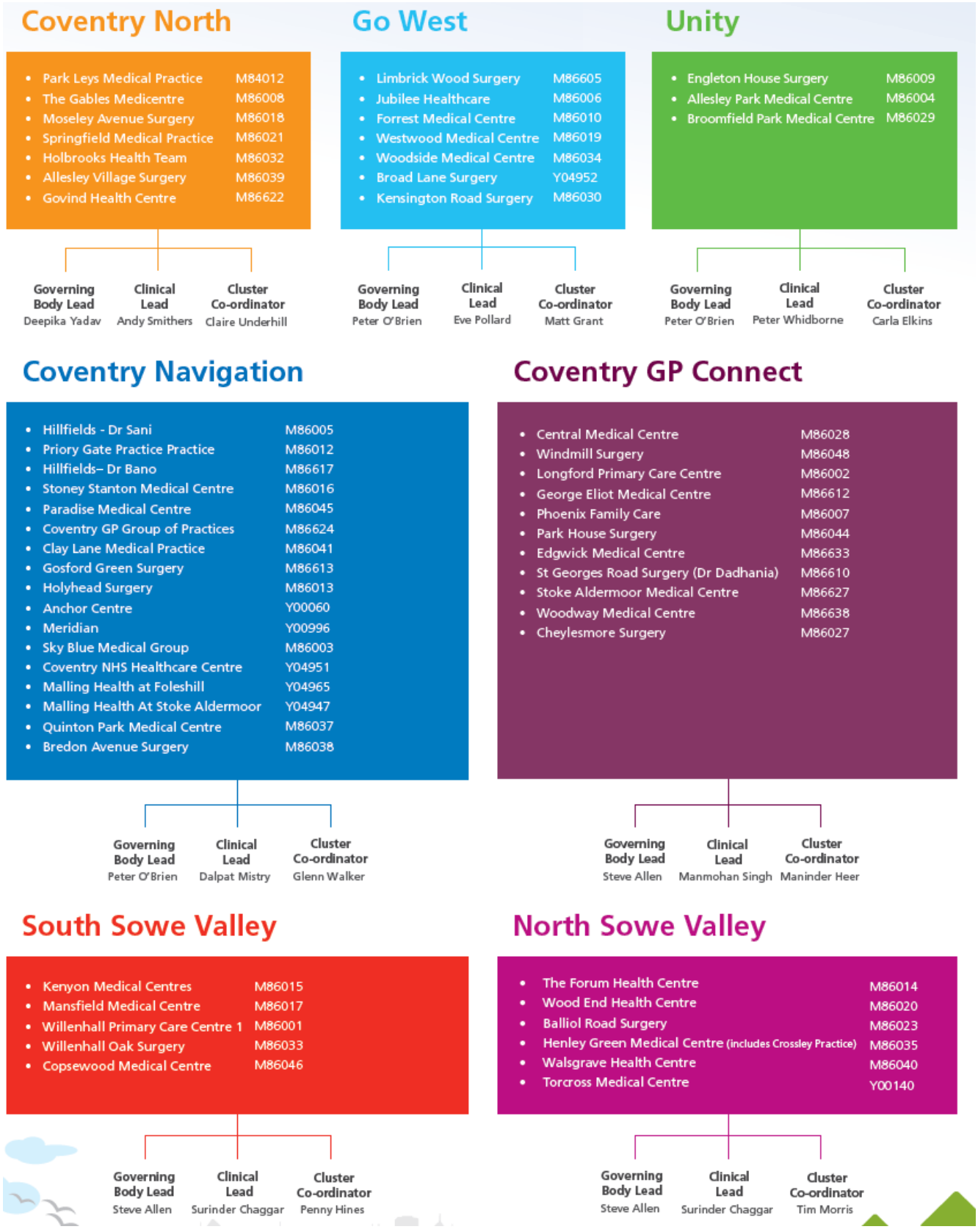
To implement the vision, three key work streams were identified:

- **Model of care-** The model of care work stream focuses on agreed sets of standards, e.g. around equality and access, pathways and choice of pathway, the principle of “right care, right time, right person”. New ways of working and embracing technology will also be explored.
- **Workforce**- The workforce work stream looks at recruitment, retention and training of primary care staff at all levels in the GP practice, the development of new roles within wider primary care to support multi-disciplinary working, and exploration of training, research and the adoption of best practice.
- **IT and information sharing**- The technology work stream will build on the roadmap already put in place by the CCG IM&T Strategy 2015-2017, to make information more readily available, more appropriate and convenient for clinicians, managers, patients / carers and citizens.

Enabling works associated with these were also undertaken, within a clear governance framework, in the areas of commissioning, premises and engagement with patients, carers and stakeholders.

In 2016/17, the strategy concentrated on general practice and it’s staffing and in 2017/18 it looked at integrating the role of pharmacists, dentists, community optometrists and other parts of the system.

Figure 5: Coventry Primary Care Networks



3.3.4 **Commissioning Intentions 2019 / 2020**

For the CCG, the strategies and plans summarised are brought together in its commissioning intentions, developed in collaboration with stakeholders, including provider trusts, GPs, voluntary sector organisations and over 1000 members of the public to ensure that the right services are provided for the local population.

Local population and stakeholder feedback is summarised in figure 6.

Figure 6: Local population and stakeholder feedback

It is clear that people are keen to be able to look after their health, be informed and have access to their GP and other services through clear signposting and easily navigated information.

Since the OBC was approved, Coventry & Rugby CCG have refreshed their commissioning intentions and a new document has been produced called Our Commitment to Health – refresh document 2019/2020[i]

The plan is updated every autumn although the latest direction is summarised in figure 7.

Figure 7: Commissioning Priorities

Primary care	• Providing extended access to GP services, including at evenings and weekends, for 100% of the population • Delivering their contribution to the workforce commitment to have an extra 5,000 Doctors and 5,000 other staff working in primary care • Ensuring every practice implements at least two of the high impact 'time to care' actions • Actively encourage every practice to be part of a local primary care network
Maternity, children and young people	• Deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025 • Increase the number of women receiving continuity of the person caring for them during pregnancy • Continue to increase access to specialist perinatal mental health services
Urgent and emergency care	• Deliver national performance targets for A&E and other urgent care targets • Deliver integrated urgent care services with simple access for patients • Standardise Urgent Treatment Centres in line with national standards
Planned care	• Meet and maintain planned care referral-to-treatment waiting time standards • Deliver reduction in avoidable demand for elective care by tackling variations in referrals and providing advice first options for primary care • Creation of redesigned and efficient hospital pathways, avoiding duplication and unnecessary hospital visits
Cancer	• Expanding cancer screening uptake – focus on bowel, breast and cervical cancer • Ensure all eight waiting time standards are met, including the 62 day referral –to-treatment cancer standard
Mental health	• Dementia diagnosis rate to be delivered at maintained 67% of prevalence • Maintain delivery of access target for IAPT (19% of prevalence in 2019/20) • Maintain 2 week standard for being seen in early intervention for psychosis • Reduction in Out of Area placements • Further develop crises response for children and young people and fully implement a 'CAMHS 3.5 service' model
Transforming care for people with learning difficulties	• Continue to reduce inappropriate hospitalisation of people with a learning disability, autism or both

Extended primary care services is an important element of these priorities.

GPs have fed back that growing list sizes will create a greater imperative for better infrastructure to meet the needs of the population.

[i] https://www.coventryrugbyccg.nhs.uk/mf.ashx?ID=ae7ca194-03d3-4e06-8f01-aceb6d76c57f

3.3.5 QIPP Plans- 2018-2020

The financial framework supporting commissioning intentions allows for efficiency savings as set out within QIPP plans. Locally and nationally, the NHS is managing the impact of constrained public spending and a challenging funding settlement.

The combination of requirements upon the CCG creates a significant challenge and £21.2M of savings were expected to be delivered through QIPP during the year in 2017/18. Table 3 shows the main areas of opportunity.

Table 3: QIPP SMART objectives 2017

Programme	Opportunity Identified FYE	Opportunity Identified PYE	Risk adjusted PYE Feb 17
	£m	£m	£m
Elective (ELs, OPAs)	6.0	5.4	5.0
Urgent Care (NELs, A&E attends)	4.0	2.3	1.4
CHC	3.6	3.0	2.7
Care Homes / EOL (NELs)	1.4	1.1	0.9
Mental Health & LD	1.2	1.2	1.0
Prescribing	5.2	3.9	3.6
Cost Avoidance	2.8	2.4	5.2
Total savings identified	**24.2**	**19.3**	**19.8**
Total savings required		**23.8**	**23.8**
Shortfall		**4.5**	**4.0**

At the time of completing the FBC, the CCG were agreeing QIPP objectives for 2019/20. However, it is expected that they will reflect previous expectations, in terms of the level of savings required and where they are likely to come from.

3.3.6 Joint Health and Well Being Strategy

Coventry and Rugby CCG covers both Coventry City Council and Rugby Borough Councils.

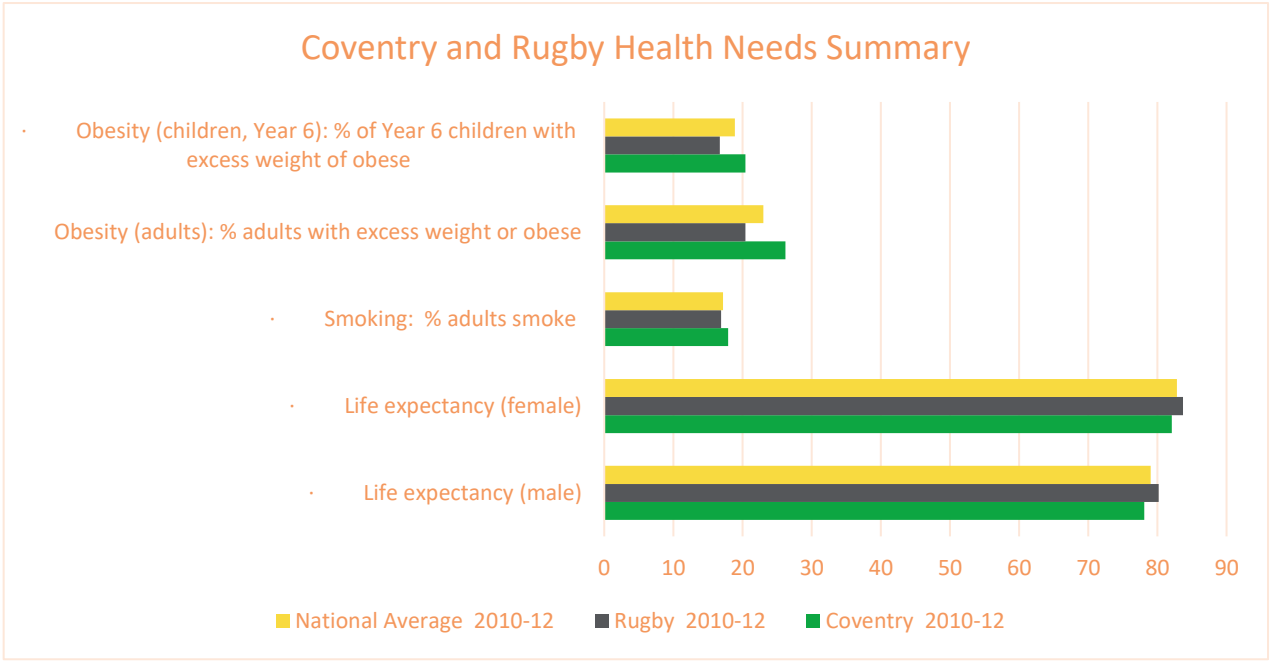
The members of the Joint Health and Wellbeing Board, operated through the Councils, work together to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way and to offer better services. Duties of the Board include:

- providing a strategic influence over commissioning decisions across health, public health and social care;
- involving democratically elected representatives and patient representatives in commissioning decisions, alongside commissioners across health and social care;

- providing a forum for challenge, discussion and the involvement of local people;
- bringing together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community;
- undertaking the Joint Strategic Needs Assessment (JSNA) and developing a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care; and
- driving local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

In Coventry, this means supporting the provision of services that meet the particular needs of the local population, in respect of size and acuity. According to ONS mid-year estimates, in 2012 the combined population of the CCG area was 424,000, with Rugby providing 24% of this population, and Coventry providing 76%. Both areas within the CCG are projected to experience population increase over the coming years.

Figure 8: Coventry at a glance[i]



To ensure that the Health and Wellbeing Strategy and the work of the Health and Wellbeing Board is focused, the strategy for 2016-2019 concentrates on three priorities where the Board believes it can bring the greatest benefit to the lives of Coventry people.

These are:

- Working together as a Marmot City to reduce health and wellbeing inequalities
- Improving the health and wellbeing of individuals with multiple complex needs

[i] *Source: Public Health England – Health Profiles, 2014*

- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well[i]

Table 4 shows how the new centre at Foleshill aligns with the Joint Health and Wellbeing Strategy.

Table 4 - Alignment with the Health and Wellbeing Strategy

Priority	Alignment of Foleshill scheme with priority
Working together to reduce health and wellbeing inequalities	More access to services in one place for patients and capacity for a growing population included in the design
Improving the health and wellbeing of individuals with multiple complex needs	A 'closer to home' hub style building with a variety of services available to patients can only benefit patients and promote health efficiencies
Developing an integrated health and care system that provides the right help and support to enable people to live their lives well.	Ensuring GP and community services are available to assist with a wide range of health and social care needs, all under one roof. The building will be designed with patient safety at its heart. Easier access to a well-lit building will promote a safe environment for patients

3.4 Supporting high quality healthcare: the local estate

Coventry and Rugby are comprised of population and services as shown in table 5:

Table 5: Coventry and Rugby population and services

Population and services	Coventry	Rugby
Population	330,000	101,000
Acute Hospitals	1	1
Health Centres	20	1
GPs	56	12
Dental Practices	41	14
Pharmacists	96	16
Optometrists	62	10
Children's Centres	17	8
Primary Schools	86	32
Secondary Schools	23	6
FE Colleges	3	0
Libraries	17	3
Parks and open spaces	35	7
Leisure centres	17	1

[i] Coventry City Health and Wellbeing Strategy
http://www.coventry.gov.uk/downloads/download/2061/draft_joint_health_and_wellbeing_strategy

In recent years, investment has been made to improve and release the estate, with some notable examples:

- NHS led development took place pre-LIFT at Tile Hill Health Centre and Willenhall Health Centre, which brought together GP practices and a range of community services releasing surplus estate.
- PFI Hospital developed in 2006, releasing Coventry and Warwick Hospital Site for redevelopment.
- Third Party GP led developments have taken place in Holbrooks, Jubilee Crescent and Allesley Park Coventry to improve quality of primary care in area and release poor quality surplus sites.
- Forrest Medical Centre, Canley, developed a practice based over two sites and created new space for additional services to accommodate population growth.

In addition, £34 million has been invested over the last 11 years through LIFT, funding for:

- Keresley Green Medical Centre
  - 2 x large practices & pharmacy – releasing a number of sites.

- Longford Primary Care Centre
  - 3 x practices with range of community services – releasing a number of GP sites.

- City of Coventry Health Centre
  - Number of GP practices and wide range of services including walk in centre, out of hours and a pharmacy
  - Released a number of surplus sites including; Coventry and Warwick Hospital Site, Hillfields Health Centre, River House, Gulson Clinic, Foleshill Road GP surgery Broad Street clinic.

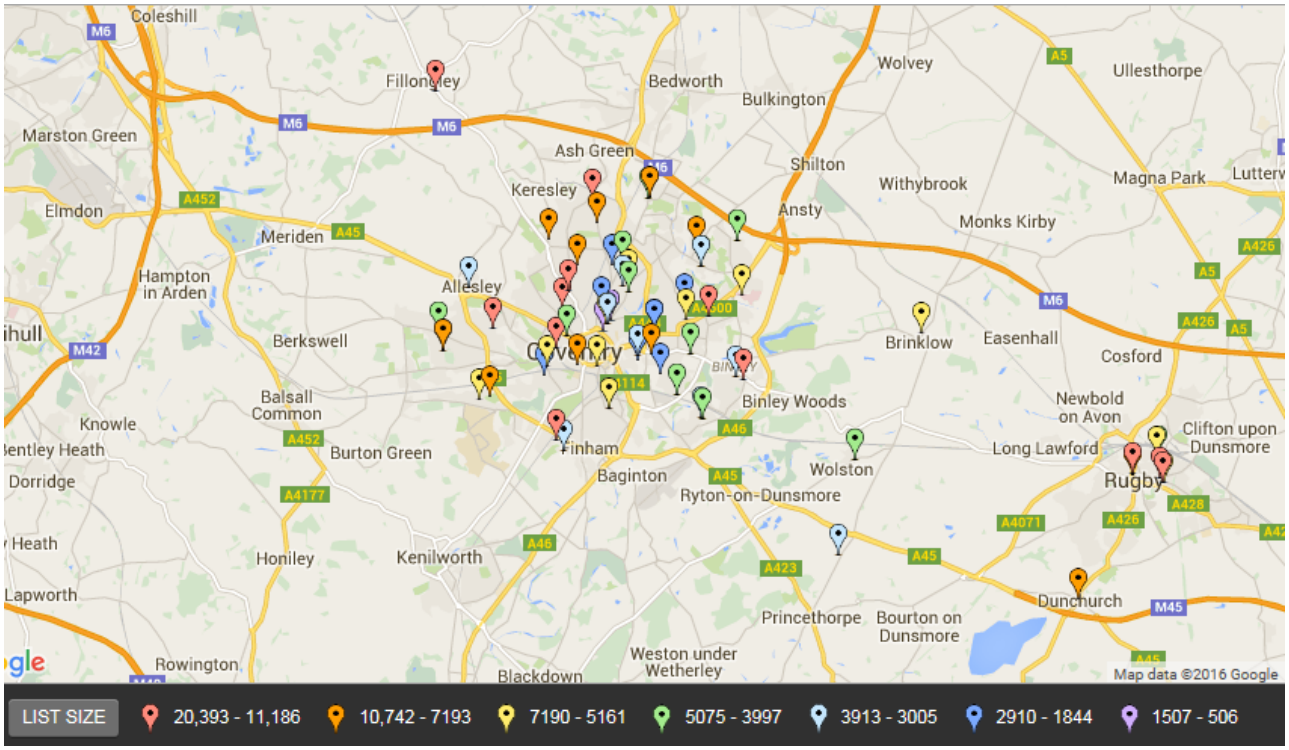
- Clay Lane Health Centre
  - 3 x practices come together & pharmacy released 3 x poor quality GP facilities
  - Rugby Health and Wellbeing Centre, Market Quarter, Rugby. This development brought together two GP practices, formerly in separate buildings in Rugby, a pharmacy and some community space and opened in March 2014.
  - Utilisation studies undertaken at key sites & implementation work streams in place (renal/ Coventry & Rugby GP Alliance Limited (CoCHC) /Mammography etc.).

Notwithstanding this investment, a number of poor quality, GP owned premises remain. Some of these are in converted residential properties and require attention. Data on the quality of this estate is limited and additional work is needed to consolidate understanding of the full GP estate.

Following a gap analysis to determine future commissioning requirements, the Coventry & Rugby CCG Strategic Estates Plan (January 2016) identified the Foleshill project as being a key strategic requirement to meet the predicted population growth in the locality.

Figure 9 shows the location of current surgeries in the area along with their approximate list size.

Figure 9: Current surgeries with list sizes



3.5 Supporting high quality healthcare: meeting needs in Foleshill

3.5.1 Profile of Foleshill

Foleshill is an area of approximately 1.4 square miles to the north east of the Coventry city centre and has a population of 19,943 people (2011 census).

Housing is a mixture of Local Authority, Housing Association and owner-occupied properties. Growth plans within the Foleshill catchment area have identified a number of sites set for residential development, as outlined in table 6.

Table 6: Residential development sites in Foleshill catchment

Development Area	Housing Units
Paragon Park	700
Little Heath	344
Total	1044

The size profiles of residential accommodation are unknown for these sites, although an average of 2.4 persons per dwelling would result in a population increase of 2,506.

Foleshill is one of the most ethnically diverse wards in the city. Over 50% of Foleshill residents are in the Asian/Asian British ethnic group (50.1%). This is the highest proportion in the city. About a third of residents are white (30.8%). It is a highly transient population with the highest proportion of residents who were born in other countries (36.2%) and has the lowest proportion of households who are 'not deprived' in the whole City (21.6%), compared to the City average of 38.4%.

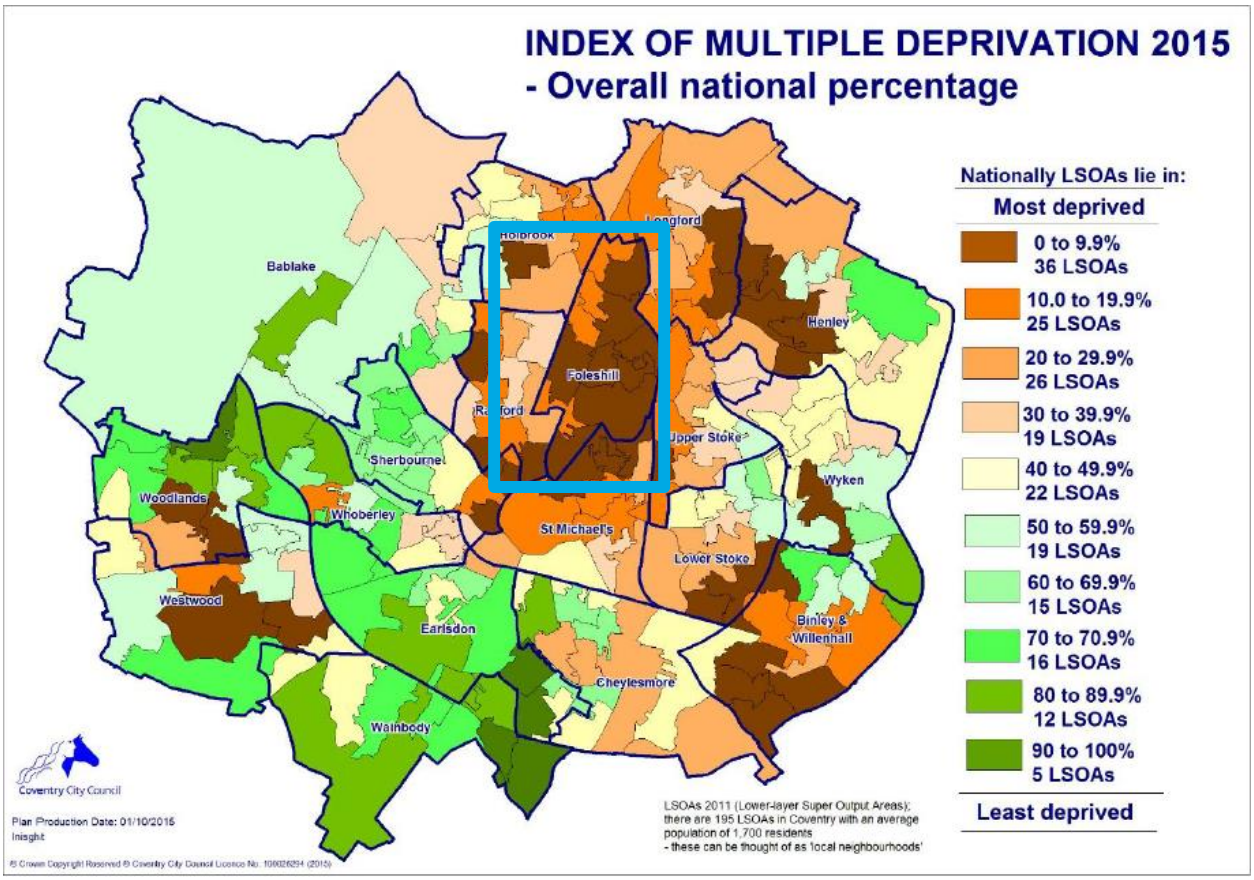
3.5.2 **Health Needs: Foleshill**

The population of Foleshill have higher levels of income deprivation, child poverty and older people living in deprivation than the average for England. In addition, compared to the average for England:

- Significantly more people are suffering from limiting long term illness or disability
- The rate of emergency admissions for all causes is significantly higher
- Rates of emergency admissions for coronary heart disease (CHD), Myocardial infarction and chronic obstructive pulmonary disease (COPD) are greater
- Life expectancy for both males and females living in Foleshill is lower
- Only 13.1% of the population surveyed in 2011-13 eat 5 portions of fruit or vegetables per day (the average for Coventry is 26.6%).

Figure 10 below shows a map of the index of multiple deprivation for Foleshill in relation to Coventry as a whole.

Figure 10: Index of multiple deprivation 2015



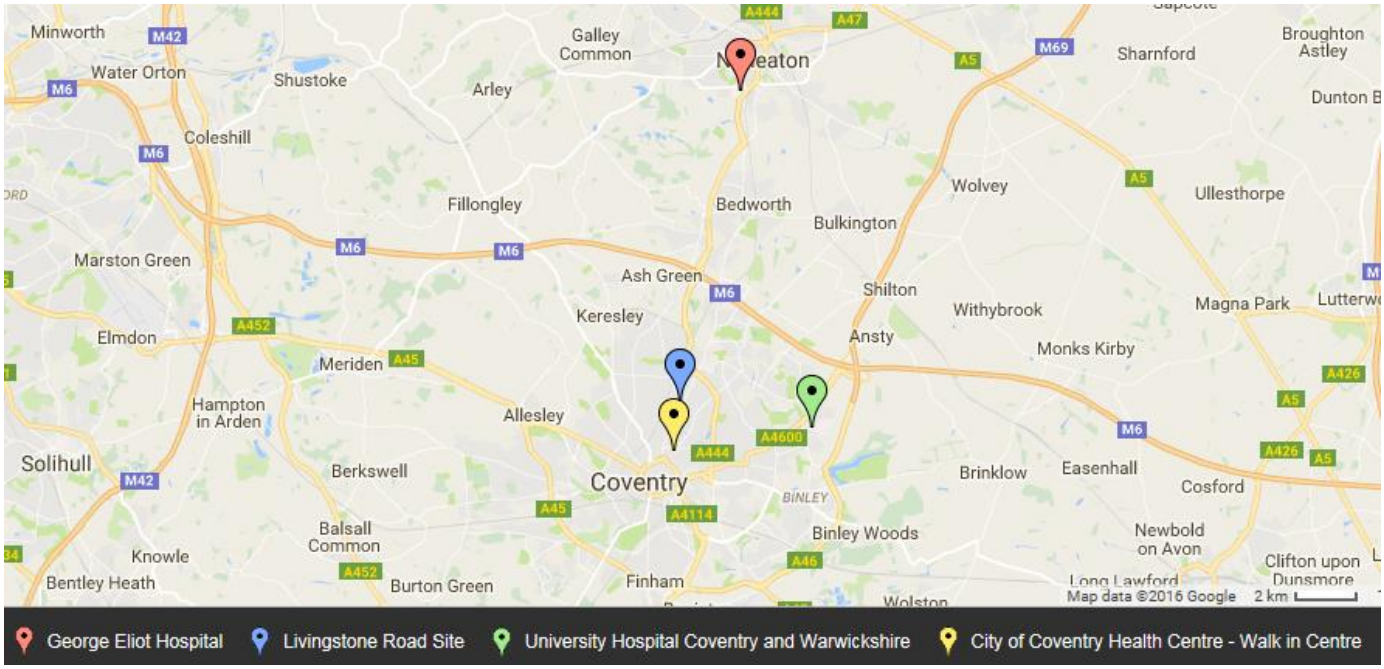
3.5.3 **The Local Healthcare System**

The current model of Primary Care in Foleshill is a traditional model of GMS and APMS services provided by a range of GP practices in an estate of varying age and condition. The patient profile across these practices demonstrates a younger profile compared to the CCG, with fewer patients over 65.

Figures for July 2015 – June 2016 show that Foleshill 'corridor' practices (normalised per 1,000 population) have a 14% higher attendance rate at the Walk in Centre and an 8% higher attendance rate to UHCW A&E (10% higher aggregated together) than other Coventry practices. The high attendance at the Walk In Centre could be attributed to the close proximity of the locality to the Walk In Centre but this does not account for the higher attendance at A&E. The CCG continues to work with practices to reduce attendances through increasing capacity within other services, improved access and patient education.

Secondary care activity is delivered from the main acute site at University Hospital Coventry and Warwickshire less than four miles away, along with further services across the border in Warwickshire at George Eliot Hospital Trust, just under seven miles, as shown on the map in figure 11.

Figure 11: Map showing secondary care sites and walk-in centre



3.5.4 **Malling Health Practice**

The APMS contract was agreed in April 2010 and has been extended from April 2015 to 31 March 2020. It is designed to address inequalities in primary care provision in the Foleshill ward, serving a registered list of up to 6,000 patients.

The core hours for the APMS contract are 52.5 over five days:

Table 7: Malling Practice Opening Hours

Day	Hours
Monday	08:00 – 18.30
Tuesday	08:00 – 18.30
Wednesday	08:00 – 18.30
Thursday	08:00 – 18.30
Friday	08:00 – 18.30
Saturday	Closed
Sunday	Closed

The APMS service is contracted to deliver the core General Medical plus Additional Services, summarised as;

- Asthma Clinics
- Child health and development
- Child Immunisations
- COPD clinic with spirometry
- Dressings clinic (nurse led)
- Drug and alcohol services
- Joint injections
- Long-acting reversible contraception (LARC – e.g. IUD or implant)
- Minor injuries
- Minor surgery
- Phlebotomy
- Smoking cessation
- Young person's clinic
- Learning Disability Health Check

The current APMS provider has a range of Key Performance Indicators (KPI) against their contract which ensures the CCG can measure quality against the service provided. They have been adapted to ensure that the improvement agenda is aligned to the needs of the community. It allows more relevant services to be brought into the community which, in turn, will strengthen clinical outcomes.

The current contract KPIs are shown in table 8.

Table 8: Foleshill KPI's

No.	KPI	Measurement frequency	Requirements
1	Access	Quarterly	Appointments in core hours per week and average per quarter Minimum 30 practice nurse or ANP per 1000 patients Minimum 70 per GP per 1000 patients
2	Patient engagement	Quarterly	There is a representative PPG with at least 1 member per 1000 population. The meetings are quorate if attended by 4 or more members. Minuted meetings are held quarterly. Minutes with actions from previous meetings are reported to the APMS contract meeting.
		Annually	An agreed method of formal patient feedback is carried out annually (this can be a survey, facilitated group, or other qualitative method of feedback). The Area Team to agree the format and content of the feedback. The patient group devise actions as a result of the patient feedback. Patients are informed of the results of the feedback (e.g. via posters, webpage) and are invited to comment further.
3	Child vaccinations and immunisations	Quarterly	Achievement of at least 90% coverage children up to the age of 5 in accordance with routine immunization schedule for England. To include DPT, Hib, Pneumococcal, Rotavirus, Men C, MMR (excluding influenza). An underpinning of up to 3% (i.e. to 87%) is allowed in any one quarter, providing the difference is made up in the following quarter (if the national target increases above this percentage, the target for the KPI will revert to the national target).
4	Cytology	Quarterly	Achievement of 80% coverage or equal to or above the CCG. Average is whichever is the highest.
5	Flu vacs achievement	Annually	Achievement of 75% in the over 65 age group. Average achievement of 60% for at risk groups in year one, rising by 1% for each year until 65% in year 5 (if the national target increases above this percentage, the target for the KPI will revert to the national target).

The priority for the Practice is to develop and provide new services to improve patient care. However, the limitations of the building have meant that many aspects of patient care have had to be compromised.

3.6 The Case for Change

The case for change is built on physical limitations with the current building, the constraints with the lease arrangements, the potential to deliver a great range of services and the capacity requirements of a growing population.

3.6.1 **Service Limitations**

Some of the key indicators the APMS provider would like to address are prevented by accommodation constraints, as described in table 9.

Table 9: Key Indicators the APMS would like to provide

Issue	Description of Issue	Proposed solution
Patient list growth	Development of 1044 dwellings Possible migration of patients at those practices with GP at retirement Possible migration of patients at those practices with accessibility issues	Provide a new build facility
Ageing population	Aspirations to tailor commissioning services from under one roof.	Provide increased capacity for additional services
Increased community care	Pressure to avoid referral and to increase care in the community Providing additional services that could be commissioned such as the Community Diabetes Transformation Programme	Provide flexibility of space with consult/exam rooms at 16m².
Recruitment and retention	Poor facilities result in a less attractive working environment when recruiting and retaining staff.	Provision of clinical space that enables practitioners to implement evidence-based practice when delivering services. Layout and design that fosters communication and strong morale amongst the team

3.6.2 **Current lease arrangements**

An APMS contract will be mandated by Coventry & Rubgy CCG to provide services from the new health facility.

The current APMS provider delivers services from a temporary, demountable located at the rear of a former pub car park. The lease for this facility expired in December 2015. However, the lease was not 'contracted out' therefore, notionally, the lease continues until brought to an end by notice of not less than 6 months. Planning for the temporary facility has recently been extended until 2020. (Appendices 17 and 18).

Capacity in this area is very limited and there are risks regarding the planning approval for the demountable and the possibility of the retirement of GP's in the immediate vicinity. The APMS provider is needed to meet the planned increase in population in the ward and to offer patients a choice of provider.

The current rent and rates charges are shown in table 10.

Table 10 - Current rent and rates charges

Existing costs (£)	Foleshill temporary surgery in demountable
Rent (£)	19,000
Rates (£)	5,628
Total (£)	24,628

3.6.3 Scope of Services

As noted within the strategic case, the space available currently limits the opportunity to provide extended care support in the community, close to where people live.

The new building will provide the potential for services to be extended significantly, over the coming years, as care models change and more care is delivered closer to home.

3.6.4 Capacity Planning

The new development is being built for a patient list of up to 10,000. The current APMS contract holder is contracted for a list size of up to 6,000 patients. However, a neighbouring GP practice (owner occupied) is considering retirement (list size c. 4,400) and both NHSE/I and Coventry & Rugby CCG must develop a succession plan to sustain the necessary capacity for the future.

In addition, housing developments in the area have commenced, generating population growth that must be factored into capacity plans.

Foleshill, therefore, will serve a larger population comprised of:

- 4,000 – from the current APMS list
- 2,500 – coming from housing growth through two developments[i]
- 3,500 – patients of those GPs in the vicinity who are either approaching retirement age or are in poor premises, along with developing new models of Primary Care.

This is an area with a growing and aging population with complex multiple health conditions. This building will provide the opportunity for the greater use of technology to enhance patient care and experience.

The patient requirement is broken down as shown in Table 11.

Table 11: Projected capacity growth for Foleshill

Period	List Size
Year 1	4, 000
Years 2-3	7,000
Year 4	10,000

The GP Forward View (April 2016- the precursor and foundation of the 2019 contract) outlines a number of developments in the delivery of care that are required, and this development will allow these to be met:

[i] Based upon ratio of 2.4 persons per dwelling. Type / size of dwellings unknown. 1044 dwellings planned

- Out of hospital care and managing long term conditions
- Greater use of technology to enhance patient care and experience
- Redesign of space to enhance capacity for clinical consultation
- Wider integration of health and social care
- To promote health and wellbeing for the workforce
- Discuss with other practices the possibility of 'working at scale' and collaborative working

3.7 Stakeholder engagement and consultation

In February 2015, Healthwatch Coventry published the approach to, and details of, surveys undertaken with the local people in Coventry and Rugby in the document "GP quality in Coventry: what is important to local people and recommendations for action."[i]

The document states that GP services are frequently the subject of national policy initiatives because of their central function in the health system. It is important to Healthwatch that the views of local people are a driver in future development of local GP services.

Therefore, Healthwatch Coventry undertook to gather qualitative information about what is important to local people, when they are using GP services via their GP practice or the Coventry Walk in Centre. They ran two qualitative surveys and four focus groups. Meetings were also held with a sample of GP practice managers and visits made to local the Walk in Centre.

Surveys were available to the whole city and the focus groups and conversations with practice managers were focused on Foleshill and Henley wards, which are areas where public health indicators show less favourable outcomes for local people.

In addition, stakeholders have been invited during the OBC process to work through site options, benefits and risk elements of the project. These elements are explored more fully throughout this document in the Economic case.

The proposed site for the new development did cause controversy when it was reported in 2014 that the existing leisure centre was to be demolished. Since that time, however, there has been strong support from local patient groups who are keen to get the project underway.

The Foleshill project has utilised the Design Quality Indicator process for ensuring that a good mix of views and knowledge have helped to shape the design of the building and the important elements to be considered therein. The DQI is explored more fully in the Commercial Case (section 5.13). A list of attendees at the three events and the reports are appended to this case (Appendices 5 and 9).

Whilst representatives of Infection Control were unable to attend, they have reviewed the plans and provided detailed analysis and feedback and infection control requirements for final build.

The three DQI events (April 2016, February 2017 and November 2018) sessions covered:
- An appraisal of the options and benefits
- Detailed planning
- Design

3.8 The proposal for Foleshill

Figure 12 shows the proposed site for a new building in Foleshill.

[i] http://www.healthwatchcoventry.co.uk/sites/www.healthwatchcoventry.co.uk/files/HWCov-report_GPquality_whatisimportanttopatients_feb15FINAL.pdf

Figure 12: Proposed site for the new building in Foleshill

3.8.1 Expected services

Initially, the hub will deliver GP services as per the standard APMS contract. This will include essential services are for patients who are or believe themselves to be;

- Unwell with conditions from which recovery is generally expected;
- Terminally ill; or
- Suffering from a long-term condition.

In addition, the APMS provider will also provide:

- Vaccinations and Immunisations;
- Contraceptive Services;
- Maternity Medical Services (excluding intra-partum care);
- Child Health Surveillance Services;
- Cervical Screening Services;
- Minor surgery; and
- Childhood Immunisations and pre-school boosters.

In time, it is anticipated that this list may grow, as extended primary care services develop.

3.8.2 Utilisation schedule

Initially, the practice will be open from 08:00-18:30, Monday to Friday. There is potential for the practice to operate extended opening times in future years, especially as Primary Care Networks grow and demand shifts from secondary care settings.

3.9 Conclusion

3.9.1 Alignment of Foleshill Project to Local and National Priorities and Needs

The table below shows the projected benefits from the Foleshill project and how they align to the STP priorities, the Long-Term NHS Plan and Five Year Forward View.

Table 12: Alignment of Foleshill Benefits with STP and National Priorities

Foleshill Development: Benefit	STP Priority	Long Term NHS Plan & Five Year Forward View Alignment
Strengthen capability of current service provision across core and non-core services Improved quality of care Provide facilities that encourage the integration of health and social care, allowing for new working practices and subsequently providing working efficiencies Design incorporates flexible facilities Increase the capacity of service provision to meet demand from an increased local population; and a growing list of patients	Integrated teams or communities (approximately 15-20 across the footprint covering 50k population) bringing together services that meet the needs of the population they cover Focus on prevention, keeping people well, reducing demand & pressure on more expensive parts of the system Primary care at the core, with social care, mental health, community services, and acute services out-reach and in-reach, forming a network of care and support Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community Proactive in-reach into the acute by integrated teams, pulling people out of acute care and support recovery and rehabilitation.	Build public understanding of online services and pharmacies Stabilise core funding for General Practice Work with CCGs to design new incentives Smaller hospitals – more community care More specialised care Aligned national NHS Leadership
The facilities meet the needs of the local population, therefore providing appropriate care and catering to increase in number of patients including, children, adolescents, vulnerable adults and the elderly	Patients supported in most appropriate setting and helped to access care in a planned way through education and earlier intervention where appropriate More services (including early diagnostics/outpatients) moved into the community coordinated by integrated teams, when there are benefits to patients/system	Incentivising and supporting healthier behaviour Support a modern workforce

Foleshill Development: Benefit	STP Priority	Long Term NHS Plan & Five Year Forward View Alignment
	Inpatient services delivered at scale, at high quality and achieving economy of scale Potential consolidation of some specialised services at a larger footprint level	
Address "legacy" estates issues to provide a safe patient environment, i.e. statutory compliance, eliminate high-risk backlog maintenance	Consolidation of services/back office functions/clinical support to achieve economies of scale/reduce waste Working together to optimise the workforce, joint negotiation of agency contracts and sharing of best practice. Developing a shared collective estate to improve productivity and facilitate a standard offer for facilities management and collective contract negotiation to reduce running costs and ensure full utilisation	Support a modern workforce Engaging communities Encourage community volunteering Stronger relationships with voluntary and charitable organisations NHS as a local employer
Ensure access to the facility remains "all inclusive", removing barriers to access and ensuring patients feel comfortable with their surroundings		Local democratic leadership in Public Health Stabilise core funding for General Practice Work with CCGs to design new incentives
The facilities provide a high degree of independence and self-care for those with special needs and disabilities.	Prevention: enhanced self-care Proactive management of those with LTCs through integrating health, social care, mental health and other services required	Targeted prevention Stay in work help Workplace health Empowering patients Encourage community volunteering

Foleshill Development: Benefit	STP Priority	Long Term NHS Plan & Five Year Forward View Alignment
Improved facilities for staff and patients, assisting in recruitment and retention Improved patient experience A place the local community can identify with and have a sense of ownership Effective care delivered by well trained staff	Simple access without duplication, reflecting the national direction for U&EC facilities and move towards integrated delivery Reduced reliance on U&EC over time, with integrated teams proactively managing people at risk Integrated rapid response and support once people are in the urgent / emergency care system, with urgent social care response incorporated Implement new stroke pathway	Empowering patients Engaging communities Encourage community volunteering Stronger relationships with voluntary and charitable organisations NHS as a local employer NHS accredited health app
Deliver the appropriate capacity and service requirements within necessary timescales and the cost estimates Clean and modern building	Reduced costs Reduced requirement for capital and additional estate Fit for purpose primary care estate Sustainable estates workforce Care closer to home Estates changes associated with STP plans in place	Stabilise core funding for General Practice Work with CCGs to design new incentives Drive efficiency and effectiveness on demand and budget

Plans are also consistent with the priorities set out in the Joint Strategic Needs Assessment. Table 13 shows how the Foleshill development is consistent with these relevant key priorities.

Table 13 Alignment to JSNA priorities

JSNA key local priority	Foleshill development alignment with priority
Create an attractive cleaner and greener city	The building will benefit from the latest innovations in healthcare building design ensuring maximum efficiencies with utilities, building materials and carbon efficiencies generally. With BREEAM excellent rating, designers and contractors will be expected to drive these carbon efficiencies promoting a greener and more Cost Advisor building footprint.
Improve health and wellbeing	A 'closer to home' hub style building with a variety of services available to patients can only benefit patients and promote health efficiencies
Protecting our most vulnerable people	Ensuring GP and community services are available to assist with a wide range of health and social care needs, all under one roof.
Make communities safer	The building will be designed with patient safety at its heart. Easier access to a well-lit building as opposed to the current location in a pub car park will only promote a safer environment for patients
Reducing health inequalities	More access to services in one place for patients and capacity for a growing population included in the design.

In summary, the redevelopment of the Foleshill practice represents an opportunity to deliver strategic priorities directly for the benefit of this particular community of Coventry.

- It will ensure that the growing population has access to healthcare in the community where they live.
- It will present the opportunity for a 'spoke' in a hub and spoke model, enabling the delivery of specialist support outside of an acute setting.
- By delivering within budget and to plan, it will represent a good use of public resources to promote wellness and prevent ill health and reduce pressure on acute beds.

3.9.2 Investment Objectives & Benefits

Reflecting the opportunities that Foleshill represents, table 14 sets out the key objectives for the development and how success can be measured.

Table 14: Objectives for a new development within Foleshill

Objective	Expected outcome	Indicator
To replace temporary APMS accommodation at Station Street West, Foleshill, Coventry, CV6 5ND with new, purpose-built premises supporting a projected population of up to 10,000.	Improved patient access and continuity of care in an area of Coventry that is among the most deprived wards in England.	New development Patient list sizes
To provide patients with improved access to a range of services aimed at reducing the demand for urgent care and supporting patients to manage their conditions at home or in the community.	Integrated services that wrap around the patient provided from a purpose-built facility that will enhance patient comfort, safety and dignity.	Reduced unnecessary attendance, referrals or admissions to hospital.
To ensure security of tenure of APMS service.	Purpose built property on land held for health use	New development
Providing modern Primary Care services to meet Commissioning strategies.	Continuing to improve the clinical quality of care	Improved health outcomes for locality population
To meet the required standards to deliver the Coventry and Rugby Primary Care Strategy	Continuing to improve the clinical quality of care.	Reduced unnecessary attendances, referrals or admissions to hospital.
Reduction in waiting times for practice appointments.	Provision of better reception facilities and processes.	Updated waiting times issued.
Improved patient experience and choice	Increase in patient satisfaction	GP patient survey
Provision of bookable appropriate clinical space.	Increase in outreach services, public health, Local Authority and third sector organisations.	Updated utilisation figures provided by Centre /Practice Manager.
Provide appropriate choice and services to the locality.	A wider variety of services offered.	Improved health outcomes for locality population.
Better community relationship	Targeting localities specified problems.	Improved health outcomes for locality population.

Objective	Expected outcome	Indicator
High quality personalised care	Improved level of GP provision delivering improved health outcomes	Reduction in health inequalities

A full benefits realisation plan has been created and is available at Appendix 19.

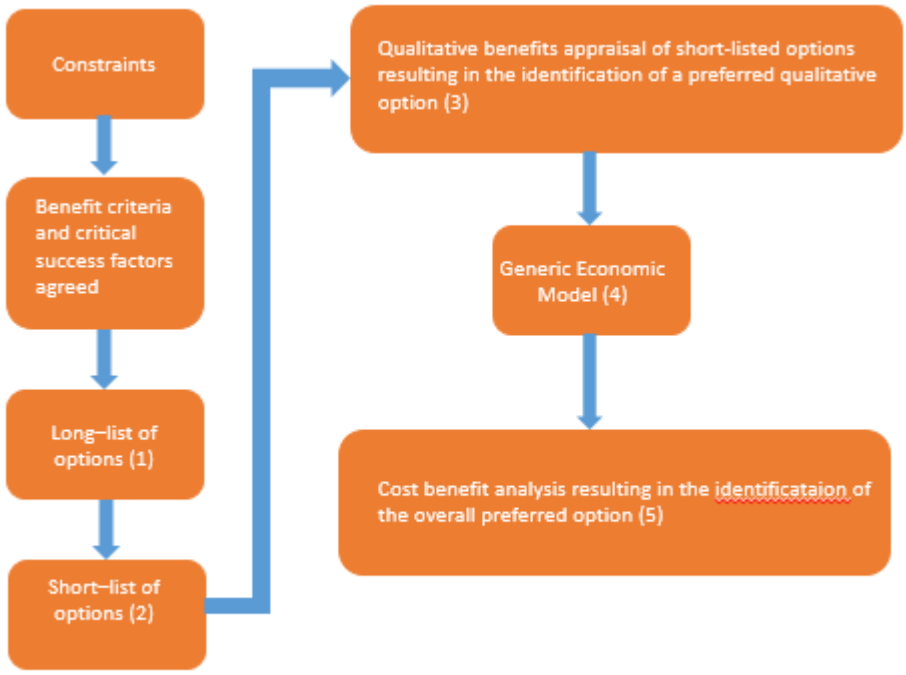
4 The Economic Case

This chapter primarily focuses on how the scheme represents value for money. The initial section revisits option appraisals that took place at OBC. These processes determined the preferred option in regard to the future provision of primary care services in the Coventry area.

4.1 Summary of the preferred option at OBC

To determine the preferred option a number of processes were used, these are summarised in figure 13.

Figure 13 The route to the preferred option



4.1.1 Qualitative option appraisal

The short list of options was scored at a workshop (workshop slide pack at Appendix 20) and the results are summarised in table 15.

Table 15: Qualitative option appraisal scores produced at OBC

Benefit Criteria	Weighting	Option 2 – Do Minimum			Option 3 – New Build		
		Raw Score	Weighted Score	Total	Raw Score	Weighted Score	Total
Service Delivery	25	4	25	**100**	8	25	**200**
Estates related issues	15	4	15	**60**	9	15	**135**
Clinical Quality	15	7	15	**105**	9	15	**135**
Staffing	15	6	15	**90**	9	15	**135**
Teaching and Training	5	4	5	**20**	9	5	**45**
Ease of implementation	10	3	10	**30**	8	10	**80**
Strategic fit within national priorities	5	4	5	**20**	8	5	**40**
Culture	10	2	10	**20**	8	10	**80**
Total	100	**34**	**100**	**445**	**76**	**100**	**850**

The qualitative preferred option was identified as;

Option 3, to provide a new build development on the Livingstone Road site.

4.1.2 Quantitative appraisal

Subsequent to the qualitative appraisal, a quantitative appraisal was then undertaken using the Generic Economic Model to determine the preferred option from a financial perspective.

The Foleshill scheme quantitative appraisal ranked the 'do minimum' option as the preferred option. This was unchanged after applying risk and sensitivity analysis

The outcomes of both the quantitative and qualitative appraisals was then merged. Table 16 shows the combined appraisal of options at OBC

Table 16: Combined appraisal of options

Option	Non-financial scores	Risk adjusted NPV Impact of Option £000s	£000 NPV per benefit point	Rank	Margin of score below highest %
Do Minimum	445	4,630	10.4	2	84.0%
New Build	850	4,807	5.6	1	-

A copy of the full sections comprising the option appraisal process as detailed in the OBC can be seen at appendix 21.

Coventry & Rugby CCG have confirmed that no changes to the option appraisal have taken place and therefore the preferred option *to provide a new build development on the Livingstone Road site* remains.

4.2 Value for money procurement assessment

Although CHP has tendered for the construction cost of this project, CHP have used the capital costs developed at OBC stage to underpin their rental model. It has, therefore, been agreed with NHS England & NHS Improvement and Coventry & Rugby CCG that reliance will be placed on the District Valuer, as an independent assessment, for confirmation that the CHP rental represents value for money in the current market. Refer to Appendix 50 for confirmation from CHP to the CCG around lease value.

4.2.1 Capital costs

CHP have advised that the capital costs for the scheme based on the schedule of accommodation at Appendix 8 are as follows.

Table 17: Summary of Capital Costs

Costs		Net	VAT	Total
Works Costs		2,450,953	490,191	2,941,144
Project fees	13.91%	340,911	n/a	340,911
Non-Works costs	Land	207,385	n/a	207,385
	Other	73,524	14,705	88,229
Equipment cost		197,350	39,470	236,820
Total		**3,270,123**	**544,365**	**3,814,488**

The capital costs for the new build options are set out in Appendix 22 in the standard form FB forms. A value for money report on the capital costs, prepared by AECOM, is also attached

4.2.2 Optimism bias

Optimism bias has been removed at FBC.

4.2.3 Revenue costs

Revenue costs for the new build are £154,000 as summarised in table 18.

Table 18: Revenue Costs

	New Costs (£)
Rent (reimbursement level)	119,000
Rates	25,000
Water and Clinical waste	10,000
TOTAL COST	154,000

4.2.4 District Valuers Report

The Foleshill development has been reviewed by the District Valuer on four occasions, due to the elapsed time and changes to the proposals since the OBC.

The first review, in June 2018, concluded that the scheme did not represent value for money. Changes were made and a second appraisal took place in August 2018 (please find report at Appendix 23). The conclusion, at this stage, was favourable.

As the scheme has changed further and market conditions have evolved, a revised assessment was sought from the DV in March 2019.

Having considered all the information made available, the March 2019 DV report is, again, positive in respect of value for money, with a proposed rent of £127,255 pa (the actual rent will be £119,000 pa, as agreed with CHP).

Key extracts from the DV's March report include:

- *From a Development Appraisal received from CHP I understand they are seeking a rent of **£127,255 per annum plus VAT** on a tenant's internal repairing lease (TIR) with the landlord responsible for external repairs and maintenance and the payment of building insurance. I understand this is based on a lease of 25 years with rent reviews to market rent at 3 year intervals on an upwards only basis and on standard commercial terms. I have considered the rental required to finance the project on the same terms as above and **I agree that an initial annual investment income return, represented by an initial annual lease rent payment of £127,255 per annum plus VAT is reasonable based on the projected development costs** of the project as presented to me at the above mentioned meeting.*

- *My estimated Current Market Rent figure for reimbursement purposes, based on a lease length of 25 years, rent reviews every 3 years to market rent, is £108,900 (one hundred and eight thousand nine hundred pounds) per annum plus VAT. This based on an accommodation rate of £192.50/m2 and 21cars @ £288.75 each.*

- *From a Development Appraisal based on TIR terms with a lease length of 25 years, rent reviews every 3 years to market rent, my estimated initial annual investment income return represented by an initial annual lease rent necessary to finance the scheme on the 'Passivhaus' design, based on the projected development costs is £**127,255** (one hundred and twenty seven, two hundred and fifty five pounds) plus VAT. This rent is in line with the development appraisal produced by CHP. It is above the level of CMR and accordingly, if this level of rental is necessary to finance the scheme, a 'top up' payment under Direction 6 of the NHS Directions will be required, representing the difference between the initial lease rent and the CMR. Such a top up payment would reduce to zero where a future rent review results in a CMR that equals, or exceeds, the actual lease rent, on review.*
- *I am of the opinion that subject to all of the terms and conditions recommended in this report being fully complied with and if the proposed scheme will satisfy NHS requirements in being built to a 'Passivhaus'*

design, then a rental of £127,255 (One Hundred and Twenty Seven Thousand Two Hundred and Fifty Five Pounds) per annum will provisionally represent VFM to the NHS based on the lease terms set out at Section 4.3 (2) above.

- *I emphasise that the above is not an opinion of value of the initial rental value of the scheme but is a VFM rental based on the financial inputs required for this particular scheme.*
- *In order to ensure that VFM is ultimately obtained it will be necessary to review costs in more detail as this information becomes available.*

The full report can be viewed at Appendix 3.

Following the reduction in GIA, the estimated current market rent was reconfirmed by the DV in their report of 30 January 2020, as follows:

- My estimated Current Market Rent figure for reimbursement purposes, based on a lease length of 25 years, rent reviews every 3 years to market rent, is £108,900 (one hundred and eight thousand nine hundred pounds) per annum plus VAT. This based on an accommodation rate of £196.00/m2 and 21 cars @ £300 each.

5 The Commercial Case

5.1 Introduction

This section sets out the commercial arrangements for the project and the procurement strategy. It looks at the strategies for the provision of equipment and IM&T and identifies the key risks the projects faces and who is best placed to manage these risks.

5.2 Procurement strategy overview

5.2.1 Preferred Procurement Option

For the scale of this development, the Department of Health Joint Development Group has determined that a Lease plus Agreement (LPA) synonymously linked to LIFTCos, is not appropriate due to the high costs on fixed items such as legal, financial and future maintenance and lifecycle factors.

A more commercial approach to a leased property has been requested by the Commissioners, having recently visited the newly completed third party development completed by Arden Estates Partnership (AEP LiftCo) in Coventry. LIFTCo approval to this project can be found in Appendix 48.

To this end, the various procurement routes available to the NHS to deliver this development, have been appraised with the Commissioners. The conclusion of these options is shown in table 19.

Table 19: Procurement Option Review

Procurement option	Review
Capital development	This is the preferred option NHS England & NHS Improvement have requested a revenue scheme. CHP will purchase the land, manage the design and build of the property and the lease with the tenant, on a Tennant Internal Repair basis.
LIFT development	Fixed costs, legal documentation and construction methods in excess of a Full Repairing and Insuring (FRI) lease model for size of development considered too expensive.
GP-led development	Due to nature of APMS contract, the practice is not in a position to take risk and fund themselves.
Third party development	Development company to take risk and fund themselves. Allows NHS England & NHS Improvement to control and simplify the building contract structure.

This represents a change from the OBC where a third party development was expected. The change in preferred option is due to affordability considerations, after discussion with the District Valuer. Alternative approaches were explored which led to CHP adding Foleshill to its capital programme with the support of DHSC and the CHP Board.

5.2.2 Alignment to Government Construction Industrial Strategy

In 2016, a new construction strategy was published by the Government. It seeks to ensure collaborative procurement and address the five key needs before the sector:

- Better-performing buildings that are built more quickly and at lower cost;
- Lower energy use and cheaper bills from homes and workplaces
- Better jobs, including an increase to 25,000 apprenticeships a year by 2020;

- Better value for taxpayers and investors from the £600bn infrastructure and construction pipeline;
- A globally-competitive sector that exports more, targeting the $2.5tn global infrastructure market.

This is supported by the Sector Deal for Construction which builds on Construction 2025 (published by the Government and the Construction Leadership Council CLC in 2013) and provides the framework for the delivery of:

- a 33% reduction in the cost of construction and the whole life cost of assets;
- a 50% reduction in the time taken from inception to completion of new build;
- a 50% reduction in greenhouse gas emissions in the built environment –supporting the Industrial Strategy's Clean Growth Grand Challenge; and
- a 50% reduction in the trade gap between total exports and total imports of construction products and materials.

These goals are to be met by focusing on:

- **Digital techniques** deployed at all phases of design to deliver better, more certain results during the construction and operation of buildings. Clients, design teams, construction teams and the supply chain working more closely together will improve safety, quality and productivity during construction, optimise performance during the life of the building and better the ability to upgrade and ultimately dismantle and recycle buildings.
- **Offsite manufacturing** technologies- to help to minimise the wastage, inefficiencies and delays that affect onsite construction, and enable production to happen in parallel with site preparation – speeding up construction and reducing disruption.
- **Whole life asset performance- to** shift the focus from the costs of construction to the costs of a building across its life cycle, particularly its use of energy.

5.2.3 Application of Government Industrial Strategy to Foleshill Procurement and Construction

Although not specifically referenced in the document, P21+ and subsequently P22, has historically been the default option for construction projects. For Foleshill, this route is not the preferred procurement option but rather a CHP capital funded project with use of the SBS framework for procurement of the main contractor as this will ensure compliance with the national strategy.

The Government strategy has influenced Community Health Partnerships (CHP) approach for the delivery of the Foleshill Health Centre via a modular offsite solution that will deliver whole life value thorough use of an energy efficient design methodology. Further details of the approach and methodology are considered below

A) PROCUREMENT

Community Health Partnerships procurement policy has the use of frameworks at its core. For the Foleshill project, the use of a framework represents the best value for money as the project will debut several new approaches.

CHP can access a wide range of frameworks including Crown Commercial Services, NHS Shared Business Services, Scape and NEPO.

Given CHP's relationship with the NHS and as a part of the Department of Health & Social Care, use of NHS Shared Business Services (NHS SBS) framework was thought to be most appropriate. In addition, the NHS SBS has frameworks for modular buildings and construction consultancy services, so is aligned to the concept and approach being considered, presenting a significant opportunity to pilot a different approach to the delivery of health care buildings.

The following (in italics) is an extract from the NHS SBS Modular framework.

The efficiency gains from modular and offsite manufactured solutions support the delivery of the government's construction and industry strategy targets, which include time and cost savings as well as

whole life cost benefits and in use savings. This framework in turn provides a fully EU complaint route for Public Sector Organisations to procure all types of modular buildings. The framework has been awarded following a fair and open competition across the offsite construction and modular buildings market. The specification has been developed through thorough consultation with the market and experts in the field.

Why use it?

- 50% FASTER DELIVERY THAN ON-SITE CONSTRUCTION
    - With direct award and mini-competition options available, timescales will be further reduced
    - Permanent and temporary solutions with preferential pricing without the need for a further complex procurement process
- LESS ON-SITE DISRUPTION
    - Ideal for live and busy hospital sites
    - Buildings pre-manufactured in a controlled factory environment and assembled on site
- CONTROL OF COSTS
    - Options to purchase and hire from the capital and revenue budget
    - Production in a controlled factory environment will keep the project on time and on cost
- EU COMPLIANT
    - No need to repeat the procurement process; simply appoint a supplier through the framework, choose a preferred construction contract and sign a Service Level Agreement (SLA)

The framework covers both Education and Healthcare modular buildings for both hire and purchase, with ten suppliers list for Healthcare building purchase with a value over £1M and further ten for Bespoke Modular Buildings. Providers fall into two categories, Modular Manufacturers and Modular Contractors.

Given the approach identified for Foleshill Health Centre it was considered prudent to use an established Modular Manufacturer.

B) PASSIVE HOUSE

Passive House buildings are characterised by high levels of comfort with very low energy consumption. This is achieved primarily using Passive House components (e.g. Passive House windows, insulation, heat recovery). From the outside, Passive House buildings do not differ from conventional buildings, because "Passive House" means a standard and not a particular type of construction.

Passive House offers:

- Excellent levels of comfort
- Consistent fresh air all throughout the building
- Structurally-sound and durable construction
- Extremely low energy costs - even with rising energy prices
- Improved indoor air quality and hygiene

Full details can be found in the Technical Report, Appendix 37.

Five key principles are applied.

- Passive House windows- In temperate and cold climates, triple-glazing and insulated window frames ensure heat gains in winter. In warmer climates, double glazing is usually sufficient.

- Adequate ventilation strategy- Passive House buildings are supplied with consistent fresh air via the ventilation system. The heat exchanger ensures that air is supplied to rooms at nearly the room temperature without the need for additional heating – cold and heat remain outside.
- Thermal insulation- A well-insulated building keeps warmth in during winter and heat out during summer.
- Airtightness- A Passive House building has a continuous air-tight outer shell. This protects the building structure, prevents energy losses and improves comfort.
- Thermal bridge reduced design- Especially in temperate and cold climates, Passive House buildings are planned without thermal bridges. This ensures even lower heating costs and prevents building damage.

Through using Passive House, Foleshill will:

- have the full benefit of offsite manufacturing;
- ensure that the whole life performance of the asset is factored into the cost of construction; and
- be delivered to BIM level 2.

CHP will ensure that a Principal Designer is appointed in relation to Health and Safety on the project and that the main contractor adheres to the Considerate Constructors Scheme. The main contractor will be expected to run a safe site and employ only staff and sub-contractors who are qualified to undertake the work expected of them (i.e. use of CSCS cards for example). They will also ensure a smooth transition from construction to occupation and use by:

- Planned commissioning and occupation timescales within the project plan
- Training for staff to use the building effectively
- Reporting and resolution of any issues with the building

In summary, given HM Government Industrial strategy for Construction, the approach for Foleshill supports

- Better-performing buildings that are built more quickly and at lower cost;
- Lower energy use and cheaper bills from homes and workplaces
- Better value for taxpayers

5.3 Required services

The GP practice will occupy the premises under a five-year APMS contract on a Tenants Internal Repairing (TIR) basis protected by the security of tenure provisions of the Landlord and Tenant Act 1954. CHP will work with the tenant to agree the arrangements for soft FM.

* Soft FM generically covers items such as cleaning, ground maintenance, pest control etc.

5.4 Process for appointment of contractor

The procurement of the contractor for the works is a key part of the project. This will be done by CHP. A number of tasks have had to be undertaken to reach this point; these are detailed in table 20. This timetable is in line with the overall master programme for this project.

Table 20 – Process and timeline for appointment of contractor

Task	Start
Contractor's proposals received	21 February 2020
Contractor's proposal agreed/planning permission granted	4 March 2020

Construction commences	23 March 2020

5.5 Potential for risk transfer

The general principle is that risks should be passed to 'the party best able to manage them', subject to value for money. This section provides an assessment of how the associated risks will be apportioned between the NHS and CHP. Table 21 shows the current risk transfer matrix.

Table 21: Potential for risk transfer

Potential risk	Risk management	Risk allocation	Risk to project
NHS England & NHS Improvement approval refused	Early engagement with NHS England & NHS Improvement and Coventry and Rugby CCG to determine approval routes	CCG	High
Inability to negotiate appropriate terms with the current landowners	Initial discussions have already taken place with CWMIND.	CHP	Mitigated
Poor site / building conditions	Site surveys have been carried to support the Planning application and engineering solutions have been developed and managed by CHP to offset any risk.	CHP	Low
Stakeholder engagement	Communication is open, and discussions are on-going. This will ensure all stakeholder requirements are met.	CHP	Low
Changes to Design following Planning Approval	The contract allows for the variations by the Head Tenant. CHP will manage variations in the appropriate way as and when they occur during Construction. Outline planning consent has been granted with an amendment application which was submitted on <>	CHP	Low
Project costs incorrectly estimated	It is the responsibility of CHP to deliver the project within the bounds of the financial case set out within this document. It is also CHP's responsibility to ensure Value for Money is achieved and signed off by the District Valuer. A Price Tender Estimate has been produced to show the robustness of the costs assumed.	CHP	Low
Growth in capacity not achieved	Looking at additional service providers and services Residential growth and future proofing	CCG	Medium
Proposal does not achieve Value for Money	The rent proposed will have to satisfy the District Valuer as providing Value for Money and the costs incurred in getting to this stage are carried by CHP. CHP have recently completed a similar sized scheme within the City and will be bringing experience to the Foleshill development.	CHP	Low

Potential risk	Risk management	Risk allocation	Risk to project
Increased Construction Costs due to unforeseen circumstances	These risks are carried by CHP with the proposed rent agreed prior to commencement of works on site. Any additional costs will fall to CHP.	CHP	Medium
GP rent is unaffordable if current high land purchase cost is used in the affordability calculation	The cost of all of the site has been used in each appraisal but there is the opportunity, once final design is approved to reduce this cost as it may be possible to sell on the surplus site.	CCG	Mitigated
Unable to procure a suitable APMS provider	Look to procure early on in the development stage Soft market test to understand availability	CCG	Medium

5.6 CCG Cost of Risk

The CCG has evaluated the costs of these risks and only two currently carry a clear cost. These are detailed in the table below.

Table 22: The cost of risks

Risk	Mitigation	Estimated financial impact	Cost (£ 000)
Business case approval refused or delayed and managing expectations	Early and continuous engagement with NHS England & NHS Improvement and Coventry and Rugby CCG to determine approval routes. Addendum submitted to PAU early Dec 2017 re vfm. Addendum approved August 2018 by PAU to allow Foleshill to progress to FBC. Ongoing dialogue with all approving bodies to mitigate	Abortive Costs, plus continuance of existing revenue costs while alternative solution developed	150
Growth in capacity not achieved	Looking at additional service providers and services Residential growth and future proofing	Building oversized and therefore excess rent incurred. Estimated at 10% of rent.	14

All other risks are carried by CHP or have sufficient mitigation arrangements to provide the CCG with confidence that their financial impact will be minimal, if they do arise.

5.7 Commercial and legal issues summary

5.7.1 Charging mechanism

There is a commitment to deliver services from the facility for the 25 years of the lease. With a strong commissioning intention, CHP will provide capital funding for this development.

It has been agreed that the GPs will have use of the building under a Tenants Internal Repairing lease which has been drafted and agreed. Refer to Appendix 44 for HoTs.

5.7.2 Contract length

The GP’s will lease for the whole building for the period of their APMS contract. The CCG will underwrite the contract for the commissioning of NHS services on the site for 25 years.

5.7.3 Key contractual clauses

The land at Livingstone Road is under the ownership of Coventry and Warwickshire MIND (CWMIND) who purchased the site making 0.38 acres available for health use at a cost of £125,000.

5.7.4 Personnel implications (including TUPE)

It is likely that TUPE arrangements will not apply.

5.7.5 Accounting treatment

The accounting treatment of the project is governed by a number of accounting standards. UK Generally Accepted Accounting Practice (GAAP) will govern the classification of the asset for CHP. The accounting position for the Department of Health's (DH) balance sheet, is governed by European System of National and Regional Accounts (ESA 2010). This replaces ESA95 and became effective from September 2014.

It has been confirmed that the asset will be accounted for on CHP's balance sheet and they have the CDEL to cover. Refer to Appendix 49.

5.8 Equipment Strategy

As the contract for the project will be for purely design and build of the new health centre, the CCG will be responsible for procurement of all group two and three equipment.

The procurement of group two equipment is included in the timeline for delivering this project and will need to commence in parallel with the building contract. It is expected that this will commence during on approval of the FBC to ensure timely delivery for installation. In respect of the group three items, this will need to coincide with the delivery of the building.

Where practical, it is planned to transfer equipment from the existing facilities to the new building. Where this is not practical, equipment will be procured, purchased, supplied, installed and commissioned, and will be set out in the Equipment Responsibility Matrix.

For the purposes of calculating the capital costs of the projects, a prudent approach has been taken and it has been assumed there is no equipment transfer.

CHP will be required to enter into discussions with the tenants and will be responsible for ensuring environmental conditions, space and services installation supplies are appropriate for the equipment. For those items of equipment which CHP are responsible for supplying, installing and / or commissioning, such activities will form part of the Completion Tests required to be carried out by the Employer's Agent in order for the DV to be satisfied on their appropriateness.

The procurement and choice of Furniture, Fittings and Equipment, will be the responsibility of the CCG.

The CCG will need to: -

- Determine where transfer items can be removed from current position and moved to new facilities.
- Ensure prompt payment of invoices to ensure that any prompt payment discounts are achieved.
- Understand when the warranty period starts i.e. when equipment is brought into use or when delivered.
- Ensure that any equipment is calibrated and electrically installed where necessary.

5.8.1 Equipment Identification

Table 23 sets out the different equipment groups, an explanation of the type of equipment that falls in each group and specific notes relating to the equipment group.

Table 23 Equipment groups

Equipment group	Explanation	Purchased by	Owned operated and maintained by
Group 1	• Group 1 fixed equipment to be included within the building construction cost (integral to the building and engineering installations) in respect of supply, installation, & commissioning. These will include items including engineering terminal outlets, supplied and fixed within the terms of the building contract. • There may be items of Group 1 fixed equipment, (to be determined) for which there are clinical considerations. Where applicable, the tenants will provide input-based equipment specification during the construction phase. • There may also be some Group 1 fixed equipment items, (to be determined) which will include specialised equipment and may have service requirements. These may be installed by third parties during the construction or the commissioning phases. It is unlikely that such items will be transferred from the existing healthcare facilities. • It is essential therefore that it is clear from the commencement of the process as to the responsibility of selecting, procuring and installing items based upon the attached groups.	• As part of the contract unless otherwise specified in the ERM	• CHP
Traditional Group 2 Items (all items)	• Items which have implications on space, building construction or engineering services, and which are fixed within the terms of the building contract but supplied under separate arrangements. • Items will be purchased and delivered to CHP for fixing in the new facilities.	• CCG	• CCG
Traditional Group 3 Items (all items)	• Outside the building contract, loose items of equipment supplied by the CCG and which have a space implication. May have engineering requirements. These will be funded from the 10% allowance included in the OB forms.	• CCG	• CCG
Traditional Group 4 Items (all items)	• Outside the building contract, will be required departmentally, but don't really have space implications. Have no effect on engineering requirements. These will be funded from the 10% allowance included in the OB forms.	• CCG	• CCG

An equipment responsibility matrix has been prepared and can be found at Appendix 24.

5.8.2 IM&T Strategy

The CCGs GP IT support team will maintain systems within the new building. It is expected that the system will have standard N3 (or equivalent) connectivity with appropriate telephony infrastructure to meet the size of the anticipated patient list. There are established networks and clinical systems in place across the CCG and GP IT funding and plans which include the wi-fi connectivity funding, electronic prescribing, triage systems, patient self-check in screens etc. These are all part of the standard operational practices of GP surgeries across the CCG.

The NHS Long Term Plan and 2019 GP Contract includes a commitment to greater use of technology to enhance patient care and experience, as well as streamlined practice processes.

CCGs were tasked to produce Local Digital Roadmaps (LDRs) setting out how they will achieve the ambition of operating Paper-free at the Point of Care by 2020.

Paper free at point of care is defined as:

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation

Digital road maps outline;

- How new care models, seven-day services and effective triage (for primary care and unscheduled care access) can be underpinned by access to digital, real-time and comprehensive patient information
- How clinicians and care professionals can make more effective decisions through synthesising information from a range of sources
- How clinicians can be alerted promptly to deteriorating or 'at risk' patients
- How contact time for community-based staff can be increased through mobile working
- How unnecessary diagnostics, no access visits or duplicate equipment orders can be avoided through having access to a comprehensive patient record
- How acute productivity can be improved through solutions such as e-rostering, asset tracking and blood stock management
- How patient-recorded information can contribute to an increased role for self-care across pathways
- How population health management can be supported through the analysis of data from across the system
- How the take-up of personal health or integrated health and care budgets can be accelerated through providing digital information and tools to patients

The CCG will be responsible for the procurement of hardware and software for the site in respect of computers and associated items. There are a number of items to be transferred from the temporary demountable premises including CPU's, monitors, keyboards, printers etc.

5.9 Disposals

There will be no income from sale of land to include in this business case as the current APMS provider delivers services from a temporary demountable located at the rear of a former pub car park.

5.10 Planning

Planning consent for the building was granted on 14 April 2016 and CHP have made an amendment to this consent – attached at appendices 1 and 4. Full planning permission was granted on 16 January 2019 along with a number of conditions (Appendix 7).

These conditions are set out in Appendix 25 which details both the condition and the mitigation.

5.11 Schedule of Accommodation & Derogations

A schedule of accommodation has been developed for the scheme based on accommodating a list size of up to 10,000 patients.

The schedule shows the space recommended at the OBC stage and FBC stage and provides commentary to explain the reasons for any changes made.

There are no derogations. Refer to Appendix 8 for the schedule of accommodation.

5.12 Capital Costs

A set of standard FB forms have been produced based on the Schedule of Accommodation. These have identified the costs shown in table 24.

Table 24: Capital costs from FB forms

Costs		Net	VAT	Total
Works Costs		2,450,953	490,191	2,941,144
Project fees	13.91%	340,911	n/a	340,911
Non-Works costs	Land	207,385	n/a	207,385
	Other	73,524	14,705	88,229
Equipment cost		197,350	39,470	236,820
Total		**3,270,123**	**544,365**	**3,814,488**

5.13 Design Principles

Drawing/design considerations:

- The drawings included in this FBC (Appendices 10 and 11) are 1:200 and 1:50 scale designs for a primary care health centre based on the SoA provided at Appendix 8.

- The clinical areas and their organisation are a key consideration, but the plans have considerable flexibility should the spaces need to be moved around i.e. there are some shared spaces and receptions and shared utility space.
- The key dimension is that between the external wall and the corridor wall which is 4.7m so in effect a 16m^2 consulting or treatment room is 4.7m x 3.4m which is HBN compliant.
- Spaces, particularly in the clinical areas have walls aligned that are likely to prevent cross joints from impinging on consult or treatment rooms, this is more likely however in the non-clinical areas. In staff spaces it is assumed that the continuous use and practitioner administration areas are in an open plan space with six desk areas of 6.6m^2. Partitions could be included.
- The drawing that places the accommodation over two floors follows the splits suggested by discussions with NHS England & NHS Improvement and other stakeholders and has the same setting out across the width as previously mentioned with the same central corridor. The design required two extra stores /spaces at 8m^2 which is felt to be acceptable at the design concept stage.
- BREEAM – The facility has been designed to meet BREEAM Excellent. Interim and final design certificates are included in Appendices 28, 29 and 45.
- BIM – CHP have committed to design this facility to BIM Level 2.
- The FBC estates standards are based on compliance with HBN 11-01 - 'Facilities for primary and community care services' and HTM 05-03 FireCode.
- The FBC estates standards are based on compliance with HBN 11-01 - 'Facilities for primary and community care services', and HBN00-09 Infection Control in the Built Environment. The design/ drawings have been signed off by the commissioners Infection, Prevention and Control Nurse in respect of clinical and non-clinical adjacencies and, in respect of compliance with Privacy and Dignity by an approved nurse advisor. Written evidence of this is attached at Appendix 30.
- 8m^2 per person is a space budget for planning overall space required on a WTE/Space basis in respect of administrative accommodation.
- Eight desks per 10 people is an agility ratio in respect of administrative space.

5.14 DH&SC Consumerism compliance

In addition to the good design principles shown in section 5.13, it is important that the design is compliant with DH&SC consumerism requirements for healthcare buildings.

The following have been considered and included in design for Foleshill:

- A design that provides acceptable levels of privacy and dignity at all times
- High specification fabric and finishes to reduce lifecycle costs
- Natural light and ventilation
- Zero discomfort from solar gains
- Dedicated storage space to support high standards of housekeeping and user safety
- Dedicated storage for waste awaiting periodic removal
- Single sex toilet facilities
- Immediate access to patients to call points for summoning assistance

5.15 DQI

The Design Quality Indicator (DQI) is a toolkit to measure, evaluate and improve the design quality of buildings.

To ensure good governance, involving stakeholders in creation of a robust design, the project has used the DQI tool for evaluation at different stages throughout the lifecycle.

The first two evaluations; “The briefing stage” and the “Concept Design stage” took place at workshops in April 2016 and February 2017. The events were well attended and given good feedback. Full reports of the events, including the attendance list can be seen at Appendices 5 and 9.

A third DQI event (mid stage design) took place in November 2018 (Appendix 9). DQI Stage 4 will be held as soon as possible after the building is open, with DQI Stage 5 scheduled for 6 months after that.

5.16 VOA questionnaire

As part of good practice and assurance, a Valuation Office questionnaire was completed for the outline business case and has been updated for the full business case.

The District Valuation Service (part of the Valuation Office Agency) fulfils an essential and key role in the primary care development process. The role is one of ensuring that best value for money is achieved from the project, whilst helping to ensure that the Developer’s design proposals comply with Department of Health, NHS England & NHS Improvement, Health Authority, Health and Safety Executive, HM Government and other applicable guidance and requirements, room sizes and efficiency of layout.

The two completed VOA questionnaire and a comparison of the differences has been completed and can be found in Appendices 12, 13 and 14.

The reason for the main variation between the first and the second VOAQ is the availability of further information on the building design, construction process and lease arrangements. For example:

- The Design Team has now been confirmed
- The proposed design complies with building regulations, including Fire safety and certification will be provided at practical completion by Building Control.
- The building will not have pitched roofs
- The main external entrance door will be an electrically operated (DDA compliant) swing door. This is required for the purposes of Passive House certification.
- The facility will allow for a plug-in stand-by generator to be connected.
- Telephone and data connections will be the responsibility of the tenant. The development will provide suitable incoming ducts and comms room suitable for connection to LAN

5.17 Drawings

Drawings have been provided by Tooley and Foster at both 1:200 and 1:50, with the following considerations:

- The drawings have been based on the schedule of accommodation (Appendix 8)
- The drawings have been produced with good design principles in mind (see section 5.13). They can be found at Appendices 10 and 11.

5.18 Infection Control

The Coventry & Rugby CCG Infection, Prevention and Control Nurse reviewed the PSC drawings and has made the following comments: -

- In terms of adjacencies the clean and dirty utilities are shown next to each other, this is acceptable if they have entrances to each room off different corridors.
- It would be preferential for the specimen WC to be located directly behind the dirty utility to enable the specimens to go directly into a dirty area.

Except for these two points, the Infection, Prevention and Control Nurse has confirmed the proposals are in line with the guidance. However, it should be noted that until both room data sheets and room loaded plans are received it is difficult to confirm whether or not all aspects of control in the built environment have been included within the proposals. This next phase of the design process will ensure that the correct facilities are included, and the correct materials used in terms of flooring, paint, etc. Particular attention will be paid to the

ventilation requirements for each room which will depend on the functions being undertaken in them. This will all be confirmed once the design operational policy is developed with the users of the building.

On 21 November 2018, Jill Harries, Infection Prevention and Control Nurse, Coventry & Rugby CCG, prepared a review of the plans for the Foleshill GP surgery. This review covered all aspects of a new build surgery. The full review can be found at appendix 30. Overall, the only area of concern was the dirty utility:

Currently the plans show the dirty utility at the furthest point from the consulting rooms. There are options re the positioning of this room within the practice:

1. If the practice wish the dirty utility room to remain in its current position as per plans P606 November 2018, this would place consulting rooms at the furthest point from the dirty utility where it is anticipated lower risk procedures will be undertaken e.g. urine testing. If the dirty utility room is to remain in this position then I would advise that the practice undertake a risk assessment of all rooms to ensure that non-invasive/lowest risk procedures are undertaken in the rooms/environments furthest from the dirty utility and a plan is in place for the removal/disposal of clinical waste generated e.g. used specimen container/urine disposal
2. A second option is to move the dirty utility to a more centralised position amongst the consulting and treatment rooms. However, once again I would advise risk assessment of procedures undertaken and placement of rooms to ensure any issues highlighted are recognised and addressed. This might include issues other than those associated with infection control

6 The Financial Case

The purpose of this section is to set out firm financial implications and demonstrate the affordability of the project to the CCG and NHS England & NHS Improvement. It looks at the revenue and capital implications of the project and how these will be funded and by whom.

6.1 Source of Funding and Capital Costs

6.1.1 Capital Funding

The building will be funded by CHP and the cost recovered through rental income over 25 years. However, this is predicated on CHP receiving a contribution of £381,000 from the CCG of Section 106 funding drawn down from the City Council. CHP accept that this funding will not be received until, potentially formal, practical completion but it must be received before the end of March 2020 (ie the end of CHP financial year). See Appendix 42 for further details of the Section 106 funding available and timelines.

6.1.2 Schedule of Accommodation

The summarised schedule of accommodation is shown in table 25 and detailed information can be seen in Appendix 8.

Table 25 summarised schedule of accommodation

Functional content	Space requirements (m^2)
Public spaces e.g. waiting, WC's, reception etc.	231.39
Clinical spaces	145.48
Staff space	196.44
Facilities management	45.7
TOTAL	619

6.1.3 Capital Costs

The current capital cost of the scheme including VAT are as set out in table 26 and is supported by the FB forms attached as Appendix 22:

Table 26: Capital funding costs

Costs		Net	VAT	Total
Works Costs		2,450,953	490,191	2,941,144
Project fees	13.91%	340,911	n/a	340,911
Non-Works costs	Land	207,385	n/a	207,385
	Other	73,524	14,705	88,229
Equipment cost		197,350	39,470	236,820
Total		**3,270,123**	**544,365**	**3,814,488**

*Source of Capital: CHP
Revenue Costs: recovered through rental to the GPs and reimbursed by the CCG.

6.2 Value for Money- Benchmarking Capital Costs

AECOM have compared the lifecycle costs of the Passive House design for Foleshill against a standard build with following results at 15, 25 and 40 years.

Figure 14: Outturn Costs: Standard vs Passive House Design over 15, 25 and 40 years

Foleshill Lifecycle (3.6% energy inflation)

15 years

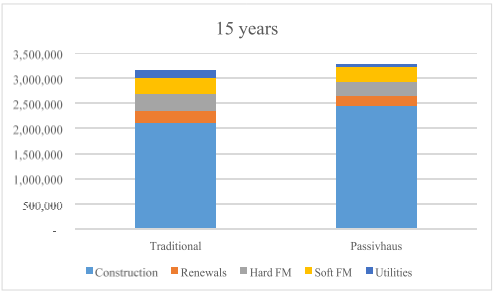
	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	254,621	338,040	300,240	153,022	3,150,474
Passivhaus	2,450,953	207,705	270,432	300,240	47,936	3,277,266

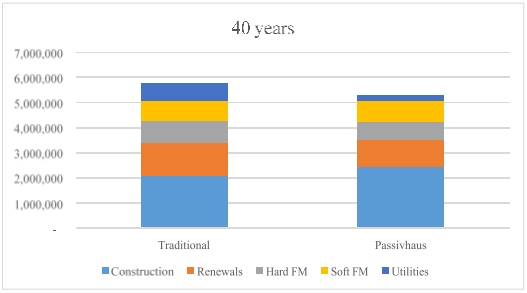
25 years

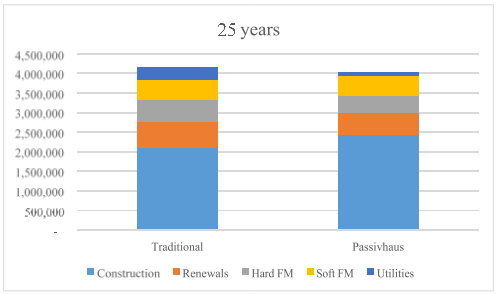
	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	663,673	563,400	500,400	310,724	4,142,748
Passivhaus	2,450,953	539,537	450,720	500,400	97,338	4,038,948

40 years

	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	1,282,109	901,440	800,640	681,189	5,769,929
Passivhaus	2,450,953	1,087,977	721,152	800,640	213,391	5,274,114







Foleshill Life Cycle

Foleshill Lifecycle (1.9% Energy inflation)

15 years

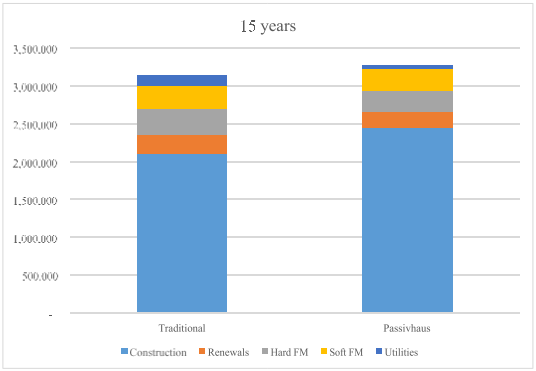
	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	254,621	338,040	300,240	135,155	3,132,607
Passivhaus	2,450,953	207,705	270,432	300,240	42,339	3,271,669

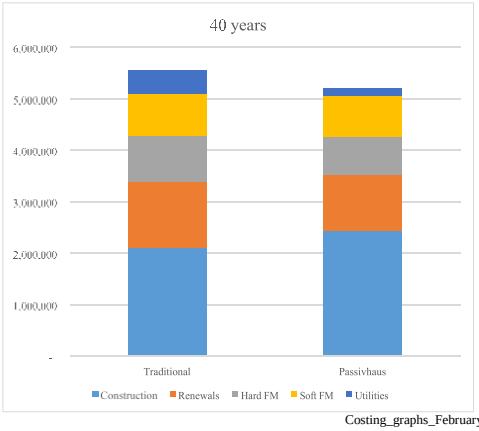
25 years

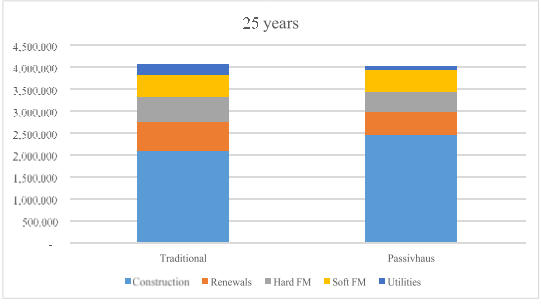
	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	663,673	563,400	500,400	248,948	4,080,972
Passivhaus	2,450,953	539,537	450,720	500,400	77,986	4,019,596

40 years

	Construction	Renewals	Hard FM	Soft FM	Utilities	Total
Traditional	2,104,551	1,282,109	901,440	800,640	465,312	5,554,052
Passivhaus	2,450,953	1,087,977	721,152	800,640	145,765	5,206,487







Foleshill Life Cycle

This shows that, at each stage and for each area of expenditure, the Passive House Design reflects value for money, relative to the estimated cost of a standard design.

6.3 Overall revenue affordability

6.3.1 Clinical costs

The clinical costs for the project remain as at present and will do so until the procurement of the APMS providers for the scheme.

6.3.2 Cost comparison

The new Foleshill Health Centre will be procured through CHP, with them taking the head lease. The property will be leased by CHP directly to the APMS provider on a lease co-terminus with their service contract. The lease will be a TIR lease with the GPs being responsible for soft FM service under the tenancy.

Coventry & Rugby CCG has agreed and approved the additional rent reimbursement and associated costs payable to the GP Practice under Primary Care Premises Costs Directions as detailed in the table 27.

The table also confirms the recurrent costs of occupying the existing centre vs. the recurrent costs of occupying the new facility with the source of additional funding to cover the additional cost.

Table 27: Recurrent Revenue Affordability. Source and application of funds

	Current Costs £	New Costs £	Difference £
Cost of occupation			
Rent (Reimbursement level)	19,000	119,000	100,000
Rates	5,628	25,000	19,372
Water and clinical waste	-	10,000	10,000
Total Cost	24,628	154,000	129,372
Funded by			
NHSE/I under PCD	24,628	154,000	129,372

The rent reimbursement figures provided are exclusive of VAT. There is an assumption of the current rate of 20% VAT recovery on the building development and VAT advice will be sought with regards to the rent from APMS to ensure this is applied correctly.

This represents an increase in the revenue cost of the building of £129,372 per annum. Whilst this does represent an increase in cost, it does reflect the need to accommodate more patients with the increasing list size increasing of up to 10,000. It also reflects the need to provide more modern, up to date facilities to meet current, future healthcare demands and meeting the demographic growth that has occurred in this area as explained in the Strategic Case.

Coventry & Rugby CCG has confirmed that as commissioners of the GP services, they will fund the additional rent reimbursement and associated costs per annum to the GP Practice. However, the non-reimbursable costs (e.g. electricity and service charges) are not included above are not reimbursed under the Premises Cost Directions. These costs for the new building will met by the GP Practice and funded from the service contract payment they receive from commissioners.

Although Coventry & Rugby CCG will reimburse the rent to the APMS provider and will continue to in a new development subject to approval of this business case, the provider will see an increase in the facility management, running and operational costs of the new facility. The Head Tenant (CHP) may look to recoup additional charges from the provider for the above and will be taken forward as part of agreeing the sub-tenancy agreement.

There are also a number of transitional, non-recurrent costs for the scheme as detailed in table 1.

Coventry & Rugby CCG has confirmed that it will cover the cost of non-recurring costs to a maximum of £50,000 which is at their discretion under Premises Costs Directions.

6.4 VAT Treatment

It will be the intention of CHP to elect to opt to tax the building. CHP has made a blanket election over all the properties it occupies. This election has the effect of making VAT on construction costs recoverable. However, it also means that the Landlord and Head Tenant would charge VAT on the rent to their under tenants. The VAT charged to GPs is currently irrecoverable for medical practices.

7 The Management Case

7.1 Introduction

This section of the FBC explains how the Foleshill scheme will be governed, setting out the delegated authority actions required to ensure its successful delivery in accordance with best practice. It outlines the internal project structure for the projects in the context of the overall primary care development programme.

The governance arrangements detailed in this section have been implemented immediately following approval of the OBC. These arrangements have replaced any existing governance structure and will be in place until the opening of the new facility.

7.2 Project management arrangements

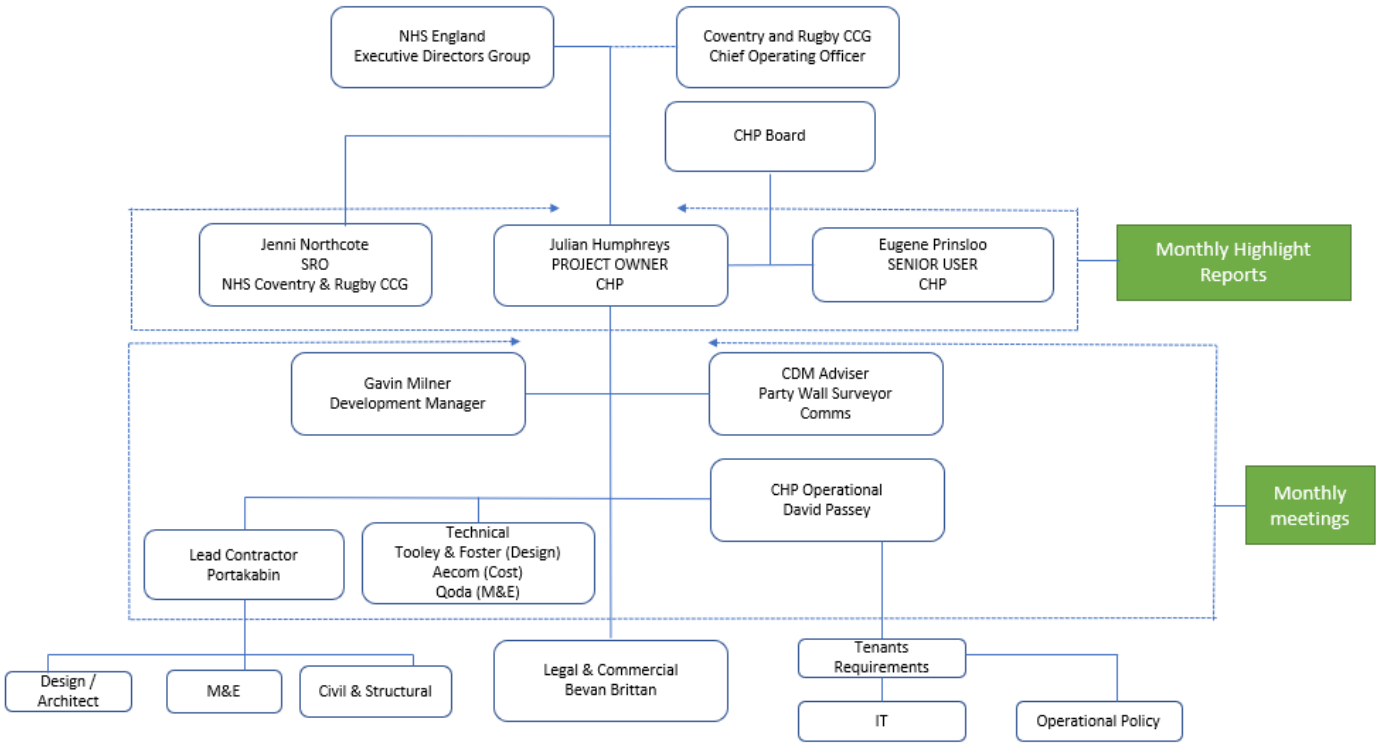
Project management arrangements have been implemented for the Foleshill scheme to ensure its successful delivery and timely completion. The key tasks and deliverables that make up the developments are:

- Design and construction of the new Foleshill primary care centre with all associated clinical and non-clinical support services.
- Relocation into the new facility.

The Foleshill project is led by NHS England & NHS Improvement and Coventry & Rugby CCG who have engaged Community Health Partnerships to support them as their delivery partner.

The project will be structured using PRINCE2 methodology. The reporting organisation and the reporting structure for the project is shown in figure 15

Figure 15: Project organisation Foleshill



7.3 Management of project phases - responsibilities

Table 28 - Management of project phases responsibilities

Item	Resource	Requirements	Outputs
Procurement process	CHP	Sign off through CHP governance, financial close.	Contractor appointment
Construction Phase	CHP		New building
Operational phase – Hard FM	CHP		Ongoing maintenance
Operational phase – services	CHP/CCG		Patient services
Operational phase – Soft FM	CHP/CCG/GP		Managed Soft FM services
Operational phase – movement of staff into building	GP/CCG/Others	Building familiarisation by contractor	Managed services

A Memorandum of Understanding (MoU) has been developed with the intention that there is a partnship arrangement between the CCG and CHP with:

- Transparency of information relating to services and activity;
- Common understanding and language which is understood by partners;
- A way of working which promotes trust and respect for the work of partners;
- Objectivity and fairness: Doing what is best for the Service User;
- Recognition that the proposed model is across the health and social care economy and therefore the benefits need to be felt by all partners;
- Clarity of risk and mitigation: Recognising the risk to respective organisations;
- Maximisation of value for money across the health system;
- Clarity of benefits across the system and monitoring whether this is achieved;
- Collaboration and information sharing;
- Ability to measure and evaluate the success of joint working; and
- The Foleshill development is a pilot that will identify issues in the delivery and operation of the next generation of sustainable buildings. Lessons learnt from this project will be used to drive down lower development costs of future PassivHaus developments.

The MOU (Appendix 46) sets out the key activities, performance targets, timeframes and monitoring and reporting processes.

The initial operational period of the MoU 25 years, commencing from the FBC approval, with MoU reviewed on a quinquennial basis to ensure it is still relevant and meets the needs of the partnership. The review will coincide with the service contract renewal.

7.4 Project plan

A development programme has been drawn up and agreed by all stakeholders, this is shown in table 29.

Table 29: Project Plan

Milestone	Target date
PID approval	February 2016
High Level Options Appraisal Approval	February 2016
Commence Stage 1/OBC	March 2016
High level Design proposals	March 2016
Completion of Stage 1/OBC Business Case	May 2016
Stage 1/OBC Approvals as follows:	
CCG BOARD	June 2016
NHS ENGLAND	July 2016
CHP BOARD	Sept 2016
Commence Stage 2/FBC Business Case (gap due to agreement around financial viability)	March 2018
2nd DQI event (stage 3)	Nov 2018
Stage 2/FBC Approval	March 2020
Financial Close	March 2020
Commence Construction	March 2020
Building Operational/Practical Completion	November 2020
Client fit out	November 2020
Operational	November 2020
Post Project Evaluation (DQI Stage 5)	May 2021

7.5 Project Costs

A budget of £320,000 has been allowed for the fees associated with the delivery of the Foleshill scheme. This has been underwritten by NHSE/I and the CCG in the event that the scheme does not progress.

This budget will cover the following:

- Legal and financial transaction advice
- Development of the FBC
- Development of the detailed design
- Technical advice
- District Valuer review
- DQI assessment
- Cost Advisor

In respect of the CCG costs, the following support items are acknowledged by the CCG.

- DQI stages 4 and 5 assessments (budgeted cost, £3,000 each, plus VAT)
- Ongoing cost advice including site inspections throughout the build
- Any unaccounted costs for removal and delivery of IT equipment

7.6 Use of advisers for FBC

The following table gives details of the advisors to the projects.

Table 30: Specialist Advisers

Advisor	Who	Breadth of appointment
Architectural	The Tooley & Foster Partnership	Executive Architects to support CHP in development of concept design
Construction / Manufacture	Portakabin	Design / Manufacture and assembly of modular solution, proof of concepts
BREEAM & Passive House	The Tooley & Foster Partnership	Support to meet certification criteria
Cost management	Aecom	QS & EA to CHP
Development Manager	Arden Estate Partnerships Limited	Development management, programme and project support
Building Services	QODA Consulting	Building services support to CHP – BREEAM & Passive House
Legal	Bevan Brittan	Land transaction and contract advice
Business case production	Arcadis/Brierley Advisory Ltd	Via CCG
District Valuer	Valuation Office	Via NHSE/I
DQI assessor	CIC	Via NHSE/I

7.7 Outline arrangements for benefits realisation

The Benefits Realisation Plan (BRP) describes the objectives and benefits associated with a project and how these benefits will be delivered. It ensures that the project is designed and managed in the right way to deliver quality and value benefits to patients, staff and local communities. The BRP also defines how and when outcomes and benefits are measured.

Key benefits identified are summarised in table 31.

Table 31 – key benefits

Benefit	How benefit will be delivered
Strengthen capability of current service provision across core and non-core services	Provide modern facilities that meet modern standards to ensure current services are being delivered to a high standard.
Strengthen capability of current extensive service provision across core and non-core services	Provide modern facilities that meet modern standards to ensure current services are being delivered to a high standard.

Benefit	How benefit will be delivered
Improved quality of care	Reconfigure services and staff teams to reflect new model of care in new facilities
Clean and modern building	Design of new facilities fully involved service users and providers
Increase the capacity of service provision to meet demand from an increased local population; and a growing list of patients	Facility allows for an increase in capacity of service provision to meet growing demography in the area locally in short, medium and long term. Match the new models of care for all patient groups. Allow flexible use of rooms for provision of services
Provide facilities that encourage the integration of health and social care, allowing for new working practices and subsequently providing working efficiencies	Improve functional relationships/adjacencies and increase operational efficiency to deliver better quality care. Reconfigure services including developing primary and community services to support the new service model. Good signposting to other local services essential.
Design incorporates flexible facilities	Facilities can be adapted for alternative future use. Allocation of shared and flexible space within the facility to encourage shared working and resources. Design flexibility to support foreseeable changes in service provision or need
The facilities meet the needs of the local population, therefore providing appropriate care and catering to increase in number of patients including, children, adolescents, vulnerable adults and the elderly	Waiting areas with appropriate facilities are provided to cater for all groups
Address "legacy" estates issues to provide a safe patient environment, i.e. Statutory compliance, Eliminate high-risk backlog maintenance	Facilities can be adapted for alternative future use. Allocation of shared and flexible space within the facility to encourage shared working and resources. Design flexibility to support foreseeable changes in service provision or need
Ensure access to the facility remains "all inclusive", removing barriers to access and ensuring patients feel comfortable with their surroundings	The service offered from the premises will be all inclusive and every attempt will be made to ensure specific groups are catered for i.e. vulnerable groups and those with English as their second language etc.
The facilities provide a high degree of independence and self-care for those with special needs and disabilities.	Patient facilities accommodate the needs of independent wheelchair users. Access between related services is not an impediment to people with disabilities
Improved facilities for staff and patients, assisting in recruitment and retention	Work towards national standards. Maintain and improve wider care in the community.

Benefit	How benefit will be delivered
	Provide better staff working environment. Teaching and training opportunities
Improved patient experience	Increase in access to a range of GMS services in one location with high staff awareness of local services and signposting for patients Links with other services such as Adult Social Services, Children's Social Services and the nearby schools and the Children's Centre. Providing health related sessions to the community utilising the community facilities being provided as part of the development. A holistic approach to the community where the APMS service provider participates with other agencies in delivering good additional services to the community.
A place the local community can identify with have a sense of ownership	Good use of facilities by community, positive feedback from users
Effective care delivered by well trained staff	Sufficient numbers of medical/clinical staff required in order to deliver appropriate service
Deliver the appropriate capacity and service requirements within necessary timescales and the cost estimates	Agree brief with key stakeholders and ensure that project is delivered on time and to budget. Continued engagement throughout design phases of project with stakeholders

A copy of the project BRP is attached at Appendix 19. This will be reviewed and updated during the development of the FBC

7.8 Outline arrangements for risk management

The objective of the risk management process is to establish and maintain a "risk aware" culture that encourages on-going identification and assessment of project risks. Risk management is an essential part of the development of any project. Risk should be managed proactively through a process of identification, assessment and mitigation.

The risk management strategy incorporates the following activities:

- Identifying possible risks at an early stage and minimising or mitigating these risks, via a risk log;
- Allocating individuals responsible for each risk and a timeframe for completion;
- Agreeing processes to monitor the risks and have access to reliable and up to date information;
- Controls to mitigate against the consequences of the risks;
- A robust decision-making process supported by a framework of risk analysis and evaluation.

All members of the project team will play an active role in the identification, analysis, classification, allocation and mitigation of risks and escalating risk where appropriate to the Project Director.

Risks have been identified and compiled into a Project Risk Register, attached in Appendix 31

The Risk Register follows the methodology recommended by the Department of Health and adopted by local NHS' for corporate governance purposes. This follows the below structure:

- Risk identification and scoring from 1 to 5 of likelihood and impact;
- Allocation of risk owner and identify mitigation procedures;
- Evaluation of proximity, probability and impact of the risk occurring, and colour coded by the traffic light system to highlight the overall risks;
- Development of risk responses and agree management actions to prevent, reduce, transfer, mitigate or accept the risks. Focusing on the red and amber issues;
- Plan and resource the response to the risks;
- Monitor and report risk status.

The Risk Register is reviewed on a regular basis by the Project Team; risks are assessed and discussed at each meeting where required. Risks are scored as per a risk scoring matrix; risks of a pre-mitigation score of 16 or above are escalated to the Programme Board on a monthly basis.

At present the key risks for the scheme include:

Table 32: Key Risks

Risk	Score pre-mitigation	Score post-mitigation
Business case approval refused or delayed and managing expectations	8	15
Poor site / building conditions	12	6
Growth in capacity not achieved	9	4
Project costs incorrectly estimated	12	6
Proposal does not achieve Value for Money	15	12
Increased Construction Costs due to unforeseen circumstances	16	6
Unable to procure a suitable APMS provider	15	8
Plans for the development to achieve BREEAM Excellent status	16	6
Planning permission for the temporary accommodation expired on 30.06.18	20	6
S106 contribution draw down not received in time to support project	15	12

The full risk register can be found in Appendix 31.

7.9 Arrangements for change management

Due to the fact that there will be only one service provider in the building, there are no formal arrangements in place in this instance.

7.10 Arrangements for FBC to be made public

This Full Business Case was approved by Coventry and Rugby CCGs Primary Care Committee. Coventry & Rugby CCG are aware that a letter confirming the approval should be sent to NHS England and CHP at the time of the approval. This should be expediated efficiently to allow further approvals and so as not to hold up the project timeline.

The Full Business Case and any addenda will be published on NHS England & NHS Improvement and Coventry & Rugby CCGs website within one month from date of NHS England & NHS Improvement CFO

approval. At the same time, a press release will be issued to all local media which will include the link to the FBC on NHS England & NHS Improvement's website and the CCGs website.

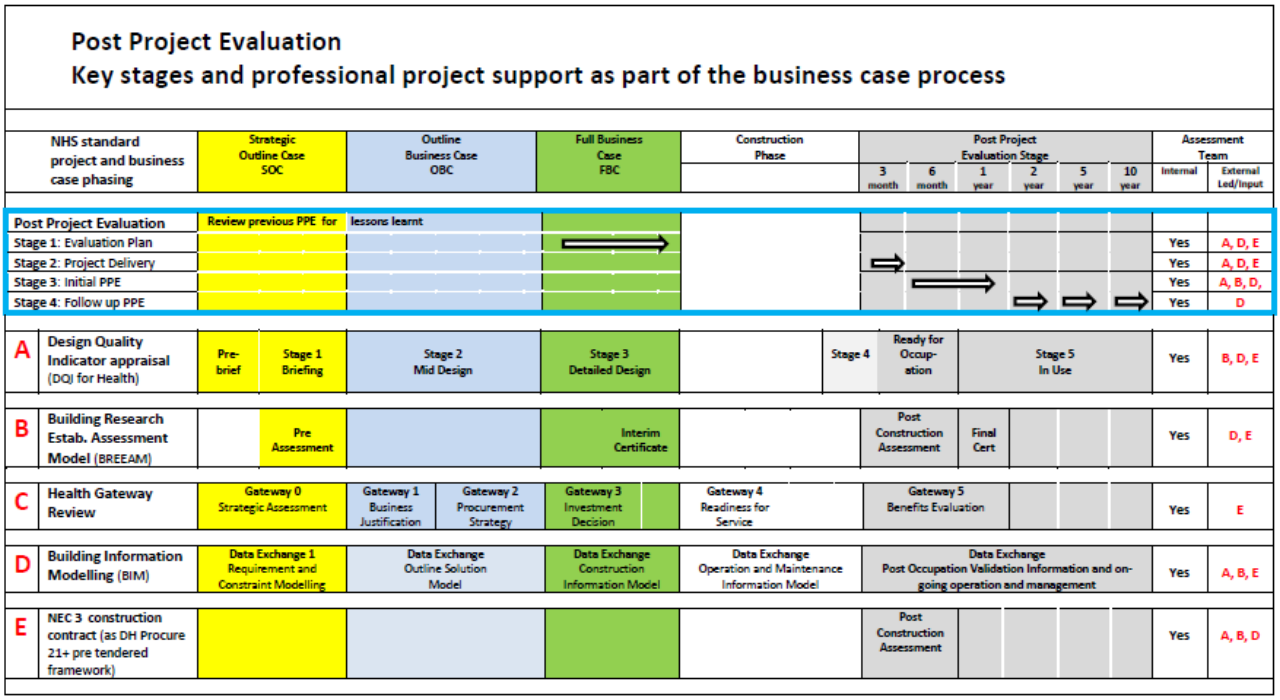
A stakeholder briefing will also be issued to key stakeholders including CCG, CHP, Local Authority, local GPs and MPs etc which will also include a link to the FBC on NHS England & NHS Improvement and the CCGs website.

7.11 Arrangements for post project evaluation

7.11.1 DQI, BIM, VOA, BRE, GSL

Figure 16 shows post project evaluation at a glance through the various stages of the project.

Figure 16: Post project evaluation at a glance



The CCG and NHS England & NHS Improvement are committed to ensuring that a thorough and robust post project evaluation is undertaken at key stages in the project, to ensure that positive lessons can be learnt. The lessons learned will be of benefit when undertaking future capital schemes.

Post Project Evaluation (PPE) also sets in place a framework within which the benefits realisation plan can be tested to identify which benefits have been achieved and which have not – with the reasons for these understood in a clear way.

Due to the healthcare element of this project, NHS guidance on PPE has been considered, this guidance is attached at Appendix 32. The proposed approach will accord fully with this during the various evaluation stages. The key stages that will be evaluated are:

- Implementation
- Shortly after the new service has been brought on line
- Once the service is well established

The following will be used to assess the effectiveness of the project at each stage:

- BIM - Building information modelling is a process involving the generation and management of digital representations of physical and functional characteristics of places.
- VOA - The Valuation Office Agency gives the government the valuations and property advice needed to support taxation and benefits.
- BRE - The Building Research Establishment carries out research, consultancy and testing for the construction and built environment sectors in the United Kingdom
- DQI - The Design Quality Indicator is a toolkit to measure, evaluate and improve the design quality of buildings. Three DQI events have been held and two more will be held - one when the building is ready for occupation and another six months after it has been operational.

This project has utilised the principles of Government Soft Landings (GSL). All five stages of the DQI process will have been followed, with stages 4 and 5 covering commissioning and post project evaluation. In addition, CHP will develop a long-term programme of robust monitoring and evaluation of the buildings performance, particularly in relation to thermal comfort, air quality, room utilisation and general use. Soft landings are important in a building that has different building service systems, some of which may be new to users, a user guide will be produced as part of the tenant induction process and in collaboration with the tenant once known, this will clearly identify the different functions for the staff using the building and the staff maintaining the building. See Appendix 43 for further design assurance.

7.11.2 Implementation

The objective of this evaluation stage is to assess how well and effectively the project was managed from the business case process through to implementation, including the construction phase.

It will be undertaken using a 360º view of the process using internal and external stakeholders.

It is planned that this evaluation will take place within three months of opening of the primary care centres and will examine:

- the effectiveness of the project management of the scheme – viewed internally and externally
- communications and involvement during the project
- the effectiveness of advisors used on the scheme

7.11.3 Evaluation of the project in use – shortly after commencement of service

It is proposed that a stage 4 DQI, Ready for Occupation, evaluation be undertaken.

The objective of this stage is to prepare a report which assesses how well and effectively the projects were managed during the initial operation of the new facility. Again, the objective is to use a 360º view of the process using internal and external stakeholders.

The evaluation at this stage will examine:

- the effectiveness of the project management of the scheme – viewed internally and externally.
- communications and involvement during initial service
- overall success factors for the project in terms of cost, time and quality
- extent to which it is felt the new facilities meet users' needs – from the point of view of service users/carers and staff.

A DQI Stage 5 PPE will be undertaken after six months of being operational.

7.11.4 Evaluation once the service is well established

It is proposed that this evaluation is undertaken approximately two to three years following the establishment of the new facility.

The objective of this stage will assess how well and effectively the project was managed during the actual operation of the service. Again, the objective is to use a 360º view of the process using internal and external stakeholders.

The evaluation at this stage will examine:

- the effectiveness of the new cohesive working practices
- the extent to which it is felt the design of the new facilities meets users' needs – from the point of view of the staff, service users and carers

7.12 Management of the evaluation process and resources to deliver

The post project evaluation process will be managed through the DQI process.

All evaluation reports will be completed within three months of the completion of the data collection. The results of each report will be made available to all participants in each stage of the evaluation and issued to key stakeholders.

7.13 Gateway review arrangements

The impacts/risks associated with the Foleshill project have been scored against the risk potential assessment (RPA) for projects.

The Foleshill project has scored a medium RPA score due to the following issues:

- further consideration to be given to governance arrangements to ensure involvement of NHS England & NHS Improvement, the CCG, CHP and other key stakeholders
- service provision continues from a temporary location
- there is an opportunity to create fit for purpose permanent accommodation, which will cater for a growing population.

The report is attached at Appendix 15.

7.14 Contingency plans

Planning permission and the land lease for the existing demountable facility are only temporary and would require renewal. Patients would continue to be seen in a portacabin on the back of a pub car park, which is unsuitable for long term delivery of quality health care. This would continue to severely impact on patient services.

8 Appendices

Appendix No.	Appendix name	Supporting Documentation
1	CHP Addendum Report	CHP Addendum v9.pdf
2	OBC approvals	Commissioner Support Letter CHP ; Signed OBC Approval Letter.pdf CHP Foleshill RH letter.pdf
3	DV Report- April 2019	DV Report April 2019.pdf
3a	DV Report – January 2020	2020-01-30 Report Livingstone Road C
4	Decision Note- Confirmation of Extension to Planning Application for demountable	Decision Notice.pdf Foleshill Planning Decision Notice 040
5	DQI report and attendance list	DQI Report April 2016.pdf DQI attendance list.pdf
6	Letter from NHSE/I to CHP confirming that they will commission services from the building and underwrite the costs for the duration of the lease	Commissioner Support Letter CHP ,
7	Planning consent	Decision Notice Foleshill.pdf Decision Notice.pdf
8	Schedule of accommodation	SoA Foleshill v10 20200227.pdf
9	DQI design stage February 2017 and mid stage November 2018	DQI report Feb 2017.pdf Foleshill GP Surgery DQI Review - Mid Sta

10	Elevations and section plans	OPP1136908 PTK-A1-ZZ-DR-A 300 OPP1136908 PTK-A1-ZZ-DR-A 300 OPP1136908 PTK-A1-ZZ-DR-A 200 OPP1136908 PTK-A1-ZZ-DR-A 200
11	1:50 drawings	OPP1136908 PTK-A1-01-DR-A 100 OPP1136908 PTK-A1-00-DR-A 100
12	VOAQ April 2016	VOAQ 2016.docx
13	VOAQ April 2019	DVS VOAQ Version 7 - Foleshill 15.04.19
14	Difference between VOAQ 1 (date) and VOAQ 2 (April 2019)	Foleshill - Tracked Changes VOAQ OBC
15	RPA report	RPA Sep 2019.pdf
16	Coventry & Rugby CCG Equality, Inclusion and Human Rights Strategy	CCG Equality Strategy.pdf
17	Planning consent for demountable	Foleshill demountable Planni
18	Planning extension request for demountable	Demountable term extension request.p
19	Benefits realisation plan	BRP.xlsx

20	Slide pack from options appraisal workshop	Appendix 5 Option appraisal slides for F
21	OBC	business-case-foles hill-brownsover OB(
22	FB forms	NHS Business Case Cost Forms CHP 260 Foleshill Aecom VfM Statement_202(
23	DV report 2016	DV Report 2016.pdf
24	Equipment Responsibility Matrix	Costed equipment schedule.xlsx
25	Planning conditions and mitigation arrangements	Planning conditions tracker.p
26	Detailed economic appraisal	GEM.xls
27	Letters of support	Letter of support for Foleshill.pdf
28	BREEAM Assessment Report October 2018	B1421 - Foleshill Surgery - BREEAM Pi
29	BREEAM update- March 2019	Foleshill Surgery - BREEAM Tracking Lo Foleshill Surgery - Tracking Log - BREE.
30	Infection Control Review	Following review of plans for Foleshill G

31	Project risk register	Risk Register updated 050919.xlsx
32	NHS guidance on PPE	PPE Guidance.docx
33	Project initiation document	Foleshill PID.doc
34	Coventry & Rugby CCG approval of Full Business Case	CCG FBC approval.pdf
35	Comparative assessment of Passive House vs Standard Design	Standard vs Passivehaus Compar
36	Delivery Plan	Delivery plan.pdf
37	CHP Technical Report July 2019	Foleshill FBC Addendum Passive De
38	Coventry & Warwickshire STP Estates Strategy – July 2018	Cov Warks STP Estate Strategy 16 07
39	Coventry & Rugby CCG Primary Care Strategy 2015-19	PC strategy.pdf
40	Coventry & Rugby CCG Sustainable Development Management Plan	SDM plan.pdf
41	NHS England & NHS Improvement Midlands Regional approval of Full Business Case	Foleshill FBC paper June 2020 - revd inc F

42	CCG confirmation of Section 106 funding letter	Letter to Julian Humphreys re S106 C
43	CHP Design Assurance	CHP Response to NHSE&I Email 24071
44	CHP Generic HoTs and Memorandum of Understanding	Foleshill Draft HoT V3.pdf
45	BREEAM Tracker (September 2019)	BREEAM Tracker Sep 2019.pdf
46	Memorandum of Understanding	Final Draft Foleshill MOU.pdf
47	STP support letter	STP support letter.pdf
48	LIFT Co approval	LIFTCo approval.pdf
49	Balance sheet & CDEL confirmation from CHP	Bal sheet and CDEl conf.pdf
50	CHP confirmation ground lease value letter	CHP Lease value.pdf
51	Long List of Options	Long List of Options.docx