NHS England

NHS Coventry and Rugby Clinical Commissioning Group

FULL BUSINESS CASE

BROWNSOVER PRIMARY CARE DEVELOPMENT

NHS England (West Midlands) and Coventry and Rugby CCG

NOVEMBER 2017

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GLOSSARY

Acronym	Meaning	Acronym	Meaning
3PD	Third Party Development	LIFT	Local Improvement Finance Trust
APMS	Alternative Provider of Medical Services	LPA	Lease Plus Agreement
BIM	Building Information Modelling	NHSE	NHS England
BRE	Building Research Establishment	NHSPS	NHS Property Services
BREEAM	Building Research Establishment Environmental Assessment Method	NIA	Net Internal Area
BRP	Benefits Realisation Plan	NPC	Net Present Cost
CCG	Clinical Commissioning Group	NPV	Net Present Value
CHP	Community Health Partnerships	OBC	Outline Business Case
CRCCG	Coventry and Rugby Clinical Commissioning Group	PCT	Primary Care Trust
DDA	Disability Discrimination Act	ETTF	Estates and Technology Transformation Fund
DQI	Design Quality Indicator	P21+	The ProCure21+ National Framework is a DH framework agreement with six Principal Supply Chain Partners (PSCPs) and their supply chains, selected by OJEU tender process for capital investment construction schemes.
DV	District Valuer	PPE	Post project evaluation
HBN	Health Building Note	PSC	Public Sector Comparator
EAC	Equivalent Annual Cost	QIPP	Quality, Innovation Productivity and Prevention
ERM	Equipment Responsibility Matrix	RPA	Risk Potential Assessment
FBC	Full Business Case	SDLT	Stamp Duty Land Tax
FM	Facilities Management	SOA	Super Output Areas
FRI	Full Repairing & Insuring (lease)	SoA	Schedule of Accommodation
GEM	Generic Economic Model	SWCCG	South Warwickshire Clinical Commissioning Group
GIA	Gross Internal Area	TUPE	Transfer of Undertakings (Protection of Employment)
HTN	Health Technical Note	VOA	Valuation Office Agency
IM&T	Information Management & Technology	WNCCG	Warwickshire North Clinical Commissioning Group
JSNA	Joint Service Need Assessment		

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1. Executive Summary

1.2 Overview

1.2.1 Purpose of the FBC

The purpose of this Business Case (FBC) is to seek approval from NHS England, NHS Property Services (NHSPS) and Coventry and Rugby CCG (CRCCG) for investment in a primary care development in Brownsover, Rugby. This FBC follows successful approval of the Outline Business Case (OBC) in December 2016. An extract of the minutes of NHS England's Board meeting giving endorsement of the OBC is available (appendix 1), also the Board of CRCCG have confirmed their support to the project (Appendix 2). The development is fully supported by local commissioners, local authorities, local MP and the general public.

It should be noted that the OBC was jointly produced with a development in Foleshill in Coventry. The two schemes are of similar size with very similar requirements and therefore it was decided that efficiencies could be achieved by this joined up approach.

Although the FBCs for both schemes are being developed separately it was agreed that wherever possible efficiencies and economies of scale would be sought and referenced in both FBC documents. There were some small savings to be made by hosting joint DQI events but due to the gap in advancement of the Brownsover scheme in comparison with Foleshill further efficiencies are unlikely.

1.2.2 Background

In April 2015, Albert Street Medical Practice and its branch surgery in Bow Fell Brownsover closed and patients were transferred to a caretaker practice in Lower Hillmorton Road. This scheme does not therefore replace an existing primary care facility.

At the time of the closure of the GP surgeries in Albert Street and Bow Fell, 'caretaker arrangements' were put in place to offer health services from temporary accommodation in Lower Hillmorton Road, Rugby. This arrangement continues up to the present time. This arrangement is not ideal for a number of reasons;

- The building is in a house that was converted into a GP surgery. This was closed but subsequently brought back into commission on a temporary basis.
- The building is in bad repair, there are holes in the floor, the bannisters are unsafe and there is damp and mould in the basement
- The building is not close to Brownsover and patients have to catch a shuttle bus to the surgery which takes around 25 minutes

1.2.3 The new facility

The new facility will be in the centre of Brownsover (by reducing at least half the distance). Patients will benefit from a purpose built practice using the latest healthcare design standards. The new facility will look to meet demand of c10,000 patients, thereby significantly enhancing the local service provision and helping to meet the NHS 5 Year Forward View objectives in the catchment area.

It is planned that the development will accommodate a mixture of primary care and community services with benefits to patients including close, accessible care; new, clean and safe facilities and provision of a range of services under one roof.

Figure 1 shows the location of the current and proposed sites.

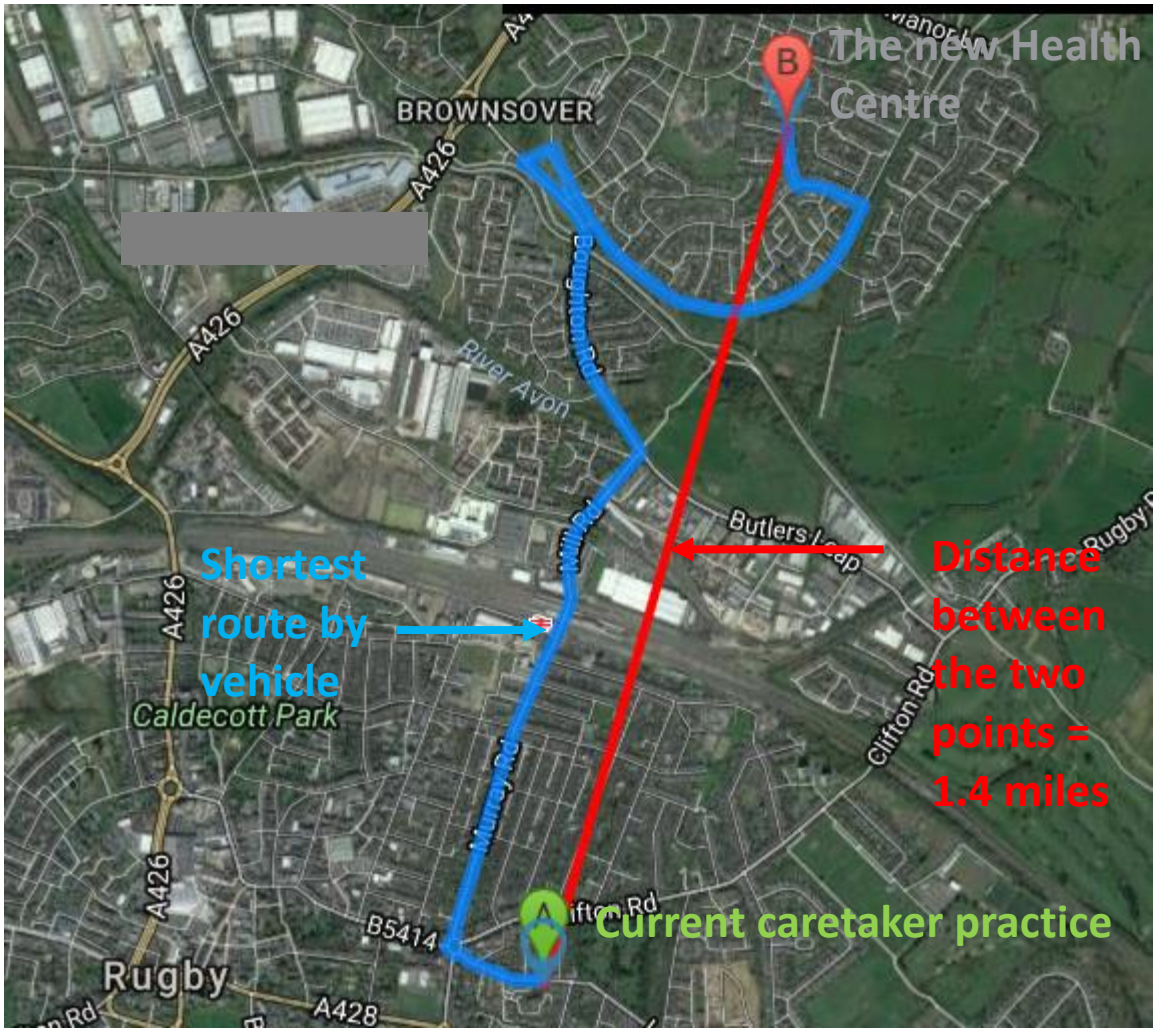


Figure 1 Map of current and proposed site with distance[i].

1.3 Strategic case

1.3.1 National

The NHS nationally is facing a number of challenges including:

- A greater life expectancy;
- Increased number of people living with long term conditions;
- Pressure to stay within budgets and to cut costs;
- Increasing levels of backlog maintenance: and
- Ongoing statutory and regulatory requirements around sustainability and energy consumption, carbon footprint and waste.

The pressure is on the NHS both nationally and locally to explore new ways of working and service provision to rise to these challenges and provide a more engaged relationship with patients, carers and the local community to promote wellbeing and prevent ill health.

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

[i] Source Google maps

The Brownsover development meets the demand of these national requirements by:

- Providing patients with care closer to home and reducing admissions to local acute hospitals;
- Promoting wellness and preventing ill health within the community; and
- Being a centre designed to meet the latest standards for health care buildings, with the flexibility to meet the changing demands of the local population.

1.3.2 Regional

The three Clinical Commissioning Groups in Coventry and Warwickshire (South Warwickshire CCG, Warwickshire North CCG and Coventry & Rugby CCG) have agreed to work together to achieve common aims and to become a larger unit of planning, utilising resource in the most efficient way to rise to local challenges.

Some of the local challenges the CCGs face are:

- Continued growth in population;
- Aging population;
- A more ethnically diverse population; and
- A life expectancy gap between more and less affluent households in the area.

The Strategic and operational plans 2014/2015 – 2018/2019 created by the CCGs in collaboration with local communities, third sector and voluntary organisations sets out a number of risks:

- Financial targets;
- QIPP delivery (see section 3.3); and
- A&E Performance.

In order to inform the strategic plan for the area and address the risks identified, the principles of the Coventry and Rugby CCG's approach to transformation are:

- To deliver care closer to home;
- Specialist care in the right place, at the right time;
- Enable 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; and
- Mental disorders are treated on par with physical disorders.

Delivery of the Brownsover scheme will address these needs by:

- Creating a locally accessible primary care spoke where services relevant to patient's needs are delivered;
- A new building means that space could be optimised providing for efficiency of use; and
- The building would be designed to be a flexible model for future service delivery and would be a light modern space to promote wellbeing for both patients and staff.

1.3.3 Local

The scope of this business case is to build a new Health Centre to meet the growing population of the Brownsover area. The building will be flexible enough to accommodate growth in the area in respect of new housing estates and an expected list size of 10,000 patients.

A business case for a new building in Brownsover was originally written in 2010. At this time, the main surgery building was located at Albert Street near Rugby town centre with a branch surgery in Bow Fell,

Brownsover. Both premises were closed when the contract with the then service provider ended on 17th April 2015.

At the time of the closure of the GP surgeries in Albert Street and Bow Fell, 'caretaker arrangements' were put in place to offer health services from temporary accommodation in Lower Hillmorton Road. This arrangement continues up to the present time.

The development outlined in the original business case was to be built on a piece of land next to the branch surgery premises in Bow Fell, Brownsover. This land, by the Brownsover local centre is owned by Rugby Borough Council who are continuing to make it available to NHS Property Services for the purpose of building the new health centre.

1.4 Economic Case

1.4.1 Background

Robust option appraisals on the possible solutions for a need of a new primary care centre in Brownsover took place at OBC stage and were included as part of the economic case. These comprised a non-financial and financial appraisal, which when combined identified the preferred option for the scheme

1.4.2 Non-financial option appraisal

On 26th April 2016, a non-financial option appraisal workshop was held (jointly for this and the Foleshill scheme) which included key stakeholders. These included representatives from service providers, the CCG, NHS England and patient representatives.

Discussions took place around possible options for service delivery resulting in a long list of options being created. The strengths and weaknesses of each of those options was appraised and the stakeholders came to a consensus on which options to take forward to a shortlist.

Once shortlisted, the key benefits of the project 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 building on Brownsover Local Centre site

Since the OBC was approved, the CCG have commissioned The Design Buro to undertake an estates strategy. Within this strategy the preferred option is still demonstrably the clear choice and only option to move forward with this project. Section 5.2.1 of the strategy (appendix 9) states:

> In terms of the Brownsover proposal, we have studied the current location of practices and list sizes for a 1 mile and 2 mile radius. We have also plotted all major housing developments resulting in the provision of over 2,200 dwellings as laid out in the proposed Planning Authority Local Plans.
>
> The plan demonstrates that there is currently no alternative GP provision within the 1 mile radius and within the 2 mile radius GP provision is clustered on the historic Rugby centre, whereas the majority of the proposed housing growth is to the North and South East.
>
> By looking at the proposed capacity and future growth up to 2031, you will see that the proposed development has capacity to meet current and future projected growth. The development will also remove the temporary provision of the Rugby Town Medical Centre.

1.4.3 Quantitative benefits- economic appraisal

A quantitive appraisal was also undertaken on the shortlisted options. A detailed appraisal of the costs and benefits associated with each of the options was carried out and the option which provides the greatest net economic benefit was identified.

The outcome of this analysis identified the following as the preferred quantitive option:

- Do minimum, remaining in the existing accommodation for the short term

The 'Do minimum' option would mean remaining in the temporary facility for the short term. However, a longer-term solution would still be required as the temporary solution is only viable for a maximum of 2 -3 years.

1.4.4 Identification of the preferred option

Following a detailed cost benefit analysis, the preferred option for the Brownsover scheme is to provide a new build development on the Brownsover Centre site.

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

1.4.5 Confirmation of value for money by the District Valuer

The District Valuer sent her report on 25th October 2017 (Appendix 40) in which she confirmed that the scheme is value for money. *"I am of the opinion that a rate of £181m2 (FRI) on the net internal area and £275 per car parking space (FRI) is appropriate for the proposed subject premises and have therefore valued accordingly".*

The breakdown of costs in the report is as follows:

Ground + First floor: 522.60 @ £181.00 per m2		£94,591
11 car parking spaces @ £275 each		£3,025
Total		£97,616
	Say	**£97,625 pa (FIR)**

This assumes a valid practical completion letter is issued within 2 years of the date of the report. The VFM annual rental figure on a Tenant Full Repairing and Insuring (TIR) lease is **£97,625** plus VAT.

1.5 Commercial Case

This section sets out the commercial arrangements for the project and explains how the delivery of the new centre will take place. In addition, this case details the strategies for the provision of equipment and IM&T and identifies the key risks the project faces along with who is best placed to manage these risks.

Brownsover is not located in a LIFT area, therefore NHS Property Services (NHSPS) will lead the delivery of the new facility using NHS capital, with the APMS contractor taking a lease with suitable guarantees from the local commissioners.

1.5.1 Procurement of contractor

At the beginning of the procurement for the scheme, a list of nine potential contractors for tender was drafted following input and recommendation from the Design Team and NHSPS. A pre-qualification questionnaire (PQQ) was issued to all nine contractors with positive responses received from six contractors. The response was generally positive, and six contractors fulfilled the requirements of NHS PS to ensure the tender process provides healthy competition.

The PQQ's were reviewed by Quadrant Surveying Ltd and all met the requirements of NHS PS and recommended for inclusion on the Tender List. Shortly prior to Tender Issue one contractor withdrew from the process resulting in five tenderers remaining. Whilst undesirable to have less than six tenderers; it was agreed to proceed.

The Tender Documents, including a comprehensive Employers Requirements with appendices based upon JCT Design and Build Contract 2016 with NHS PS amendments were issued to tenderers through NHSPS Bravo Procurement on 16 June 2017. The period to produce and complete design information was shorter than usual procurement allowances and this resulted in a number of Tender Addendums being issuing leading to an agreement to extend the Tender Return to 4 August 2017.

Upon immediate review of the Tender Bids, it was clear that the returns were all above budget and required further review and analysis to enable Value Engineering (V.E.) to be undertaken. Quadrant provided an Interim Tender Report which recommended the two most competitive tenderers be invited to proceed with a value engineering exercise upon NHS PS advice, this number was increased to three and formal documentation was issued to request Value Engineering be undertaken.

The value engineering returns confirmed there was still disparity between the second and third most competitive tenders and as such Quadrant recommended post tender contractor meetings be convened with the two most competitive contractors to discuss their V.E. returns and also general requirements of their original Tender Bids. These meetings took place 7 September 2017 and Quadrant liaised with both contractors to agree fixed revised Contract Sum Analysis documents based upon the value engineering process and those meetings. This enabled Quadrant to provide NHS PS with a Final Tender Report on Monday 11 September providing recommendation of which contractor to appoint for the Works.

NHSPS have confirmed that the value engineering exercise did not create any derogations within the design.

It should be noted that the contract will hold their price until the end of November 2017

1.5.2 Land

An original Cabinet report in 2013 approved in principle the transfer of the land to the local GP as part of the original proposed GP led scheme. In December 2015, the Council discussed with NHSE the current intention to deliver the scheme following the collapse of the original GP led scheme and subsequently confirmed that they continued to support the proposal and to maintain the land allocation agreement.

NHSPS have agreed with the Council that they will provide 100m2 of community space in a building adjacent to but separate from the Health Centre. This space will be owned and controlled by the Council.

The proposal was presented at a public consultation exercise by Rugby Borough Council, which included RBC Cabinet members, local community groups and residents in Brownsover. There was a positive reaction and the layout and configuration of the accommodation in support of the 100m2 was agreed. NHS PS has subsequently agreed the level of specification with Rugby Borough Council and the necessary legal documentation has been prepared for signature in support of the land transaction. The land transaction will be completed after the approval of the Full Business Case.

1.5.3 Design of the new facility

Figure 2 The new building approach elevation

The new building will be a two storey GP surgery with a separate but adjacent community area.

The building will be mainly brick built with some timber and glass highlights. The shaping of the building fits neatly with the natural slope of the site ensuring local residents can see an interesting stepped shape rather than a solid box.

The approach to the building is intended to be light and welcoming with easy access for wheelchair users and on entering the building patients and visitors are greeted by a curved reception in front of them through a short lobby area.

The ground floor will be comprised of public areas, reception and waiting areas, with two flexible group rooms. Beyond the reception area the building is laid out in a linear fashion with five consultation and two treatment rooms opening off a long corridor, the layout naturally preserves privacy for patients as there is clear delineation between general circulation space and consultation/treatment areas. In addition to the rooms in this area, there is also a consultation room, a clean and dirty utility, specimen room and stores.

The first floor is for administrative use only and there is no patient access to this area.

The final design of the building is the result of an original architectural concept and subsequent input from a variety of stakeholder groups including the patient action group, clinicians (including infection control), service leaders, GP representatives, NHS England representatives and suppliers through various DQI stages.

1.5.4 DH Consumerism

A consumerism compliance document has been written by the architect outlining how the building addresses key DH Consumerism requirements. Table 1 provides a summary of how this is to be achieved

Consumerism requirement	Example of how this can be addressed
A design that provides acceptable levels of privacy and dignity at all time	Adequate personal space in seating areas. Acoustic requirements in design. Acoustic report attached (Appendix 43)
High specification fabric and finishes to reduce lifecycle costs	The external fabric of the building will be completed to HBN “Core Element Standards”.
Natural light and ventilation	Large double-glazed and thermally efficient aluminium windows will be provided within the external envelope of the Building

Zero discomfort from solar gains	Careful internal planning has reduced potential user discomfort from solar gain as more specialist highly serviced clinical accommodation has been located, deep into the floor plate, away from the external wall.
Dedicated storage space to support high standards of housekeeping and user safety	A number of store rooms have been provided, to the rear of the clinical accommodation.
Dedicated storage for waste awaiting periodic removal	A waste store has been provided, to the rear of the clinical accommodation.
Single sex toilet facilities	Single sanitary and washing accommodation has been provided.
Immediate access to patients to call points for summoning assistance	Individual treatment and sanitary accommodation will be provided with staff and emergency call systems, which will be allowed for within the design.

Table 1 DH Consumerism requirements

1.5.5 Planning consent overview

Conditional planning consent for the scheme was granted on 15th June 2017.

There were 14 conditions that were issued with the planning consent. These are summarised as:

1. The development must start no later than the expiration of 3 years after the date of the consent
2. The development must be carried out using the plans submitted with the planning application
3. Details of colours, textures and materials must be approved by the council prior to commencement of the work
4. Details of external refrigeration/air handling units must be provided and approved by the council
5. A construction management plan must be submitted to and approved by the Council prior to commencement of works
6. An external lighting scheme must be submitted to and approved by the Council prior to commencement of works
7. Works restrictions in respect of hours of work will apply (Mon – Fri 7.30am – 18.00pm and Saturday 8.30am – 13.00pm with no work on Sundays and bank holidays)
8. The opening hours of the community facility is restricted to 06.00 – 23.00 (a temporary event notice can be applied for outside of these times)
9. Windows and doors must be shut in the community venue when music is being played
10. A bat/bird box scheme must be submitted and approved by the Local Planning Authority prior to the commencement of the development
11. The landscaping scheme, as detailed on the approved plans shall be implemented no later than the first planting season following first occupation of the development.
12. Accommodation for car parking as per the submitted plans must be provided before occupation of the development
13. A green travel plan must be supplied, and approval will need to be given in writing by the Local Planning Authority.
14. No development shall commence until a specification of all proposed tree planting has been approved in writing by the LPA.

Each of these conditions has been considered and a plan is in place against each one for mitigation. It is not expected that any of these points will cause delays to the scheme progressing as per the project plan contained within this business case.

Additionally, to these conditions, the LPA have issued a number of informative points to be considered during construction, these are mainly based around wildlife and planting.

1.5.6 Equipment

As the build contract for the project is for purely design and build of the new health centre, the tenants will be responsible for procurement of much of the medical fixtures and fittings, the loose furniture and any Group 2 or 3 equipment. The cost of group 1 equipment has been included in the costs for the scheme.

NHSPS will be procuring Group 1 equipment as part of the project, equipment in groups 2 and 3 will be procured through Coventry and Rugby CCG in conjunction with the user requirements. Equipment requirements have been established through use of the ADB sheets as generated from each room by NHSPS as part of standard room fit outs shown in the HBN's, the output from this has been turned into a fully costed equipment schedule (appendix 3) for groups 2 and 3. Service provider/s will be responsible for procuring their own specific medical equipment and supplies.

Some equipment will be transferred from the existing facility to the new healthcare building, this has been set out in the equipment list and the cost saving shown. In summary, the combined group 2 and 3 equipment costs are **£48,935**, offsetting the cost saving of **£14,475** for transferring existing equipment results in a total of **£34,460.**

1.5.7 Schedule of Accommodation

The schedule of accommodation developed at OBC stage and sized to accommodate a list size of 10,000 patients has been reviewed and updated appropriately. A summary of the schedule of accommodation is shown in table 2

Activity space	Quantity of rooms	Total area m2
Public spaces, Entrance, reception, waiting, WC's	9	103.3
Clinical spaces, consulting rooms and treatment rooms	7	112
Support spaces, clean and dirty utilities, stores, plant room, cleaners room, specimen WC and IT hub	10	95
Staff spaces i.e. office areas	2	51.4
Staff support areas i.e. record stores, changing rooms etc.	8	86.8
Total NIA		448.5*
Gross internal area (GIA) GF		444.6
Gross Internal Area (GIA) FF		179.5
Total Gross Internal Area (GIA)		624.1

Table 2 - summarised schedule of accommodation

The GIA is 624m2 vs the OBC allowance of 627m2.

The NIA is lower than the figure confirmed within the OBC (537m2 vs 564m2). At OBC stage there was only high level design and the NIA calculation was based on a notional reduction of 10% on the GIA allowance within the initial SoA.

The actual NIA (lettable areas) reflects a 14% reduction on the GIA and is largely attributable to the provision of a 2 storey building, (staircase GF and FF). At OBC stage a single storey building was envisaged, however once the design team were appointed after the approval of the OBC and a design solution offered that incorporated the required Community Centre it was clear that a single storey building was not practical.

*The NIA in the district valuer's report is 522.6m2 as per RICS guidance note 60 with the Total GIA remaining at 624.1m2

1.5.8 Design Principles

A number of design considerations had been outlined in the commercial chapter of the OBC, these have been addressed in the FBC. Table 3 shows the original considerations and how these have been addressed.

Original requirement	Addressed by
Referenced to a set of drawings based on the schedule of accommodation	Drawings and schedule of accommodation both form part of this FBC
That the build would include flexibility and show a clear understanding of adjacencies and patient flow	Design created through DQI sessions and driven by various stakeholders including clinicians, service leads, patients and infection control*
Building measurements and capacity was shown including GIA	Shown on Schedule of accommodation
BREEAM and BIM would form part of the design	Both form part of the design and are addressed in this business case

Table 3 – original design requirements and how they have been addressed

There is one outstanding query on the design currently, the lobby door on baby change and infant feeding may be a security risk. This could be considered for removal if the commissioners would prefer, it is suggested that a risk assessment by the H&S team is undertaken prior to any final decision being made.

The FBC estates standards are based on compliance with HBN 11-01 - 'Facilities for primary and community care services' and all HTM standards referred to / applicable to healthcare accommodation. DH Consumerism issues affecting the design of the facility are covered through compliance with HBN and HTM standards.

In respect to the commitment to the Government Construction Strategy and with regard to construction cost reduction this is reflected in the FBC by benchmarking construction costs against tendered work packages.

The project is on target for BREEAM excellent.

1.5.9 DQI

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

1.5.9.1 DQI Stages 1 and 2

A DQI event was held with key stakeholders on 22nd April 2016 incorporating the first two stages of the DQI process. The team wanted to test the:

- strength of the existing brief

- assess functionality and
- to revisit the potential of the site.

The brief 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.

The intent of the workshop was to validate the work carried out to that point in time to support the draft OBC and proposed Schedule of Accommodation. Two architects were asked by NHS England to undertake an outline design of the proposed facility. The team wanted to test the strength of the existing brief. This was a useful exercise as it raised questions on both functionality and the site. Local authority representation contributed positively to the discussion.

The two architects presented their concept designs. All parties present completed assessments for the design and these were summarised in the report (appendix 4) it also shows the concept designs presented at this time. Figure 3 shows an excerpt from the analysis of the assessment exercise from this first DQI session.

The session ended with all present confirming that positive progress had been made.

RESPONDENT	LIKES	DISLIKES
Participant 1	Needs to respond to current and future needs, particular concern Brownsover	None
Participant 2	Natural light	Lack of character
Participant 3	Circulation space, natural light and ventilation	Artificial light, air conditioning square oblong block
Participant 4	Considered functional content, consideration of patient needs.	None
Participant 5	None	None
Participant 6	None	None
Participant 7	None	None
Participant 8	Good locations and access, focus on patient experience, sustainable designs	Liners design/number of CP spaces/outdoor spaces to open
Participant 9	None	Building should promote well-being
Participant 10	Economical and Functional/Murphy Philips approach/shared input from client groups	Not focused on place /no input from GP/earlier input from stakeholders

Figure 3 - excerpt from the analysis of the assessment exercise from the first DQI session

1.5.9.2 DQI stage 3

In February 2017, the third Stage DQI event took place, in attendance were 15 relevant stakeholders, this representation included CCG's, NHSE, local authority, Patient Action Group, and Healthwatch.

The intent of the workshop was to validate the work carried out by preparing RIBA stage 2 designs to support the business case and the schedule of accommodation for 10,000 patients. The architects (now appointed by NHSPS) made a strong presentation and included plans, elevations, massing and visualisations.

There were positive reviews of the plans.

Figure 4 shows an excerpt from the analysis of the assessment exercise from this DQI session. Figure 5 shows the comparison between the first sessions and this mid-term session.

RESPONDENT	LIKES	DISLIKES
Participant 1	good design will fit into local area	Provide drop off area
Participant 2	Ease of movement in the centre	none
Participant 3	Scale of building/simplicity of design	no door to toilet lobby
Participant 4	Like stepped solution/internal flows	Provide drop off
Participant 5	respects surrounding properties/ use of landscape	None
Participant 6	respects surrounding properties/potential to separate clinical and community spaces	None
Participant 7	Design well though out	Concern with relationship with residential properties
Participant 8	Modern building	Small reception
Participant 9	Open and welcoming/sympathetic to surroundings	Stepped relationship to community centre
Participant 10	efficient layout/economical good use of materials	none
Participant 11	Careful design/impact on community	None
Participant 12	Stepped elevation/use of brick	None
Participant 13	good use of site and locality	Concern about step and provision for partially sighted
Participant 14	Simple engineering design/good interiors	landscape limited
Participant 15	stepped design /internal flows	car park drop off

Figure 4 - excerpt from the analysis of the assessment exercise from the mid design DQI session

1.5.10 VOA checklist

As part of good practice and assurances, a Valuation Office checklist has been completed (appendix 5). This document assists with identification of key areas of compliance of the development of the premises. An analysis was undertaken to show the difference between the initial VOA checklist submitted at OBC stage and the new checklist completed post detailed design. The checklist comparison is summarised in table 4. It should be assumed that sections not referenced below are compliant.

Section number/name	Comment/change
1.03 Compliance	This is confirmed as true except for: Treatment rooms to deliver level 1 services Non Invasive and minimally invasive procedures. Design undergone extensive consultation with CCG Infection Control Lead.
3.06 External envelope: cladding and infill panels	The building has some localised decorative timber cladding which is fixed to the external cavity masonry walling however its function is purely decorative, it offers no thermal, weathering or structural performance. For this reason, we don't believe Section 3.06 is relevant therefore it is un-checked.
3.07 External envelope: Windows	The intention would be for the 1st FL windows to be cleaned externally
	The building facade is accessible to the public as there are no boundary security fences, so a landscaping scheme has been developed to restrict access to building elevations/rooms where confidential discussions are likely to take place.
4.03 Internal elements: walls	Robust metal stud partitions will be used for WC accommodation
4.04 Internal elements: Partitions	Confirmed, an Acoustician has been appointed and recommendations incorporated into the tender documents in order to comply with the speech privacy requirements.
4.05 –Internal elements: Doors	Compliance with HBN00-04 Circulation & communication spaces will take precedence for key areas which equals or betters BS8300
4.06 – Internal Elements: Ceilings	Treatment rooms to deliver level 1 services Non Invasive and minimally invasive procedures. Design undergone extensive consultation with CCG Control of Infection Lead.
4.08 Internal finishes	Plasterboard metal stud partitions are either taped and jointed prior to direct decoration or receive a plaster skim finish. All masonry walls to receive 2 coat plaster finish, therefore agreed.
5.00 Resilience	There is no requirement for a permanent generator facility. The facility to plug in a stand-by generator should the need arise had been provided. The provision of UPS will be two fold and driven by need both tenant driven; 1. The need to support voice and data services. 2. Support to any other business critical systems.
6.03.01 Cold water supply and storage	No cold water storage is proposed on this project.
6.08 Electrical services	N/A Health Centre is single Occupancy
6.08.3.4 light switching arrangements	This will be the case in all areas except the waiting area, so the public have no access to switches
8.0 BREEAM Healthcare (New build Projects > £2million total cost inclusive VAT)	Rainwater harvesting BREEAM credit is not being sought therefore box is unchecked

Table 4 - valuation checklist comparison summary

1.5.11 Project synergies

Early project synergies between the Foleshill and Brownsover projects were sought to maximise opportunities such as joint preparation of the OBC and the DQI events however the schemes are now at very different stages of development and future cost savings will be unlikely.

1.5.12 Lease terms

NHSPS will use generic Heads of Terms (Appendix 6) for lease arrangements.

1.5.13 Community space

In return for the provision of the land, NHSPS has agreed to include as part of the new facility an area of 100m2 for community use. This will be a separate building to the health element on the site but will be in close proximity which will mean good access to a range of groups within the local community. Having these two elements on one site allows effective and high quality services to be delivered, as well as promoting a sense of ownership for the local community.

NHS PS has worked extensively with Rugby Borough Council in determining the requirements for the Community Centre. The proposal for the Community Centre remains for a building of 100m2 GIA and required a community consultation as provided for within the original Cabinet Approval in 2013, this took place from March 2017, concluding on 5th May 2017. Following a positive outcome to the consultation a formal planning application was submitted with an approval received following the Planning Committee meeting on 14th June 2017.

NHS PS instructed an independent Surveyor – Montague Evans to value the proposed freehold that would be transferred to NHS PS. The market valuation based on C3 – residential use exceeds the cost of building the Community Centre. Heads of Terms have been agreed with Rugby Borough Council and the formal legal documentation supporting the land transaction will be drafted ready for signing on confirmation of the approval of the Full Business Case.

The site has been independently valued by Montague Evans and the valuation for the land to be retained by NHSPS is £300K. The outturn cost of the development of the Community Centre, including professional and statutory fees is £271,238 – referred to in this FBC as the capital land value. NHSPS have appointed solicitors Freeth LLP who are liaising with the “in house” legal services of Rugby Borough Council. Heads of Terms for the land sale for a peppercorn have been agreed and formal legal agreements have been drafted for completion in anticipation of approval to the FBC on 30th November 2017.

1.6 Finance Case

An affordability analysis has been undertaken for the Brownsover scheme. The additional revenue cost compared to current cost is £50,900 as reported in the OBC. NHS England have reviewed the additional rent reimbursement and associated costs payable to the GP Practice under the Primary Care Premises Costs Directions, and following advice from the District Valuer, consider 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.

1.7 Management Case

1.7.1 Project management

The Brownsover project is led by Coventry and Rugby CCG, who are working in collaboration with NHSPS. The project delivery will be managed by NHSPS.

The project is structured with NHS England and Coventry and Rugby CCG as sign off authorities and NHSPS delivering the scheme. Within NHSPS are various key workstreams who report into NHSPS's project manager. These workstreams are

- Technical
- Building contractor
- FM
- Operational

A dedicated project team is in place this is summarised in table 5.

Project team member	Company
Project Manager	Quadrant Surveying Ltd
Architect	The Design Buro (Coventry) Ltd
M&E Advisor (including heating and ventilation)	Stewart Associates
Structural advisor	JMS Consulting Engineers Ltd
Civil engineer	JMS Consulting Engineers Ltd
QS/cost advisor	Quadrant Surveying Ltd
BREEAM Healthcare Assessor	Scott, White & Hookins LLP
Principal Designer	Quadrant Surveying Ltd

Table 5 – project team summary

1.7.2 Key deliverables

The key deliverables of the scheme are:

- Design and construction of the new Brownsover primary care centre with all associated clinical and non-clinical support services
- Relocation of primary care services from the caretaker practice at Lower Hillmorton Road to the new centre

1.7.3 Project plan

A summary project programme has been developed for the scheme which shows an anticipated operation date of November 2018 the key milestones of the project are shown in Table 6

Milestone	Target period
Planning consent	15/06/2017
Procurement of contractor	September 2017
FBC approval and publish	10/11/17 - 30/11/17
CRCCG Primary Care Committee approval	22/11/17
Financial Close	30/11/17 – 7/12/17
Site set up	08/12/17 – 26/1/18
Construction period	26/01/18 – 08/11/18
Commissioning and handover	09/11/18 – 23/11/18
Building Operational	26/11/18
Post Project Evaluations commence	03/12/18

Table 6 – key milestones from Project Plan

The cost of professional fees including disbursements and legal costs for the production of the FBC is £170,848 excluding VAT.

1.7.4 Benefits realisation plan

A Benefits Realisation Plan was developed at OBC stage for the project. This has been reviewed for the FBC by NHS England, the CCG and NHS Property Services. These benefits will continue to be monitored at regular intervals during the delivery and operation of the project. The main benefits identified are:

- The facilities 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;
- The facilities provide a high degree of independence and self-care for those with special needs and disabilities;
- Improved facilities for staff and patients;
- Improved patient experience;
- A place the local community can identify with and have a sense of ownership;
- Effective care delivered by well trained staff; and
- Deliver the appropriate capacity and service requirements within necessary timescales and the cost estimates.

1.7.5 Risk register

A risk register has been developed which identifies the key risks for the Brownsover scheme. A mitigation plan, and where possible estimated financial impact has been developed for the high risk items. This continues to be reviewed on a regular basis. The key risks identified in order of severity and prior to and after mitigation plans being applied are shown in table 7

Risk	Score pre-mitigation	Score post mitigation
Proposal does not achieve value for money	20	5
Unable to procure a suitable APMS provider	15	8
Delays due to inclement weather	12	12
Increased construction costs due to unforeseen circumstances	12	2
NHS business case and approvals not in place	12	12
Delay in signing off contract documents	12	12
Risk to public due to location of site	10	5

Table 7 - key risks in order of severity pre and post mitigation

1.7.6 Project evaluation

Clear guidance for evaluation of the project during and after its lifecycle has been developed. This includes undertaking review at regular intervals during the operation of the new facilities. The Post Project Evaluation will include the use of BIM, DQI and the monitoring against the Valuation Office checklist

1.8 Key financial information

The total cost of the project is £2,101,704, the elements that comprise cost are shown in table 8

	£
Capital Cost	2,101,704
Construction contract	£1,408,078
Professional fees including legals	£ 231,324
Land cost (Community Hall)	£ 271,238
Sub total	**£ 1,910,641**
NHSPS developers charge	£ 191,064
Total	**£ 2,101,704**

Table 8 key financial information for the scheme

2 Introduction

The purpose of this Business Case (FBC) is to seek approval from NHS England, NHSPS and Coventry and Rugby CCG for investment in a primary care development in Brownsover, Rugby. This FBC justifies the requirement for capital and revenue investment to construct modern healthcare facilities for General Practice (GP) services provided in the Brownsover locality.

A PID for a new building in Brownsover was originally written in 2010. At this time, the main surgery building was located at Albert Street near Rugby town centre with a branch surgery in Bow Fell, Brownsover. Both premises were closed when the GPs' contract ended on 17th April 2015. At the time of the closure 'caretaker arrangements' were put in place to offer health services from temporary accommodation in Lower Hillmorton Road. This arrangement continues up to the present time.

The Brownsover FBC follows successful approval of the OBC in December 2016. The development is fully supported by local commissioners, local authorities, local MP and the general public.

This FBC has been produced using the Treasury's Five Case model format for business cases, as set out in guidance provided by NHS England. The following chapters are addressed:

- **The Strategic Case –** sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
- **The Economic Case** – recaps on the option appraisal process followed at OBC and the relevance of the outcomes at FBC. The main focus on the case is value for money.
- **The Commercial Case –** outlines the content and structure of any commercial aspects of the project.
- **The Financial Case –** assesses the affordability and proposes the funding arrangements of the preferred option.
- **The Management Case** – explains 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. Background & Project Scope

Any questions or requests for further information in relation to this Full Business Case should be addressed to Kerry Biggs, Senior Contract Manager/Primary Care Premises Lead – NHSE West Midlands, via kerry.biggs@nhs.net

2.1 Organisational profile

This project is sponsored by Coventry and Rugby Clinical Commissioning Group and will be delivered by NHS Property Services.

2.2 Coventry and Rugby Clinical Commissioning Group

The Coventry and Rugby Clinical Commissioning Group (CRCCG) was licensed from 1 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.

CRCCG comprises 71 member practices across Coventry and Rugby working in 3 locality groups with a registered population of 431,000, which includes some of the most deprived areas in the country. Rugby, as a borough, has a natural boundary. The Coventry and Rugby practices all work together over key decisions.

CRCCG works closely with other healthcare organisations within the local health economy – NHS Warwickshire North (WNCCG) and South Warwickshire CCGs (SWCCG), the Arden /Greater East Midlands Commissioning Support Service, the local area and regional teams of NHS England and local authorities in Coventry and Warwickshire. Risk and control issues are considered and reviewed with these organisations as appropriate, for example, with the local authorities through the Joint Adult Commissioning Boards, Better Care Fund, Health and Wellbeing Boards in both Coventry and Warwickshire and the System Transformation Board.

CRCCG has developed 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. Its commissioning

intentions were developed in partnership with its provider trusts, GPs, local authority and council organisations, voluntary sector organisations and members of the public, to ensure that the right services for the CRCCG's population are commissioned.

Figure 6 CRCCG Vision and Values

NHS Coventry and Rugby CCG has a locality structure consisting of Godiva, InSpires and Rugby.

2.3 Project scope

The scope of this project is to build a new GP practice to meet the growing population within the area. The building will be flexible enough to accommodate an expected list size of 10,000.

The new Brownsover Centre is a key enabler for the sustainable delivery of health services in the locality. The project aims to support the development of integrated models of care in Rugby, centred around the patient, in a community setting and to provide a new Practice in place of a temporary 'caretaker' practice arrangement that is not sustainable in the long term.

The new centre complements the national NHS Five-Year Forward View, the General Practice Forward View and the Coventry and Rugby Health and Wellbeing Board strategies for the future of health services, providing seamless provision of care and support for patients in their local environment.

The future shape of health services in Rugby will be driven by a desire to fulfil the CRCCGs vision as set out in figure 6. This means providing primary care services available to Brownsover patients by shifting care closer to patients' homes, delivering care efficiently through networks of practitioners working together and integrating health and community services.

2.4 Local Stakeholders

The key project stakeholders are:

- Coventry and Rugby CCG,
- NHS England,
- Rugby Town practice (the caretaker practice offering services on a temporary basis to the patients of Brownsover)
- Patients – including the Brownsover Patient Action Group.

All the key organisations have confirmed their support for the project. Support has been demonstrated through the involvement of clinical and non-clinical stakeholders in the development of the scheme proposals. Letters of support for the scheme are available (appendix 1 and 2).

Stakeholders have been involved with the design of the building through participation in DQI events. NHSE and the CCG are committed to the ongoing engagement of the public, a communications plan has been developed clearly showing steps and actions to be taken to ensure this continues.

2.5 Equality and Diversity

CRCCG is committed to promoting equality, diversity and human rights for the population it serves and for its staff. Regardless of the financial pressures currently faced by health economies across the country, the goal is for every employee of CRCCG 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 CRCCG must be fair and consistent in managing the needs of staff, partners, and service users.

CRCCG have produced an Equality & Diversity Strategy.

2.6 Approvals

A process of review and subsequent approval for the FBC has been agreed.

- Coventry and Rugby CCG Primary Care Committee (Appendix 45)
- NHS England West Midlands (Appendix 46)
- National NHS England DCO/DoF (Appendix 47)
- NHSPS IAP (Appendix 48)

The timeline for this is set out in the project plan (appendix 7)

3 The Strategic Case

3.1 Overview

This section provides information on the current national, regional and local contexts of the NHS. It seeks to outline the vision and objectives of Coventry and Rugby CCG as well as demonstrating the strategic fit of the Brownsover project within these contexts. This section also presents the case for change with regards to the health needs assessment and programmes for the locality.

3.2 National Strategic Context

3.2.1 NHS Five Year Forward View

The NHS nationally is facing a number of challenges, as people live longer and live with long term conditions. Funding for health is not keeping pace with demand, resulting in the need to provide services more efficiently. Nationally and locally, health and social care budgets have been under unprecedented pressure and future years will be even more challenging, resulting in the need for a serious focus on new ways of working to provide services. In addition to these challenges, there are a number of statutory, regulatory and policy requirements specifically concerned with sustainable development, including various requirements to reduce energy consumption, carbon footprint and waste.

The NHS Five Year Forward View (October 2014) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that it can promote wellbeing and prevent ill-health. It sets out a vision of a better NHS, the steps it should now take to get there and the actions it needs from others.

What will the future look like?

- Getting serious about prevention;
- Empowering patients;
- Engaging communities;
- Multispecialty Community Providers (MCP); expanding the leadership of primary care;
- Primary and Acute Care Systems (PACS); to better integrate care;
- Urgent and emergency care networks; transitioning to a more sustainable model of care;
- Viable smaller hospitals;
- Specialised care;
- Modern maternity services;
- Enhanced health in care homes;
- New models of care; and
- A new relationship with patients and communities.

Some of the change needed can be brought about by the NHS itself whilst others require partnerships with local communities, local authorities and employers. The NHS has therefore set out complementary approaches required in order to achieve its Forward View:

- Backing diverse solutions and local leadership; driving change locally;
- Providing aligned national NHS leadership;
- Supporting a modern workforce; ability to deliver innovative new care models;
- Exploiting the information revolution; capitalising on the opportunities it presents;
- Accelerating useful health innovation; supporting research to transform services and improve outcomes; and
- Driving efficiency and productive investment; to sustain a high quality NHS.

The CRCCG has set out its intentions in response to the Five Year Forward View and intends to collaborate with local Partners to explore how services can be better integrated to improve the patient experience and to make best use of specialist skills as part of these plans.

3.2.2 GP forward view

The General Practice (GP) Forward View (April 2016) recognises that GP services are central to the successful delivery of the modern NHS but that investment in GP services has not kept pace with demand. The GP Forward View sets out to address this, providing “specific, practical and funded steps” to resolve issues relating to investment, workforce, workload, infrastructure and care redesign.

An additional (14%) £2.4 billion a year investment by 2020/21 will be made into General Practice services. This will be combined with other initiatives to strengthen investment into primary care, and when CCGs build community services and new care models, in line with the NHS Five Year Forward View, investment is expected to increase.

The pooling of budgets required by the Better Care Fund (BCF) allows CCGs and local authorities to agree an integrated spending plan for jointly commissioned services, promoting the wider integration of health and social services, as can be demonstrated by some of the vanguard schemes (see below).

There will be a continuing development of primary care estate and IT infrastructure following the NHS England investment programme that commenced in 2015/16, backed by both capital and revenue funding (incorporating the Estates and Technology Transformation Fund). Investment in primary care is intended to improve and extend facilities, to increase their flexibility to accommodate multi-disciplinary teams and meet training needs, to provide the opportunity for innovations in care (recognising the likelihood of significant population growth) and to increase the use of technology.

There will also be an expansion of workforce capacity, across the spectrum of primary care professionals, and initiatives to “reduce practice burdens and help release time”.

3.2.2.1 High Impact Changes

The GP Forward View identifies ten “high impact changes” for the primary care sector, as shown in figure 7

Figure 7 - the ten high impact changes (GP Forward View)

3.3 Coventry and Warwickshire Sustainability and Transformation Plan

In December 2016, the Coventry & Warwickshire Sustainability & Transformation Plan (STP) was produced. This plan is based on:

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

The need for a single vision aligns to that of the Health and Wellbeing Boards.

Transformation workstreams include;

- Proactive & Preventative Care;
- Urgent & Emergency Care;
- Planned Care (including Maternity & Paediatrics and Cancer); and
- Productivity & Efficiency.

These are supported by a number of Enabling Workstreams;

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

3.3.1 Primary Care Development workstream

A Primary Care Development supporting workstream is in early stages of development.

There is a commitment to focus on how to strengthen and invest in primary care and key areas within this commitment are:

- Develop GP services in line with the GP Forward view;
- Create a primary care development workstream that will focus on developing GP services at scale and pace closely aligned to other STP activity to facilitate transfer activity from hospitals into care closer to home;
- Ensure patients will have a better and extended access to GP services;
- Ensure that a number of services, for which patients currently have to travel to hospital, will be available within their local community or even in some instances at home; and
- To provide high quality, easily accessible, clinically and operationally sustainable GP and primary care services for our communities.

3.3.2 Estates workstream and alignment with the Brownsover project

Within the STP document, the Estates workstream is summarised in table 9:

Activities	Outcomes
• Consolidation of estate and making best use of existing estate • Primary care estate • New estates operating models • Identifying opportunities to share/use other partners' estate	• 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

Table 9 – Summary of estates workstream activities and outcomes in STP

Elements from the STP plan pertinent to this development have been included in this section, the full copy of the STP plan which includes all workstreams is available on the CCG website.

3.4 Local Health needs

3.4.1 Strategic Plan 2014 – 2019

There are three Clinical Commissioning Groups in Coventry and Warwickshire, the CRCCG, South Warwickshire CCG and Warwickshire North CCG. Each CCG has individual plans as to how it will deliver healthcare for its population, but they have all agreed to work collaboratively to achieve common aims, to become a "larger unit of planning".

Health and social services are delivered in a variety of ways, as demonstrated by Figure 8. The aim is for the best use of the resource available to conquer the local challenges.

Figure 8 Health and care services

The three CCG's are facing many health challenges;

- 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%);
- 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;
- A mix of urban and rural populations, with Warwickshire's rural population being generally older than in the urban areas. The proportion of people aged 65 or over in rural areas is 21%, whilst in urban areas it is 17%;
- In Coventry, there is a high ethnically diverse population, with 33% of the city's residents coming from minority ethnic communities compared to 20% for England as a whole; and
- There is a large gap in life expectancy between the richest and poorest areas of both Coventry and the county of Warwickshire

The growing and ageing population means increasing financial and service delivery pressure on health and social care services, and this will continue and increase. Services which are flexible and responsive will need to be commissioned with more services 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 services are sustainable. The acute sector challenges can be summarised as follows:

- A national drive to achieve and deliver changes in the way hospitals work and their relationship with the communities they serve;
- A workforce with an older age profile. Many local clinicians are approaching retirement over the next few years and there are not enough new doctors and nurses to take their place;
- Clinicians increasingly wish to work in specialist areas, rather than in a general hospital setting.

3.4.1.1 The aims of the strategic plan

The strategic plan sets out 5 specific aims for Rugby. These are:

- Increase life expectancy
- Improve the quality of life for people with multiple long-term conditions
- Reduce the amount of time people unnecessarily spend in hospital
- Give more people a positive experience of hospital care
- Give more people a positive experience of care outside hospital.

The strategic plan gives details on how the CCG will establish six programmes of work to enable the realisation of these aims, these are shown in table 10

Programme of work	Description
Enabling patients to manage their own health	Develop ways to support people in taking responsibility for their own health Empowering people to care for themselves at home where appropriate Make lifestyle choices to prevent ill-health Assist patients in managing their own long term conditions, without unnecessary hospital care
The future of primary care	The majority of healthcare will be delivered out of hospital and close to people's homes Primary care teams will guide and coordinate a patient's care at every stage Professionals from across health and social care will work together to provide care that is tailored to the individual needs of the patient By collaborative working, people will be kept happy and healthy in their own homes and communities for as long as possible. This approach means going into hospital or being admitted to a care home should be planned and in line with a patient's needs.
Integrating health and social care	Clinicians and professionals will work together across health and social care, with services available seven days a week. This will reduce duplication and ensure a patient's care is coordinated more effectively. The patients experience should be of a seamless transition throughout their care.
Urgent and emergency care	By changing the way care is provided in the community, the majority of health conditions will be treated out of hospital. People will only use urgent and emergency care services when necessary This approach will allow emergency are services to focus on providing high quality services to treat more complex health conditions in hospital.
Improving planned hospital care	Improvement of processes and use of technology will ensure people are seen by the right clinician, at the right time. Where possible care will be provided in the community. Specialised services will be offered in a small number of hospitals to provide safe, effective services whilst ensuring there is sufficient capacity to meet demand for these services
Value and efficiency	Services will be run efficiently and provide value for money Competition among healthcare providers will be supported offering patient's choice and encouraging improvements in the quality of services which meet local needs.

Table 10 programmes of work to support the aims of the Strategic Plan

3.4.1.2 Future model of care

The Strategic Plan sets out the Future Model of Care. This is built around the needs of the patient population, providing support for individuals to look after their own health and wellbeing, whilst improving access to services that are closer to home, backed by smaller-scale specialist hospital services.

This is described in figure 9.

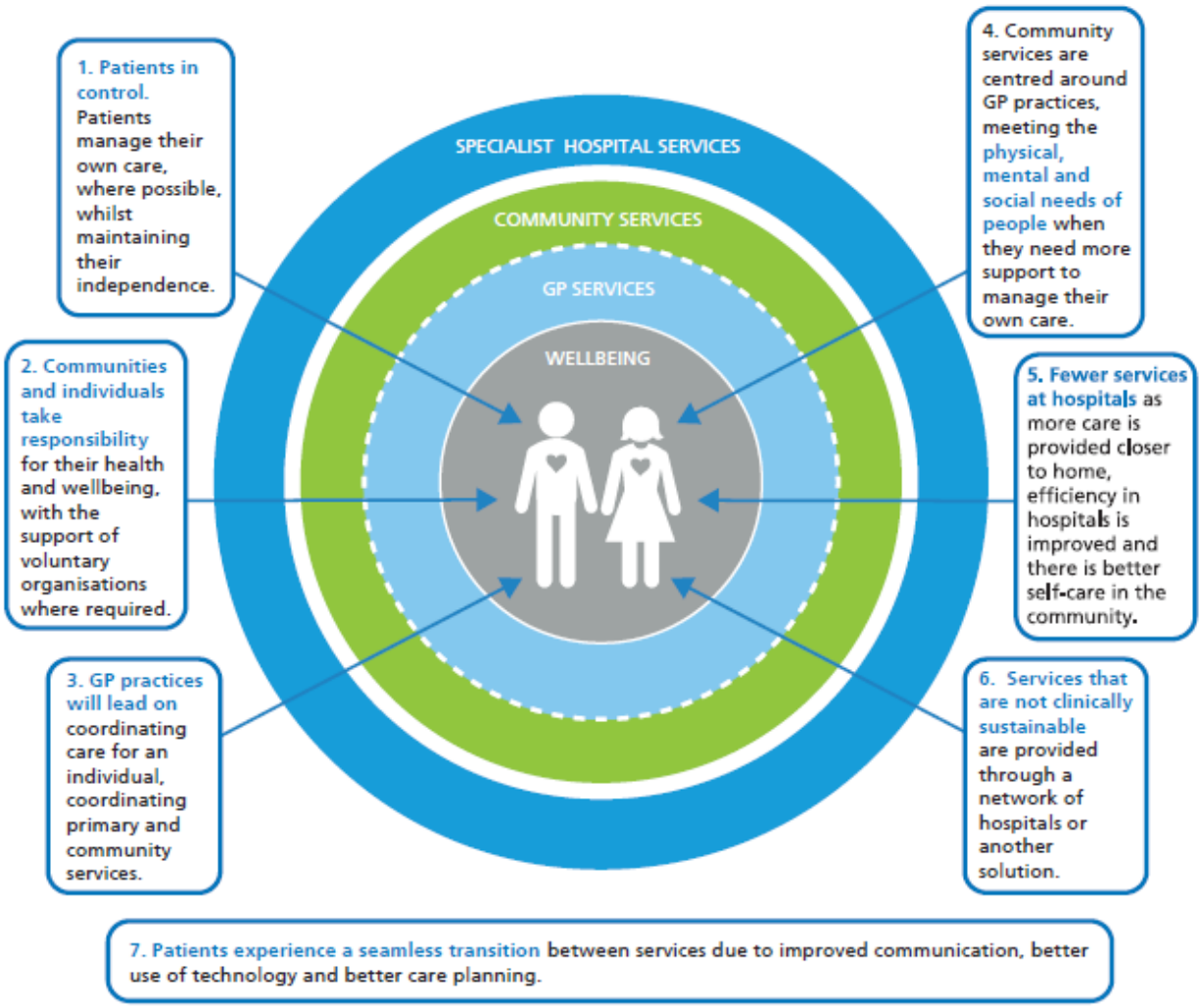


Figure 9 Future model of care[i]

Table 10 and figure 9 both clearly demonstrate that patients can only benefit from care close to home as well as the need to reduce unnecessary and unplanned hospital admissions allowing acute care to have space and resource to focus on complex needs. The new community hub will provide support to develop these aims and models and can only improve patient experience and wellbeing.

[i] *Source http://www.coventryrugbyccg.nhs.uk/About-Us/Publications-and-Policies/Coventry-and-Warwickshire-CCGs-Strategic-Plan?Highlight=strategic+plan*

3.4.2 2016/2017 QIPP plans

Locally and nationally, the NHS is managing the impact of constrained public spending and a funding settlement that is more challenging than many can remember. It is clear that all organisations will need to make bold and difficult decisions. NHS Coventry and Rugby CCG will ensure that all such decisions are taken only after an explicit consideration of the impact on quality, safety and patient experience and an open discussion with the public and our other local stakeholders.

All of the above combine to create a significant challenge for a relatively new organisation but one that the CCG are committed to facing with boldness, integrity and endeavour. The CCG has developed a QIPP Programme to deliver £21.2M of savings in year. The main priority areas for collective focus and maximisation of efficiency are shown in table 10 this table sets out the priorities measurable by SMART criteria in so far as;

- **Specific** areas have been identified
- They are **Measurable** as values have been set aside each area
- These have been agreed as **Attainable** and **Realistic** and they are
- **Time** based as set out below

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**

Table 11 QIPP SMART objectives

3.4.3 Primary Care Strategy 2015 - 2019

Developing sustainable primary care within Coventry and Rugby

[i]Primary care[2] [ii]in England is operating in an increasingly challenging environment. Rising patient expectations, an ageing population, the rising prevalence of chronic disease and the emergence of new technologies are putting real pressure on the system. This is combined with a reduction in the resources available in primary care and reduced recruitment to GP training schemes and retention, with forthcoming retirement of senior GPs. These challenges are also reflected at the local level.

Despite this, there is an expectation that primary care will continue to provide better clinical outcomes, and this requires new and flexible thinking about how and where services are delivered. One of the great strengths of primary care has, however, been its ability to adapt to meet changing demands. Health care for the majority of the population is provided in primary care by GPs, community pharmacists, dentists and optometrists. Over 90% of all NHS contacts take place in primary care with approximately 340 million GP consultations a year (an increase of 13% from 2008 - 2015[3]) equating to 8% of the total NHS budget.

Within the CCG area there are 71 GP practices of varying sizes. The GP practices are grouped into 3 localities - two in Coventry and one in Rugby. The map below shows the location of GP practices across the Rugby. 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.

Figures 10 and 11 identify the location of the primary care facilities in Rugby, practice names are shown in table 12.

[i] source: Coventry Public Health Annual Report 2014

[ii] Primary care includes GPs, practice nurses, healthcare assistants, pharmacists and specialist community nurses, community mental health nurses and therapists, community pharmacists, optometrists and dentists are part of wider Primary Care services but are not included in this strategy as at present.

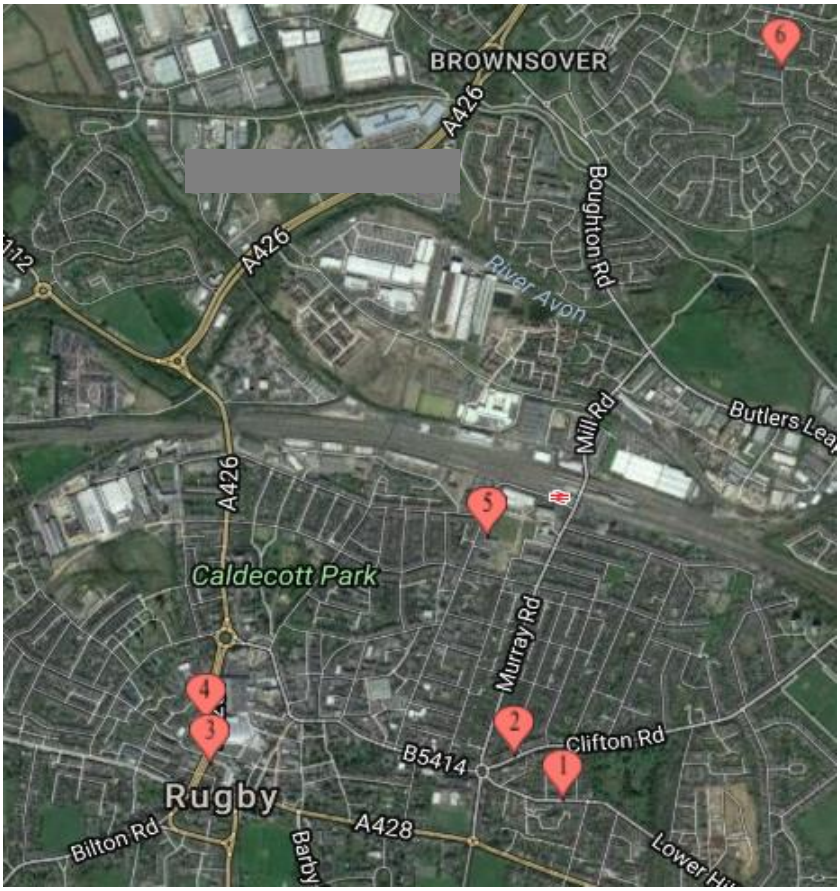


Figure 10 Practices centrally located in Rugby

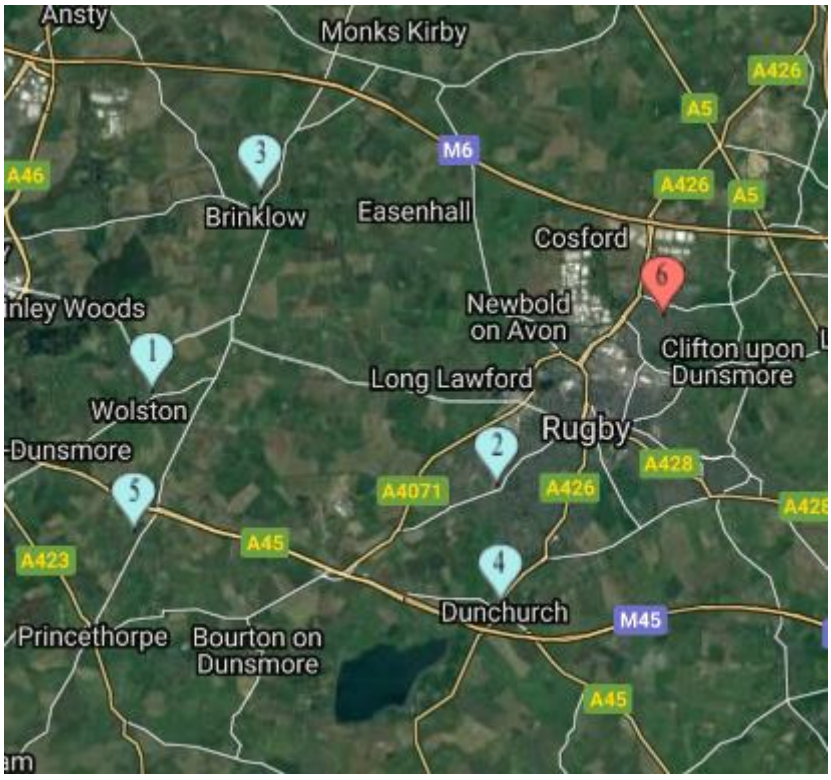


Figure 11 GP practices further from Rugby town centre

No.	Surgery	No.	Surgery
1	Rugby Town Medical Practice (temporary practice)	5	Beech Tree Medical Practice
1	Whitehall Medical Practice	6	**Site of new Health Centre**
2	Clifton Road Surgery	1	Wolston Surgery
3	Central Surgery	2	Bilton Surgery (branch)
4	Westside Medical Centre	3	Revel Surgery
4	Benfield Surgery	4	Dunchurch Surgery
5	Market Quarter Medical Practice	5	Brookside Surgery

Table 12: Current GP practices in Rugby

The original Commissioners Investment and Asset Management Strategy (CIAMS) for Coventry and Rugby, 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 and Rugby CCG is undergoing a premises utilisation review which will inform a refreshed estates strategy that will underpin our Primary Care Strategy and development of new models of care. Local authorities in Coventry and Warwickshire and provider NHS Trusts have also reviewed their estate plans and these will need to be taken into account in aspiring to make best use of the health and care estate. Ongoing review and shaping of estates to meet service delivery models continues through a Local Estates Forum and a Strategic Estates Planning Group. The Brownsover scheme is referenced in the CCG's Strategy Estates Plan (January 2016).

In early 2015, the Health and Wellbeing Board with Local Medical Committee (LMC) representatives for both Coventry and Warwickshire coordinated a visioning workshop, involving patient representative groups, General Practice, Pharmacists, the Local Authority, NHS England and the CCG to explore and develop a 5 year vision for primary care. This was followed up in September 2015 with a further workshop involving local Partners to test and further define the key agreed themes across both Coventry and Rugby recognising the differences across the whole of the CCG area.

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*".

Key priority	How the new centre addresses the priorities
Assuring quality and safety	Designing and building a new centre has the enormous benefit of building to the latest standards with patient experience at the forefront of requirements. Section 5.8.3 of this document outlines design principles and the relevant guidance that designers must follow. In addition, the VOA checklist ensures safe design principles are outlined and followed wherever possible. If these principles cannot be followed for any reason the designer must give an indication of why this is the case. The VOA checklist is available (appendix 5). Additionally, the design was created with key individuals involved such as infection control, fire safety etc. DQI events took place throughout the design where clinicians and patient reps were able to have an input into design requirements. The DQI attendance lists and reports are available (appendix 4 and 8)
Promoting integration	Throughout the design of this building it has been clear that the building is to be a hub for the community as well as a health centre. The aim is to ensure that patients are able to use this facility to address a range of health and social services promoting care closer to home. With the centre being easily accessible to staff and patients and a flexible design in place to allow multi service use of clinical and patient space generally it is clear that integration is fully promoted within the new centre.
Securing best value	As with all NHS procurement, best value for money is a key issue with the Brownsover scheme. Competitive tendering exercises are undertaken for each element of procurement with strict guidelines and evaluation processes in place giving assurance of the best price for contractors and for specialist knowledge required for the project.
Equality	Equality, inclusion and human rights strategy 2016 - 2019

Table 13 – Primary Care Strategy key priorities alignment

3.4.4 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of the local community. It is intended to inform and guide the planning and commissioning of health, wellbeing and social care services within a local area. It considers factors that impact on the health and wellbeing of the local community including economic, education, housing and environmental factors; as well as local assets that can help improve things and reduce inequalities.

The JSNA is owned by the respective Coventry and Warwickshire Health and Wellbeing Boards (HWBB), which are a meeting place for local Commissioners across the NHS, people in public health and social care, Councillors and representatives of HealthWatch.

The HWBBs work to improve the health and wellbeing of local people and reduce health inequalities through the development of the Health and Wellbeing Strategy. Board members work together to understand their local community's needs, agree priorities and encourage commissioners to work together in order which results in better services. The Coventry and Warwickshire Health and Wellbeing Boards meet every two months and are supported by their own Delivery Group(s) and have regular development sessions with a

wider range of stakeholders and are increasingly working collaboratively to ensure delivery of health and care services across Coventry and Warwickshire.

The JSNA 2016 outlines key local priorities. Table 14 shows how the Brownsover development is consistent with these relevant key priorities.

JSNA key local priority	Brownsover development alignment with priority
Create an attractive cleaner and greener town	The building will benefit from the latest innovations in healthcare building design ensuring maximum efficiencies with utilities, building materials and carbon efficiencies generally. With a target of BREEAM excellent, designers and contractors will be expected to drive these carbon efficiencies promoting a greener and more sustainable 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 will promote a safe 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.

Table 14 – consistency with key local priorities

3.4.4.1 Commissioning Intentions 2016/17

The commissioning intentions of CRCCG for 2016/17 take into account the specific local needs as described in the Joint Strategic Needs Assessments published by the Public Health Teams within Coventry City Council and Warwickshire County Council.

The CRCCG has four key principles which underpin its commissioning approach:

- Assuring quality and safety
- Promoting integration
- Securing best value
- Equality

In terms of responding to the NHS England priorities, the CCG will:

- Strengthen primary care services
- Improve the quality of care and access to cancer treatment
- Upgrade the quality of care and access to mental health and dementia services
- Transform care for people with learning disabilities
- Tackle obesity and prevent diabetes
- Redesign urgent and emergency care services
- Provide timely access to high quality elective care
- Ensuring high quality and affordable specialised care

- Enabling whole system change

3.4.5 Local Estates Strategy

Coventry and Rugby CCG have commissioned the Design Buro to create an Estates Strategy. This is available at appendix 9

The CCG have confirmed that the need for the Brownsover project forms part of this Estates Strategy. Following a review of the existing Primary Care premises within CRCCG, it has been confirmed in an early draft that, with the additional capacity proposed through this development it is anticipated that this facility will meet the population growth and capacity requirements to serve the local population.

3.4.5.1 Summary of existing capacity and proposed estate

The Estates Strategy produced in September 2017 for the CRCCG states:

'The Brownsover locality will be significantly affected by the extent of the housing development proposed for this locality. Existing premises serving the locality have been relocated to temporary facilities being provided at the Rugby Town Medical Practice whilst the new facility is developed. This temporary facility is remote from its catchment area and is struggling to meet current demand. The proposed GP premises for this locality will address the proposed growth'.

3.5 The Brownsover area

3.5.1 Overview

The Borough of Rugby covers an area of 138 square miles located in central England, within the County of Warwickshire. Brownsover Local Centre is located within Rugby Borough Council and Warwickshire County Council. The local ward is Brownsover.

3.5.1.1 Population

The Borough's overall population remained steady between 1971-2001, but between 2001-2011 the population increased significantly by 14.5%. The rise in population was largely due to people migrating into the area and more single parent families, but also as a result of increased birth rate and people living longer. The projected population increase between 2010 and 2035 is expected to be 30%, which would bring the population to in excess of 130,000. This is the largest projected population increase in Warwickshire.

Across Warwickshire as a whole, the highest rates of projected population growth are in the groups aged 65 and over. The eldest age group (those aged 85 and over) is projected to increase by over 190% by 2035.

3.5.2 Rugby health profile

3.5.2.1 Health in summary

The health of people in Rugby is varied compared with the England average. About 13% (2,600) of children live in low income families. Life expectancy for both men and women is higher than the England average. Table 14 shows how the new centre aligns with the Joint Health and Wellbeing Strategy.

3.5.2.2 Health inequalities

Life expectancy is 5.5 years lower for men and 4.9 years lower for women in the most deprived areas of Rugby than in the least deprived areas.

3.5.2.3 Child health

In Year 6, 18.9% (214) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 42*. This represents 10 stays per year. Levels of breastfeeding initiation are better than the England average.

3.5.2.4 Adult health

The rate of alcohol-related harm hospital stays is 679*. This represents 681 stays per year. *The rate of self-harm hospital stays is 208*. This represents 213 stays per year. The rate of people killed and seriously injured on roads is worse than average. Rates of statutory homelessness, violent crime, long term unemployment and early deaths from cancer are better than average.

3.5.2.5 Local priorities

Local health priorities for Rugby are:

- Improving healthy lifestyle behaviours including:
  - Reducing **obesity**
  - Increasing physical activity
  - Increasing healthy eating
- Reducing **Self Harm i**n young people in particular including building **resilience**
- Improving **wellbeing** and in QoL for people with a **mental illness**
- Improvement in diagnosis for people with **dementia**
- Reducing **alcohol and drug** related harm & misuse

For more information see http://publichealth.warwickshire.gov.uk/ and http://hwb.warwickshire.gov.uk/

* Rate per 100,000

3.5.2.6 Population profile

The information shown in figures 12 and 13 present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio. The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

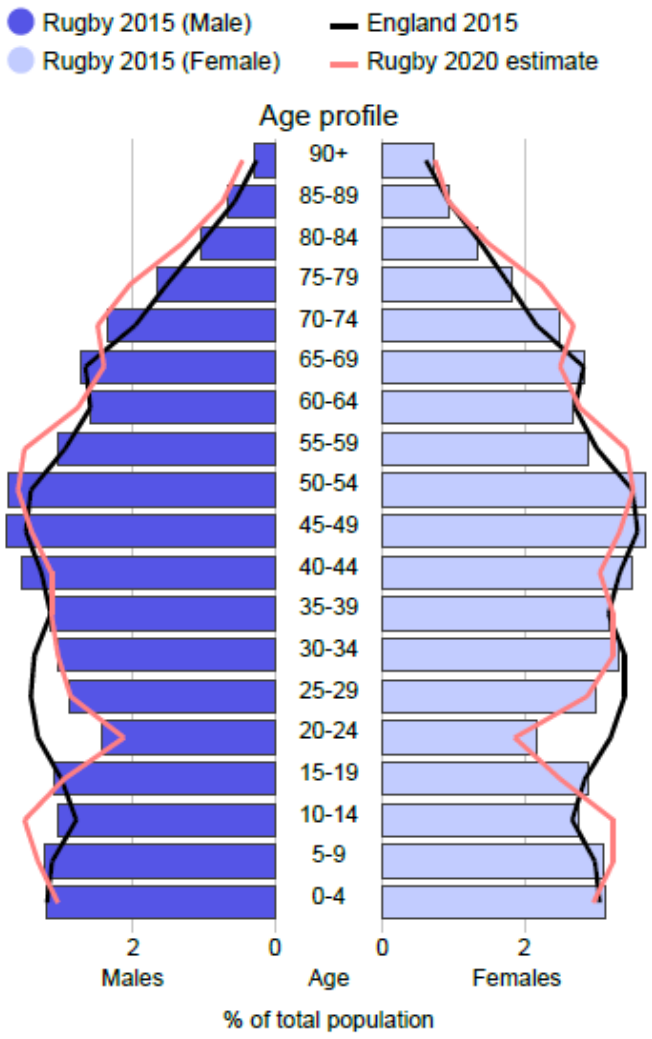


Figure 12 - Age profile for Rugby

	Males	Females	Persons
Rugby (population in thousands)			
Population (2015):	51	52	103
Projected population (2020):	54	54	108
% people from an ethnic minority group:	9.8%	10.8%	10.3%
Dependency ratio (dependants / working population) x 100			65.9%
England (population in thousands)			
Population (2015):	27,029	27,757	54,786
Projected population (2020):	28,157	28,706	56,862
% people from an ethnic minority group:	13.1%	13.4%	13.2%
Dependency ratio (dependants / working population) x 100			60.7%

Figure 13 - Population information for Rugby

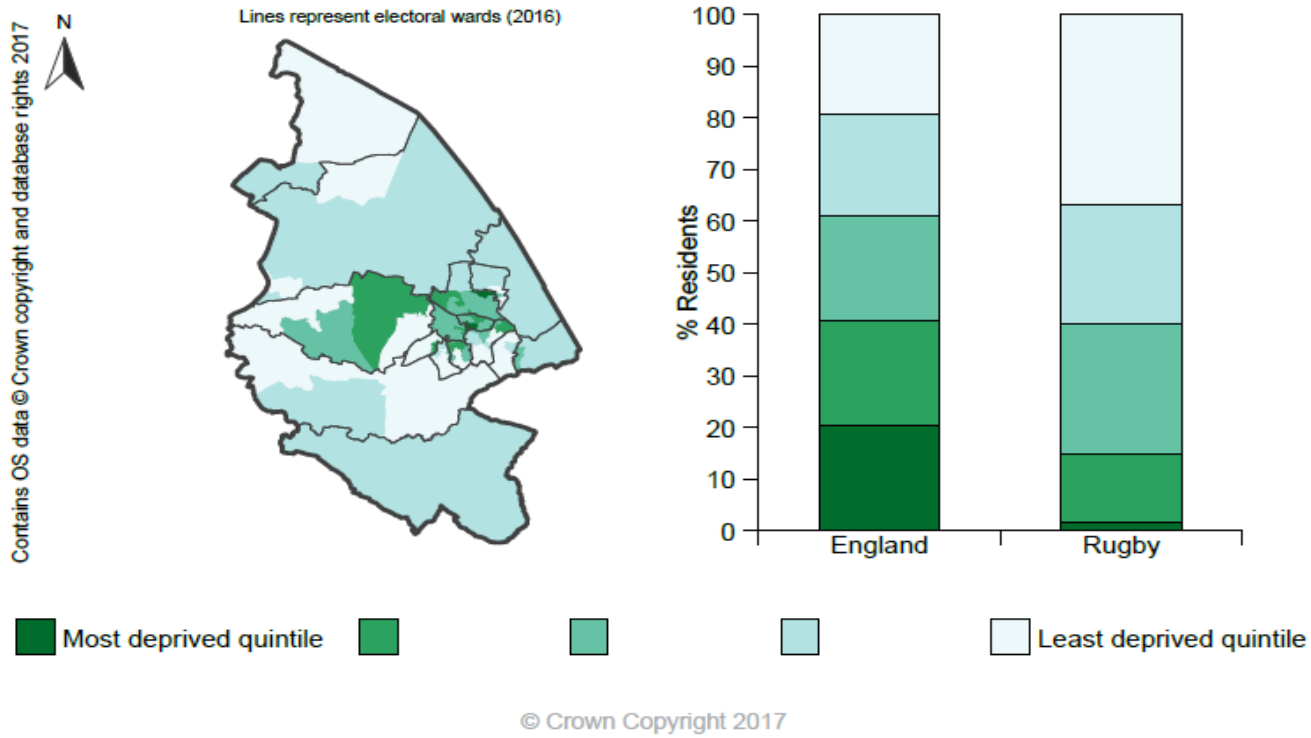
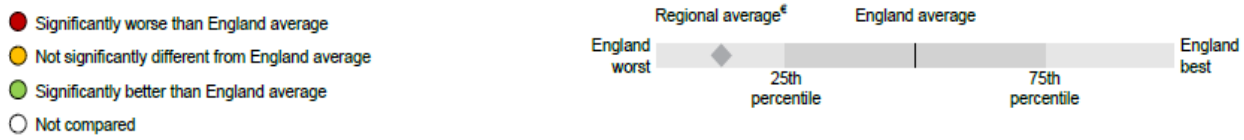


Figure 14 - deprivation map and chart

The map in figure 14 shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England. The chart in figure 14 shows the percentage of the population who live in areas at each level of deprivation.



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	13.1	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	2,565	13.3	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	15	0.3	0.9			
	4	GCSEs achieved	2015/16	624	59.1	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	1,592	15.5	17.2	36.7		4.5
	6	Long term unemployment	2016	86	1.4 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	153	12.2	10.6 $^1	26.0		1.8
	8	Breastfeeding initiation	2014/15	934	82.2	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	214	18.9	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	29	42.4	37.4	121.3		10.5
	11	Under 18 conceptions	2015	36	18.8	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	15.8	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	61.1	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	66.9	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	231	56.9	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	213	208.1	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	681	679.2	647	1,163		374
	18	Recorded diabetes	2014/15	5,135	6.2	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	29	9.4	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	475	734.0	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	125	628.9	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	80.5	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	84.0	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	10	2.7	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	194	63.1	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	24	x^2	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	n/a	n/a	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	190	70.4	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	326	121.1	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	171	20.5	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts x^2 Value cannot be calculated as number of cases is too small $^1 There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed. Please send any enquiries to healthprofiles@phe.gov.uk

Figure 15 - Health Summary for Rugby

The chart shown at Figure 15 shows how the health of people in the Rugby area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

3.5.2.7 Housing

Between the years 2011-2031, a minimum of 12,400 homes need to be delivered within Rugby Borough.

Rugby Borough Council's Local Plan (September 2016) states that 12,400 new homes will be provided at a rate of 620 per annum between 2017 -2031.

Table 15 shows that the actual amount of new homes is likely to be significantly higher than 12,400 due to other factors such as windfall sites. As shown, the amount of new homes is likely to actually be 13,664.

Dwelling information	Amount
Dwellings constructed between 1st April 2011 and 31st March 2016	2,201
Number of permitted dwellings anticipated to be completed within between 1st April 2016 and 31st March 2031	5,636
An allowance for windfall sites in this plan between 1st April 2016 and March 31st 2031	645
Number of dwellings required to be allocated in this plan	**3,918**
Number of allocated dwellings anticipated to be completed within the plan period	5,182
Total anticipated provision in the plan period	**13,664**

Table 15 - Dwelling information from Rugby Borough Council's Local Plan September 2016

Growth plans within the Brownsover catchment area have identified a number of sites set for residential development, these sites are in very close proximity to the proposed new site for the development.

The residential development sites are outlined in table 16.

Development Area	Housing Units	Development Area	Housing Units
Rugby Gateway	1,300	Land North of Coventry Road, Long Lawford	Up to 100
Rugby Radio Station	Up to 6200	Leamington Road, Ryton on Dunsmore	Up to 75
Coton Park East	800	The order, Plott Lane, Stretton on Dunsmore	Up to 25
South West Rugby	Up to 5000	Land off Squires Road, Stretton on Dunsmore 2	Up to 50
Coton House	Up to 100	Linden Tree Bungalow, Wolston Lane, Wolston	Up to 15

Land at Sherwood Farm, Binley Woods	Up to 62	Land at Coventry Road, Wolvey	Up to 15
Land off Lutterworth Road, Brinklow	Up to 100	Wolvey Campus, Leicester Road, Wolvey	Up to 85

Table 16 - Proposed development sites for housing in Rugby

These developments are predominantly due between the years 2015 – 2026, with a small percentage due after this period within the local plan timescales 2011-2031.

It is anticipated that 50% of new residents will register with the new surgery.

The population profiles of residential accommodation are unknown for these sites, although to give some context using an average of 2.4 persons per dwelling, this would result in a population increase of 5,448. In addition to the anticipated population of 5,448, there is an expectation that other patients currently registered elsewhere within Rugby that may choose to register with the new practice.

3.5.2.8 GP activity increase

Local GP practices have reported an ongoing increase in activity and identified a need for additional GP services to be provided to meet the increase in local population. The new building will not house an additional service but will ensure re-provision of an existing service which has been provided in temporary accommodation as part of a caretaker solution as the previous Provider has been terminated as of April 2015 and will allow for additional capacity due to the growth expected in the area.

3.5.2.9 Summary

The urgent need for this new facility therefore has arisen from:

- Limited capacity in other surgeries in the area
- Practice closure (now a caretaker practice only)
- Health deprivation generally
- Population growth
- Significant housing development planned for the area
- Increased GP activity and demand for GP Primary Care services

3.5.3 Health Needs

Poor health typically stems from deprivation and whilst health has been improving in more affluent areas, this is not the case in deprived locations. Given that Brownsover is one of the top three deprived areas within Rugby and across Warwickshire as a whole, it is important that the assessment of need is thorough and reflects the level of health services requiring commissioning.

In addition, the Brownsover area is the fastest growing district of Rugby with above average projected medical problems. Table 17 summarises these medical problems.

Medical problem	Description
Cardiac	Currently 2/3 of the UK population who need cardiac rehabilitation are not getting care. This figure is larger in the Rugby Area as the Rugby Hospital cannot cope with demand.
Teenage Pregnancy	Rugby's overall under 18 conception rate is marginally below the Warwickshire average (2004 – 2006). Brownsover South at 83.9 per 1000 females aged 15 – 17 years is significantly above the average. In Rugby, Brownsover South ward records the second highest rate of under 18 conceptions.

	Newbold ward which record the highest under 18 conception
Deprivation	Brownsover South and Newbold Town Centre are the only Super Output Areas (SOA) in Rugby within the top 30% most health deprived SOAs in England (The Indices of Deprivation study of 2007). Brownsover South is the most deprived SOA in the district and 13th most deprived in Warwickshire (there are 333 SOAs in Warwickshire).
Smoking addiction	Smoking prevalence for Brownsover South is the highest in Rugby at 37%
Obesity	The estimated obesity level is significantly higher in Rugby than the average across England with Brownsover South showing the highest level in Warwickshire at 27%. Families for Health programmes running in Brownsover can be accommodated with on site licences, together with the integration with the local sports network.

Table 17 - Rugby's medical problems

3.5.4 Existing Arrangements

The former GP Practice covering this area had a main surgery located in the centre of Rugby town and a Branch surgery in Brownsover. The total patient list size for the Practice was circa 6,700. This Practice closed in 17 April 2015 and a 'caretaker' arrangement was put in place with another local GP Practice delivering services under an APMS contract until a new facility was built. Figures 16 to 18 show images of the existing premises of Rugby Town Practice.

Figure 16 Side entrance view caretaker practice

Figure 17 Entrance view caretaker practice

Figure 18 Car park view caretaker practice

3.5.4.1 Current estate issues

The caretaker practice is not fit for purpose in respect of a long term solution for the patients of Brownsover, aside from the usual issues surrounding working from a building that is not specifically designed for purposes (The building is an old house that was converted into a GP Practice prior to use by the caretaker practice. It was closed and brought back into operation purely for a short term solution for Brownsover) it has the following issues;

- There are problems with the floor structure (holes in the floor)
- There are issues with safety such as unsafe stair rails
- There is damp and mould in the building

- The building is situated a distance away from Brownsover patients. A shuttle bus service is provided at the current time for patients requiring travel to access GP services

Following the closure of the former GP Practice some patients nearer to the town centre premises have registered with other practices but the remaining patients and the anticipated new patients into the area will be accommodated in this facility for 10,000 patients.

The caretaker practice is currently operating out of very old premises, which was a former GP practice. This was brought back into use for this purpose on a short-term basis. (Please refer to comments above).

3.5.5 Current caretaker APMS arrangements

The CCG have confirmed that the current caretaker APMS provider has had their contract renewed until September 2018 with an option to renew a further 12 months from that point. This will ensure that the CCG has time to procure the new provider. At the current time, the CCG have confirmed that there are no extra services planned but this will be reviewed for future provision.

The current contractor provides essential services within the APMS core hours. These 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 to these essential services as part of core General Practice, the APMS provider also provides the following:

- 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.

The core hours for the APMS contract are 52.5 per week as shown in table 18:

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

Table 18 – opening hours of the current caretaker surgery

3.5.6 The new centre in Brownsover

3.5.6.1 Capacity Planning

The proposed accommodation will provide permanent accommodation for 10,000 patients. Although it may not be fully utilised initially, it will provide the means to develop and test other models of care for the

community, this in turn will reduce the demand on secondary care in line with strategic objectives such as the GP Five Year Forward View (April 2016).

The patient requirement is broken down as shown in Table 19

Period	List Size
Year 1	5,800
Years 2-3	8,500
Year 4	10,000

Table 19: Projected capacity growth Brownsover

3.5.6.2 Site for the new Brownsover building

Figure 19 shows the proposed site for a new building in Brownsover with the illustrative master plan shown at figure 20

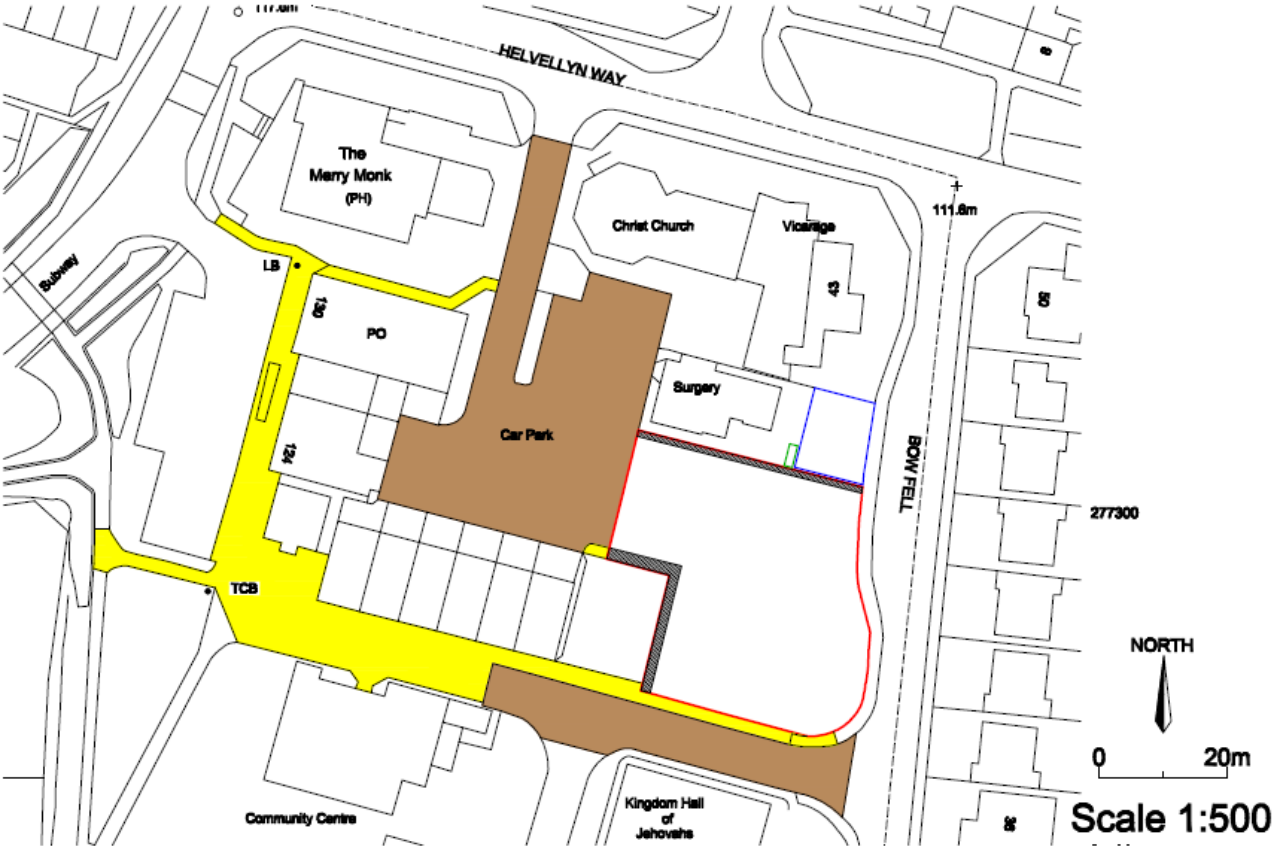


Figure 19: Site for the new building in Brownsover

Figure 20 – Illustrative master plan

3.5.6.3 Meeting the strategic need

Table 20 summarises how the Brownsover scheme meets the national, regional and local strategic context:

Key Strategic priority	Brownsover development
Meeting increased population growth	Sized for a 10,000 list size which allows for increase in population
Local Hub and Spoke model	Creating local accessible primary care spokes where services relevant to patient's needs are delivered
Challenging financial position	Project to be delivered within budget and value for money
Promoting wellness and preventing ill health within the community.	Providing patients with care closer to home and reducing admissions to local acute hospitals, freeing up valuable bed space
Delivering a facility that is fit for purpose and flexible to deliver new models of care to the local population	Being a centre designed to meet the latest standards for health care buildings, with the flexibility to meet the changing demands of the local population

Table 20 meeting the national, regional and local strategic context

3.5.7 Investment Objectives & Benefits

Table 21 sets out some of the key objectives for a new development within Brownsover.

Objective	Expected outcome	Indicator
To create a purpose-built premise supporting a projected population of approximately 10,000 patients (comprised of the list size at the GP practice which closed as well as the projected growth expected in the area) to allow the recommencement of GP services after closure of the Albert Street and Bow Fell surgeries.	Improved patient access and continuity of care in an area of Rugby 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 and or admissions to hospital.
Providing modern Primary Care services to meet Commissioning strategies.	Continuing to improve the clinical quality of care	Improved health outcomes for the local population
To meet the required standards to deliver the Coventry and Rugby CCG Primary Care Strategy and GPFV plans.	Continuing to improve the clinical quality of care.	Reduced unnecessary attendances, referrals and or admissions to hospital.
Improved patient experience, access and choice.	Increase in patient satisfaction	GP patient survey, Friends and Family Test.
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 local community.	A wider variety of services offered.	Improved health outcomes for the local population.
Better community relationships.	Targeting locality specific problems.	Improved health outcomes for the local population.
High quality personalised care.	Increased level of General Practice services provision delivering improved health outcomes for the population.	Reduction in health inequalities.

Table 21: Key objectives for a new development within Brownsover

3.5.8 Stakeholder engagement and consultation

NHS England have developed a communications plan to ensure robust stakeholder engagement and consultation (Appendix 10). This sets out a detailed list of stakeholders, which in summary are:

- Patients of the GP surgeries
- Staff within the GP surgeries
- The surgeries' Patient Participation Group (PPG)
- Patients and staff of other GP surgeries in the surrounding area who may be affected by changes
- MPs/HOSCs/elected members
- Brownsover Patient Action Group
- Media

3.5.8.1 Key messages

The communication plan developed for the scheme delivers the following key messages to stakeholders from NHS England;

- This is good news for local people living in Brownsover. We have been working closely with NHS Property Services to get to this position and can now move to the next stage of the process which is the development and approval of the full business case.
- We need to make sure that we get the best possible value for money from resources we have available. By doing this we can make sure that our local communities benefit from good quality, local GP services.
- We will continue to work with patients, NHS Property Services and NHS Coventry & Rugby Clinical Commissioning Group, as we develop a detailed plan for the completion of the full business case.
- We know that the people of Brownsover eagerly await a new surgery and remain committed to the development and construction of the new GP practice and look forward to working with local residents as the work moves forward.
- A procurement process will be required for a new provider of the GP services to commence the contract on completion of the new GP surgery premises in Brownsover.
- The procurement processes will be open and transparent, following the specific requirements set out within the Official Journal of the European Union (OJEU) regulations.
- NHS England is committed to ensuring all patients have access to high-quality, local primary care services.
- NHS England is keen to hear from and listen to patients and staff.

In addition to the communications plan stakeholder inputs into the design has been facilitated by attending DQI events (Appendix 4 & 8). A good cross section of stakeholders has been present at these events and their contributions recorded in the event reports.

4 The Economic Case

4.1. Introduction

This case gives a summary of the option appraisal undertaken at OBC stage and whether the options outlined at that time still stand. In addition, this case also sets out the value for money in respect of the costs from the provider against requirements from the District Valuer.

4.2 Summary of the preferred option at OBC

A number of options for this project were discussed at OBC stage including the option to 'do nothing'. To determine the preferred option a number of processes were used, these are summarised in figure 21.

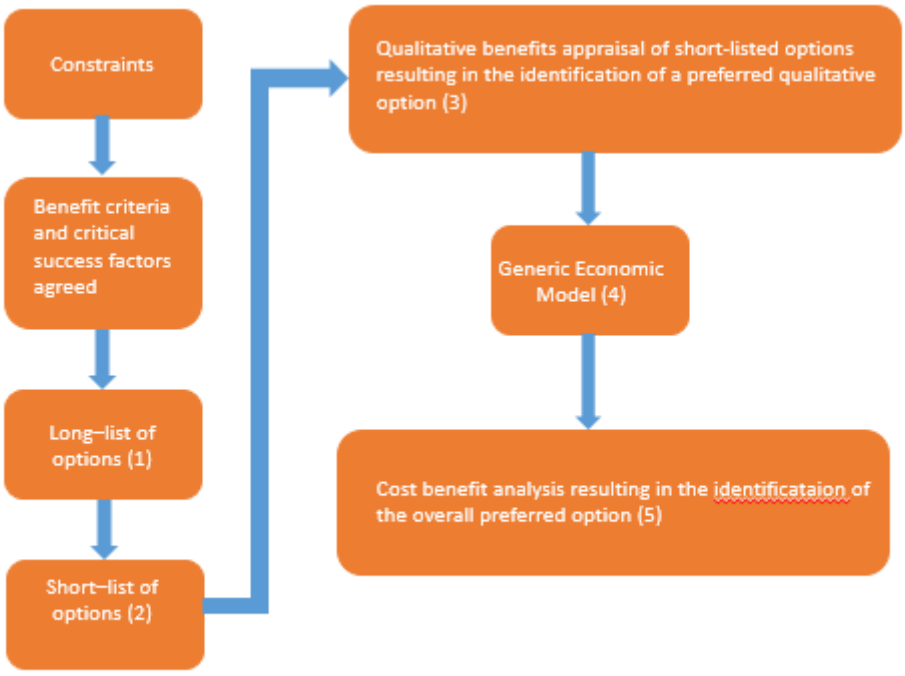


Figure 21 The route to the preferred option

4.2.1 Qualitative option appraisal

The short list of options was scored at a workshop (in conjunction with the Foleshill scheme), this workshop was captured in a report (Appendix 11). The scoring is summarised in table 22

Benefit Criteria	Weighting	Option 2 – Do Minimum			Option 3 – New Build		
		Raw Score	Weighted Score	Total	Raw score	Weighted score	Total
Service Delivery	25	3	25	**75**	10	25	**250**
Estates related issues	15	4	15	**60**	10	15	**150**
Clinical Quality	15	5	15	**75**	10	15	**150**
Staffing	15	5	15	**75**	9	15	**135**
Teaching and Training	5	5	5	**25**	10	5	**50**
Ease of implementation	10	4	10	**40**	8	10	**80**
Strategic fit within national priorities	5	4	5	**20**	10	5	**50**
Culture	10	3	10	**30**	9	10	**90**
Total	100	**32**	**100**	**400**	**76**	**100**	**955**

Table 22 non-financial option appraisal scores produced at OBC

4.2.1.1 The qualitative preferred option

The qualitative preferred option, was identified as;

Option 3, New building on Brownsover local centre.

4.2.2 Quantitive appraisal

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

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

The outcomes of both the quantitive and qualitative appraisals was then merged.

Table 23 shows the combined appraisal of options at OBC

Option	Non-financial scores	Risk adjusted NPV Impact of Option £000s	£000 NPV per benefit point	Rank	Margin of score below highest %
Do-Minimum	395	4,791	12.1	2	108.6%
New Build	955	4,978	5.8	1	-

Table 23: Combined appraisal of options

4.2.3 Preferred option

The preferred option resultant from the combining of the qualitative and quantitive options was;

Option 3 – building a new scheme on the Brownsover centre site.

NHS England and CRCCG have confirmed that since this process was undertaken at OBC there have been no changes that would affect the outcome of the preferred option and the preferred option therefore remains as above.

Since the OBC was approved, the CCG have commissioned The Design Buro to undertake an estates strategy. Within this strategy the preferred option is still demonstrably the clear choice and only option to move forward with this project. Section 5.2.1 of the strategy (appendix 9) states:

> In terms of the Brownsover proposal, we have studied the current location of practices and list sizes for a 1 mile and 2 mile radius. We have also plotted all major housing developments resulting in the provision of over 2,200 dwellings as laid out in the proposed Planning Authority Local Plans.
>
> The plan demonstrates that there is currently no alternative GP provision within the 1 mile radius and within the 2 mile radius GP provision is clustered on the historic Rugby centre, whereas the majority of the proposed housing growth is to the North and South East.
> By looking at the proposed capacity and future growth up to 2031, you will see that the proposed development has capacity to meet current and future projected growth. The development will also remove the temporary provision of the Rugby Town Medical Centre.

4.3 Value for money assessment

Although NHSPS has tendered for the construction cost of this project, NHSPS have used the capital costs developed at OBC stage (appendix 12) to underpin their rental model for Brownsover. It has therefore been agreed with NHS England and CRCCG that reliance will be placed on the District Valuer, as an independent assessment, for confirmation sign that the NHSPS rental represents value for money in the current market.

4.3.1 Value for money assessment of Lease Cost

NHSPS confirmed a rental of £97,625 pa (excluding VAT). This has been deemed value for money by the District Valuer, details contained in her report (appendix 40).

4.3.2 District Valuer's report

The District Valuer sent her report on 25th October 2017 (Appendix 40). The report sets out the following summary points:

- I have considered the information made available to me together with my Value for Money (VFM) recommendation regarding the proposed project

  In respect of the proposed lease to the GP Practices, I have set out my assessment of the estimated "Current Market Rent" (CMR) recommended for reimbursement in accordance with, and as defined in:

  National Health Service, England

  The NHS (GMS – Premises Costs) Directions 2013

- I understand the developer is seeking a rent of £98,000 pa plus VAT on a tenant's full repairing and insuring lease (FRI) for 25 years with 3 year rent reviews. This is above my opinion of lease rent which is £97,625 pa plus VAT.

NHSPS have agreed to the annual rental figure of £97,625 and this business case is reflective of this amendment throughout.

In this instance, the comment by the DV and the breakdown below is relevant and supports the project.

"I am of the opinion that a rate of £181m2 (FRI) on the net internal area and £275 per car parking space (FRI) is appropriate for the proposed subject premises and have therefore valued accordingly".

The breakdown of costs in the report is as follows:

Ground + First floor: 522.60 @ £181.00 per m2		£94,591
11 car parking spaces @ £275 each		£3,025
Total		£97,616
	Say	**£97,625 pa (FIR)**

This assumes a valid practical completion letter is issued within 2 years of the date of the report.

5 The Commercial Case

5.1 Introduction

This case sets out the commercial arrangements for the project describing the procurement strategy that has been undertaken for the development. It looks at the strategies for the provision of equipment and IM&T and identifies the key risks the project faces and who is based placed to manage these risks.

5.2 Land purchase

5.2.1 Background

An original Cabinet report in 2013 approved the in principle transfer of the land to the local GP as part of the original proposed GP led scheme. In December 2015, the Council discussed with NHSE the current intention

to deliver the scheme following the collapse of the original GP led scheme and subsequently confirmed that they continued to support the proposal and to maintain the land allocation agreement.

NHSPS have agreed with the Council that they will provide 100m2 of community space in a building adjacent to but separate from the Health Centre. This space will be owned and controlled by the Council.

The proposal was presented at a public consultation exercise by Rugby Borough Council, which included RBC Cabinet members, local community groups and residents in Brownsover. There was a positive reaction and the layout and configuration of the accommodation in support of the 100m2 was agreed. NHS PS has subsequently agreed the level of specification with Rugby Borough Council and the necessary legal documentation has been prepared for signature in support of the land transaction. The land transaction will be completed after the approval of the Full Business Case.

5.2.2 Cost for community space

NHS PS instructed an independent Surveyor – Montague Evans to value the proposed freehold that would be transferred to NHS PS. The market valuation based on C3 – residential use exceeds the cost of building the Community Centre. Heads of Terms have been agreed with Rugby Borough Council and the formal legal documentation supporting the land transaction will be drafted ready for signing on confirmation of the approval of the Full Business Case.

The site has been independently valued by Montague Evans and the valuation for the land to be retained by NHSPS is £300K. The outturn cost of the development of the Community Centre, including professional and statutory fees is £271,238 – referred to in the FBC as the capital land value. NHSPS have appointed solicitors Freeth LLP who are liaising with the "in house" legal services of Rugby Borough Council. Heads of Terms for the land sale for a peppercorn have been agreed and formal legal agreements have been drafted for completion in anticipation of approval to the FBC on 30th November 2017.

5.3 Procurement Strategy overview

As Brownsover is not in a LIFT area the procurement for the Brownsover development has been managed through NHS Property Services Ltd (NHSPS).

NHSPS is a limited company set up in 2011 and wholly owned by the Secretary of State for Health. NHS Property Services manages, maintains and improves NHS properties and facilities within their portfolio, their core business is those of landlord and advisory services which most former primary care trust estates teams provided or managed.

NHSPS considered a number of procurement options as shown in table 24.

Procurement option	Review
Third party development	Development company to fund. Allows NHS England to control, and simplify the building contract structure. Cost to NHS funded through revenue. NHSPS will require letter of commissioning requirements to underwrite Head lease. Procurement could be through Community Health Partnerships using an existing LIFTCO.
Capital development	ETTF (Estates and Technology Transformation Fund) may be available to fund this project. In this case, the CCG would be bidding for funding to "mandate" over to NHSPS via DH. NHSPS may have access to customer capital to fund this project
LIFT development	Outside of the LIFT geographical area
GP-led development	Due to nature of APMS contract, the practice is not in a position to take risk and fund themselves.

Table 24 - NHSPS procurement options

Two options were therefore available to fund this project, a 3PD or NHS capital funding. Following detailed discussions between NHSE and NHSPS it was determined that the scheme would be funded through public capital which was transferred to NHSPS for the delivery of the project. The appropriate lease arrangements would therefore be NHSPS acting as landlord, with the APMS provider and any future service provider as the lease holder.

5.3.1 The government construction strategy

The government have issued a new construction strategy 2016 – 2020.

As part of this strategy the GCS seeks to ensure collaborative procurement. This drive towards a coordinated approach for collaborative procurement includes framework development, operation and best practice. Although not specifically referenced in the document, P21+ has historically been the default option for construction projects, however, due to the relative small scale nature of the development (624m2) and the challenging construction costs to achieve value for money as determined by the DV, NHS PS procurement strategy has been to procure the building and design services on a traditional basis, seeking competitive fee quotations for design services from consultants with a proven track record in Primary Care development.

To explore the possibility of achieving cost savings by jointly working with the Foleshill development, the Project Management and design services were invited to submit a fee bid with the possibility of this joined up approach. Upon evaluation of these fee bids it was deemed that there were no financial benefits in working jointly with the Foleshill development team. Detailed designs for Brownsover were therefore completed to RIBA work stage 4 and issued to five local main contractors, all with experience of Primary Care development.

5.4 NHSPS process from OBC approval to procurement of contractor

On confirmation of the approval of the OBC on 11th October, NHS PS formally appointed the consultant Project Manager – Quadrant Surveying Ltd, following a competitive tendering process.

A competitive tendering exercise was carried out with local SME consultant design professionals with extensive Primary Care experience, invited to tender. This included the prospective design team delivering the Foleshill scheme. Following the completion of the tendering exercise, a Design team, led by The Design Buro (Coventry) Ltd were appointed by NHS PS in early January 2017.

A DQI Stage 2 event was held on Tuesday 21st February where the design proposals were presented, a report of the DQI event is included (Appendix 8).

Taking into account the comments received from the DQI event, the design team prepared the planning pack for submission to Rugby Borough Council. Rugby Borough Council requested that any planning application be deferred until the completion of their formal consultation on 5th May. The full plan planning application (appendix 13) was submitted on 8th May 2017 and went to the planning committee on 14th June where permission was granted.

In parallel with the planning application a tender pack was prepared in anticipation of an issue date of Friday 16th June.

Conditional planning approval was received on 16th June 2017 (appendix 14)

Procurement of the contractor was achieved through undertaking the following steps:

- A list of nine potential contractors for tender was drafted following input and recommendation from the Design Team and NHSPS.

- A pre-qualification questionnaire (PQQ) was issued to all nine contractors with positive responses received from six contractors.
- The PQQ's were reviewed by Quadrant Surveying Ltd and all met the requirements of NHS PS and recommended for inclusion on the Tender List.
- Shortly prior to Tender Issue one contractor withdrew from the process resulting in five tenderers remaining.
- The period to produce and complete design information was shorter than usual procurement allowances and this resulted in a number of Tender Addendums being issued leading to an agreement to extend the Tender Return to 4 August 2017.
- Upon immediate review of the Tender Bids, it was clear that the returns were all above budget and required further review and analysis to enable Value Engineering (V.E.) to be undertaken, the three most competitive tenderers were invited to proceed with V.E.
- Post tender contractor meetings took place on 7 September 2017 and Quadrant liaised with the contractors to agree fixed revised Contract Sum Analysis documents based upon the V.E. process and those meetings.
- This enabled Quadrant to provide NHS PS with a Final Tender Report on Monday 11 September providing recommendation of which contractor to appoint for the Works.
- A preferred contractor has been selected Greswolde Construction Ltd and will be appointed following the formal approval of the FBC

5.5 Design of the new centre

The new building will be a two storey GP surgery with a separate but adjacent community area. Figure 22 shows what the site massing will look like looking down on the new site.

Figure 22 - top down view of site massing

The building will be mainly brick built with some timber and glass highlights. The shaping of the building fits neatly with the natural slope of the site ensuring local residents can see an interesting stepped shape rather than a solid box. Figure 23 demonstrates how this will look.

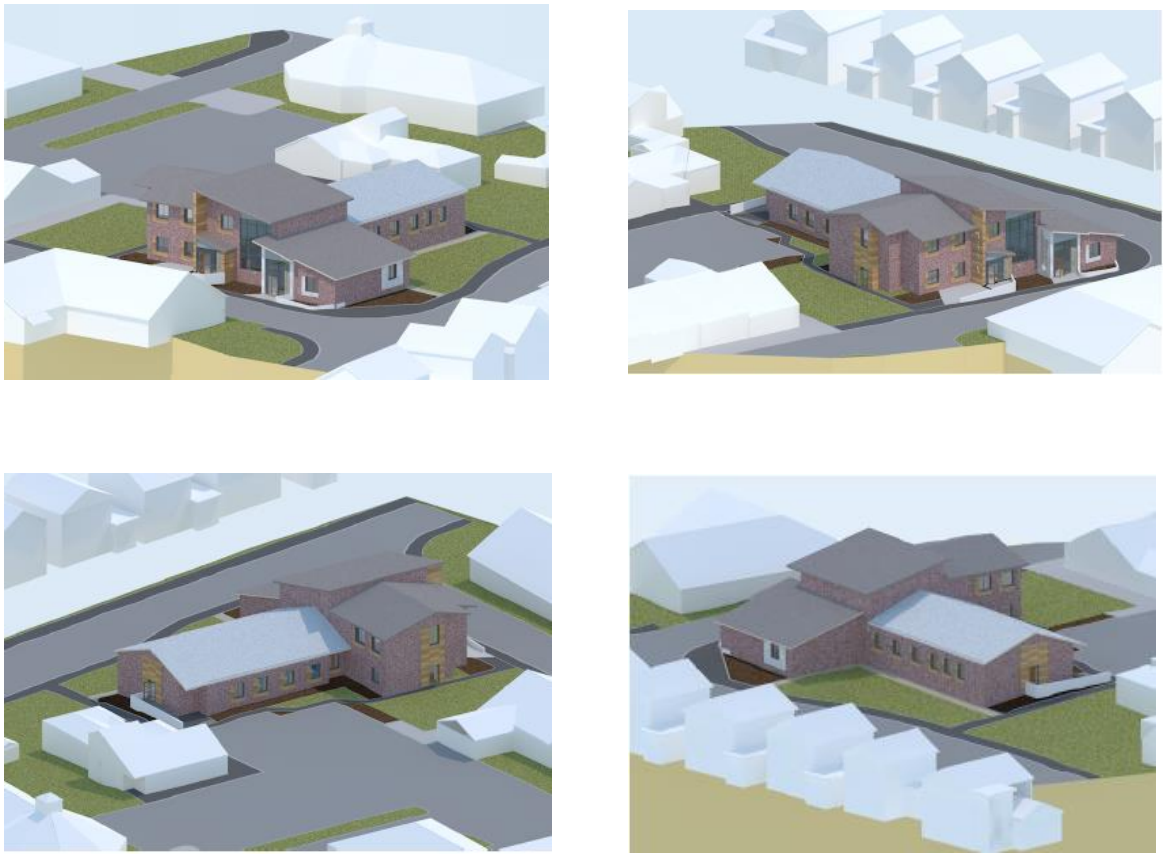


Figure 23 illustrative site massing

The approach to the building is intended to be light and welcoming with easy access for wheelchair users and on entering the building patients and visitors are greeted by a curved reception in front of them through a short lobby area. Figure 24 shows the light welcoming entrance to the centre.

Figure 24 - The entrance to the health centre with the community building adjacent

Figures 25 and 26 give some 3D visual interpretations of the building.

Figure 25 – 3D views

Figure 26 – 3D views from top

The ground floor will be comprised of public areas, reception and waiting areas, with two flexible group rooms. Beyond the reception area the building is laid out in a linear fashion with 5 consultation and 2 treatment rooms opening off a long corridor, the layout naturally preserves privacy for patients as there is clear delineation between general circulation space and consultation/treatment areas. In addition to the rooms in this area, there is also a consultation room, a clean and dirty utility, specimen room and stores. See figure 27 ground floor plan, this is marked with areas A and B for the purposes of providing enlarged views at figures 28 and 29.

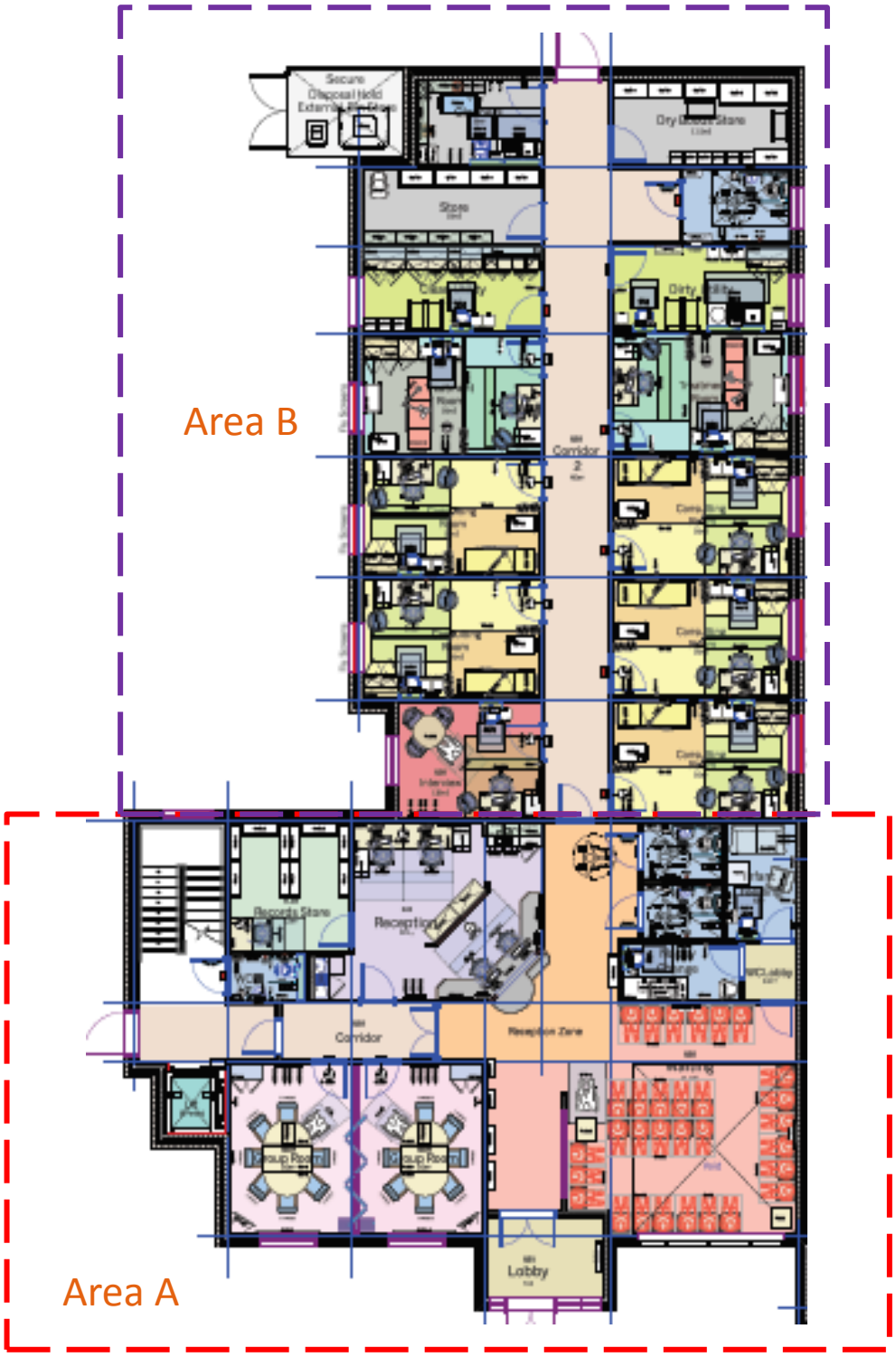


Figure 27 - Ground floor plan

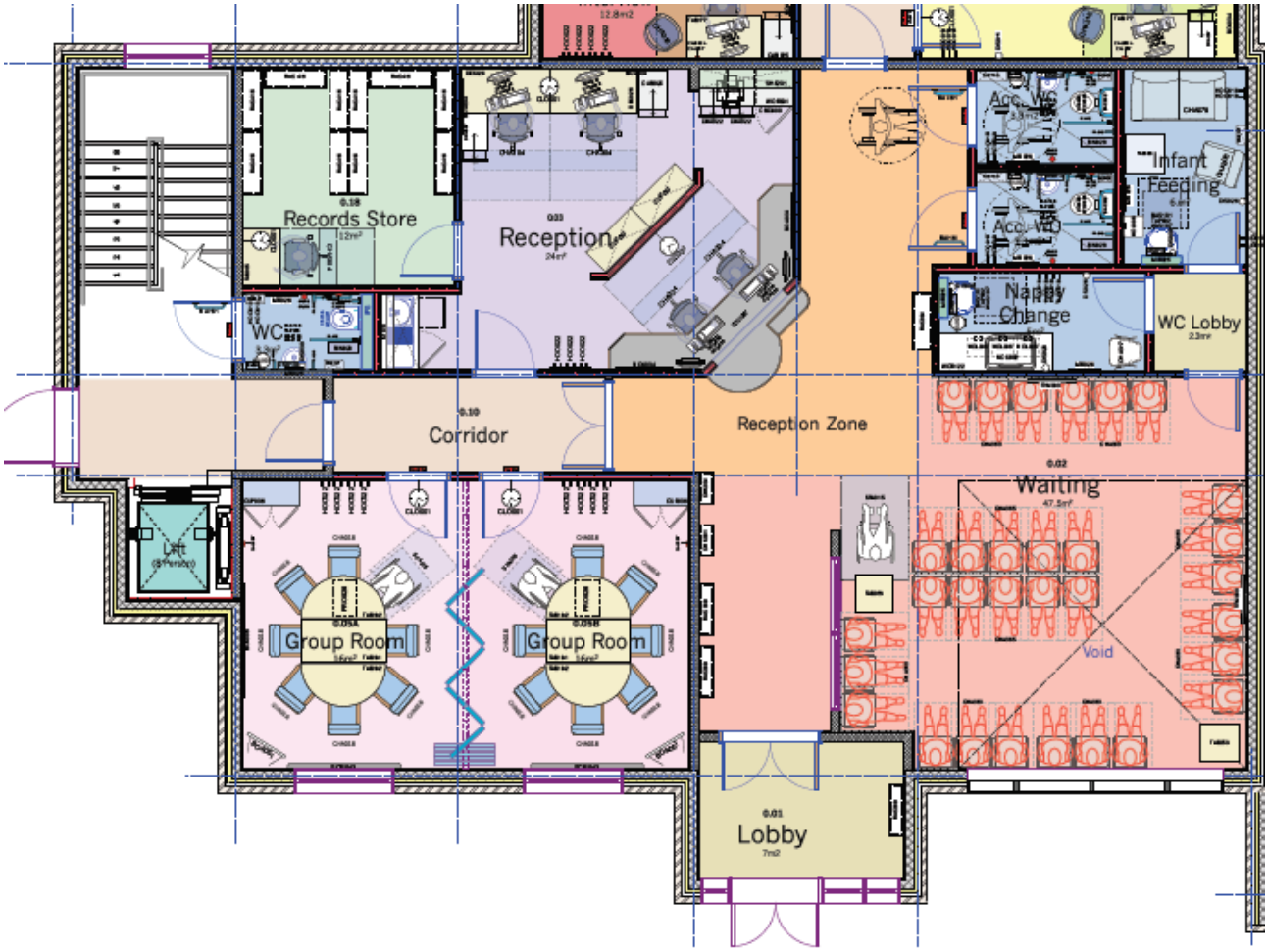


Figure 28 - Enhanced view of Area A the entrance and public spaces in the new centre

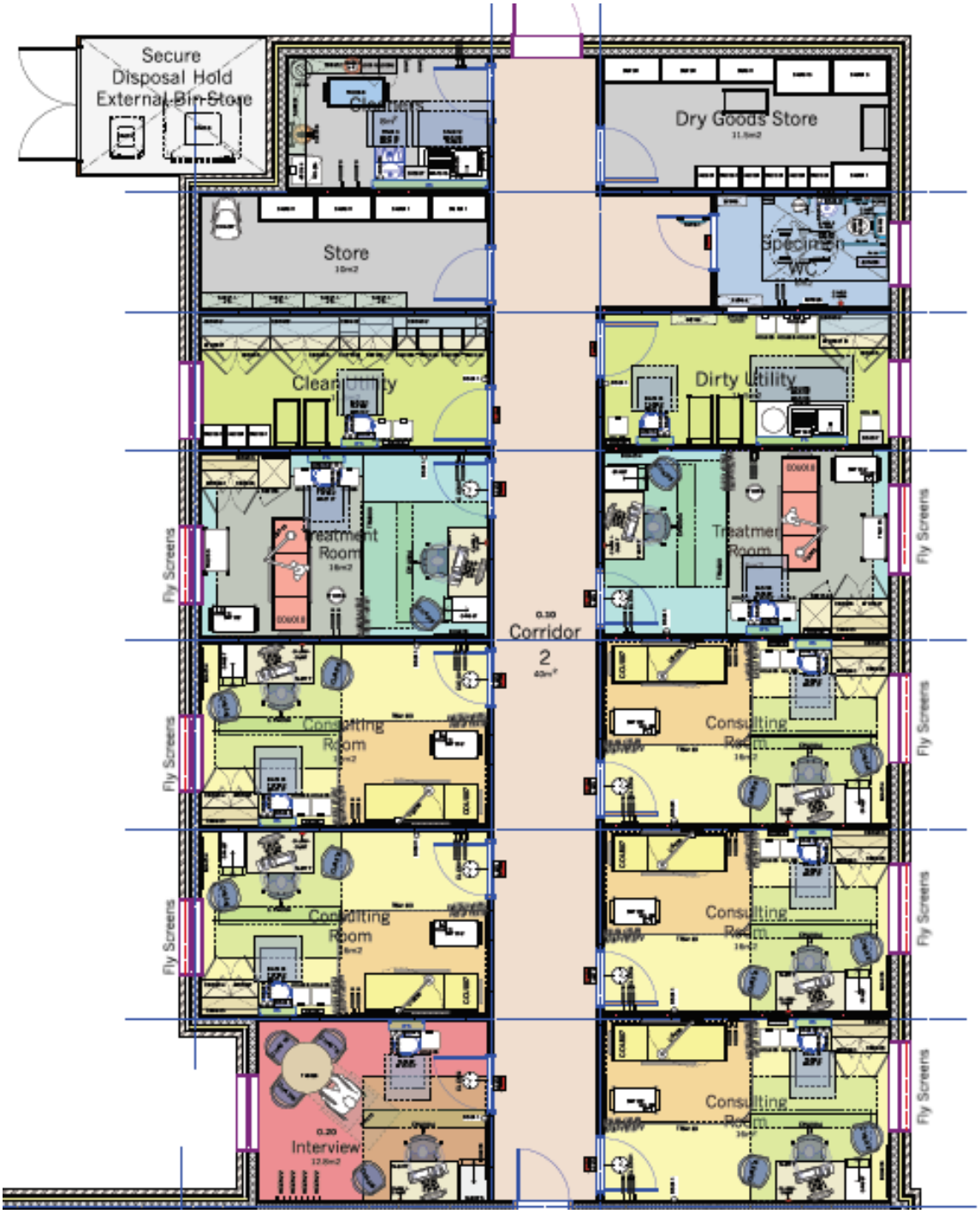


Figure 29 - Enhanced view of Area B the consultation and treatment areas of the new centre

The first floor is administrative only and there is no patient access to this area, figure 30 shows the layout of the first floor.

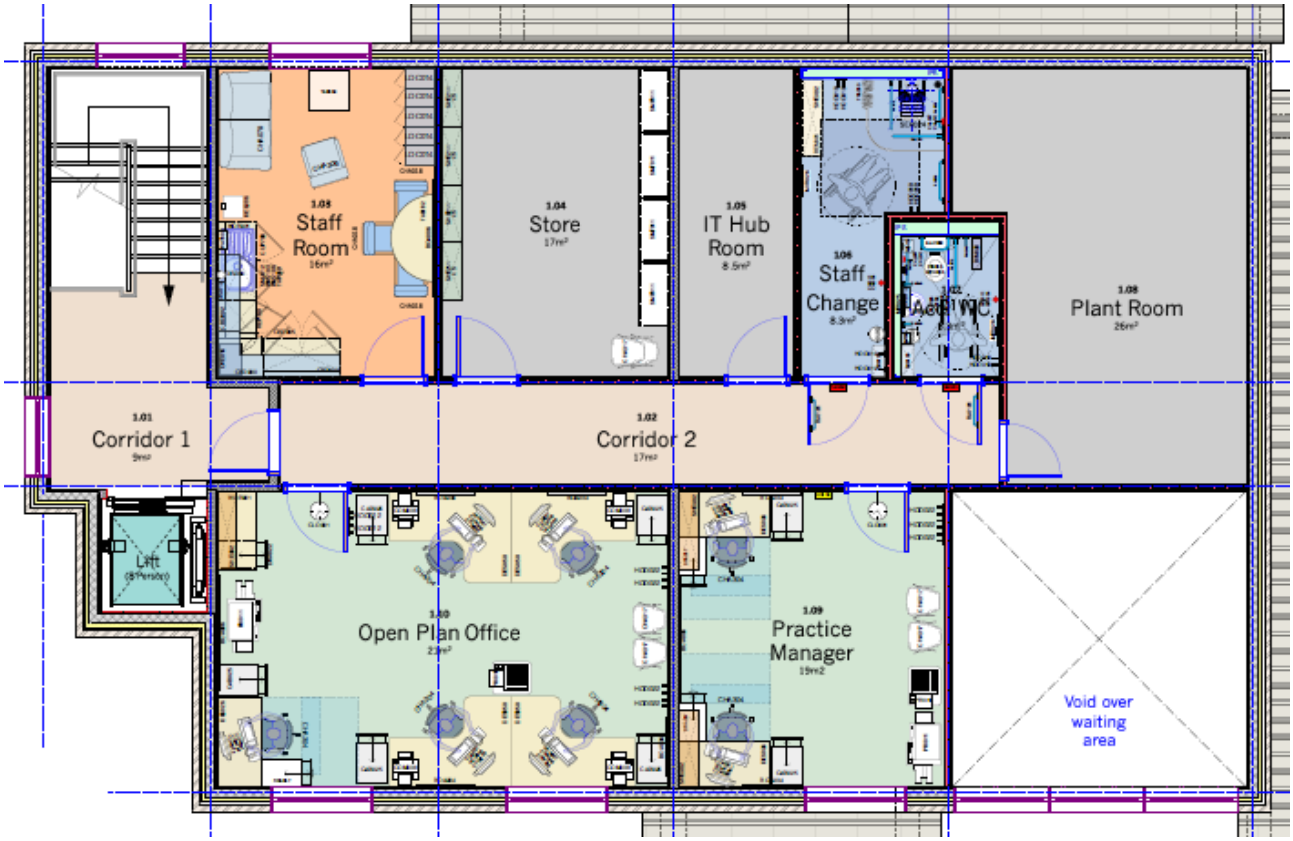


Figure 30 - layout of first floor

The final design of the building is the result of an original architectural concept and subsequent input from a variety of stakeholder groups including the patient action group, infection control representative, service leaders, GP representatives, NHS England representatives and suppliers through various DQI stages.

5.6 Potential for risk transfer

Table 25 outlines the risk transfer potential for the scheme.

	Potential risk	Risk management	Risk allocation	Risk to project
1	NHS England approval refused	Early engagement with NHS England and Coventry and Rugby CCG to determine approval routes	NHS England	Low
2	Inability to negotiate appropriate terms with the current landowners	RBC continue to support the scheme and require community space within the building in exchange for the land. Discussions have taken place around land value v provision of space and NHSPS are confident that this will be satisfactory. Draft HOTs included in the business case. RBC have been included in events for stakeholders and a representative did attend the DQI event	NHSPS	Low

	Potential risk	Risk management	Risk allocation	Risk to project
3	Poor site / building conditions	Site surveys have been undertaken. It is assumed good title can be shown and that the property is not subject to any unusual or onerous restrictions etc. as there are properties adjacent to this piece of land. NHSPS are satisfied that the appropriate site surveys referred to in this business case have been completed and mitigated in line with the LA planning requirements	NHSPS	Low
4	Stakeholder engagement	Communication plan in place, various stakeholder events including DQI sessions taken place.	NHPS/CCG	Low
5	Changes to Design following Planning Approval	The contract allows for the variations by the Head Tenant. NHSPS will manage variations in the appropriate way as and when they occur during Construction. Planning permission has been granted, condition 2 specifically states that the building must be constructed in accordance with the plans submitted with the application. Any changes to the design must be specifically instructed to NHSPS by the CCG and the cost of the risk wholly apportioned to the CCG.	CCG	Medium
6	Project costs incorrectly estimated	It is the responsibility of NHSPS to deliver the project within the bounds of the financial case set out within this document. It is also NHSPS'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.	NHSPS	Low
7	Growth in capacity not achieved	Looking at additional service providers and services Residential growth and future proofing	CCG	Medium
8	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 NHSPS. Awaiting report.	NHSPS	Low
9	Increased Construction Costs due to unforeseen circumstances	These risks are carried by NHSPS with the proposed rent agreed prior to commencement of works on site. Any additional costs will fall to NHSPS	NHSPS	Medium

	Potential risk	Risk management	Risk allocation	Risk to project
10	Unable to procure a suitable APMS provider	Current APMS provider contract renewed until September 2018 with a further 12 months roll over available after that to allow time for procurement.	CCG	High

Table 25 risk transfer table

5.6.1 CCG risk

In Table 25, risks 2,3,8, and 9 are carried by the contractor and will have no impact on the CCG, the other risks are carried by the CCG. The two main risks are covered as follows:

Risk 5 - Changes to Design following Planning Approval

Planning approval for the project has been conditional that the plans submitted with the application are those used for the construction of the building. Should the CCG wish to make any alterations to these plans the costs associated are not covered within the project envelope and would need to be paid for by the CCG. The CCG have confirmed that they have a £50k contingency sum set aside for any alterations that would arise. It should be noted that this sum of money is owned and managed by the CCG and will only be used by them if and when necessary, if not used, the CCG will the funds.

Risk 10

CCG unable to procure APMS contractor. This is an internal non-transferrable risk to the CCG. The cost of this risk to the CCG is the rental charge of the health building as per the contractual agreement between the CCG and NHSPS (£97,625).

5.6.2 Contractor risk and contingency

The scheme, although Design & build under the Contract, has been fully designed to a level that ensures compliance and incorporated within a fully comprehensive set of Employers Requirements. There are a small number of defined Provisional Sums adequately costed. All associated surveys and fees have been completed and included, this includes post-novation.

The scheme has been competitively tendered, and a full analysis concluded to ensure a fully compliant contract price. Based upon this procurement strategy and risk review it was agreed with NHS PS that no construction contingency was necessary. The contractor has highlighted a contingency sum within his CSA to cover items of design development and risk, both price and construction related. Should the client (NHSE / CCG) request significant design changes, a DCR process will be adopted where the implications will be determined and any increase in revenue cost via a “supplemental” rent would be agreed prior to issuing the instruction to the contractor. NHSPS will make a notional £50K of capital funding available in the event that the client may want to issue design changes. This contingency sum is outside of the current capital modelled in determining the rental of £97,625pa supported by the DV.

5.7 Commercial and legal issues summary

The final rent figure is confirmed as £97,625 pa (excluding VAT)

5.7.2 Charging mechanism

5.7.3 Contract length

5.7.4 Key contractual clauses

5.7.5 Personnel implications (including TUPE)

TUPE – Transfer of Undertakings (Protection of Employment) Regulations 1981 – will not apply to this investment.

5.7.6 Accounting treatment

NHSPS has opted to tax, this was the basis of the original rental cost that was included in the OBC.

5.8 Equipment

As the build 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 2 and 3 equipment

The procurement of group 2 equipment is included in the timeline for delivering this project and will need to commence in parallel with the build contract, it is expected that this will commence during early 2018 for timely delivery for installation and in respect of the group 3 items, to coincide with the delivery of the building.

Some equipment will be transferred from the existing facility to the new healthcare building, this has been set out in the equipment list and the cost saving shown. In summary, the combined group 2 and 3 equipment costs are **£48,935**, offsetting the cost saving of **£14,475** for transferring existing equipment results in a total of **£34,460,** the CCG have confirmed that they will meet this cost.

There are a number of items that can be either transferred or are NHS standard items such as dispensers etc that are provided at no charge, these items are:

- Dispensers such as paper towels, barrier cream, toilet paper, hand sanitiser, soap etc.
- Sanitary bins
- Wheelie bins
- Cleaning machines and vacuum cleaner
- Warning cones
- Cleaners trolley

For those items of equipment which NHSPS is 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.

Working together, NHSPS and the CCG will need to: -

- 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.

5.8.2 Equipment Identification

Table 26 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.

Equipment group	Explanation	Purchased 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 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.	Principle contractor
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 by the CCG to be fixed by the contractor.	Tenant
Traditional Group 3 Items (all items)	Outside the building contract, loose items of equipment supplied by the tenants and which have a space implication. May have engineering requirements. The CCG have confirmed funding of these items.	Tenant

Table 26 Equipment groups

5.8.3 Equipment Responsibility Matrix (ERM)

Equipment item	Amount to be procured	Group	Responsibility for operation and/or maintenance
BOARD, marker, magnetic whiteboard 1200H1800W	3	2	Purchased by NHSE/Tent, installed by contractor, operated and maintained by tenant and owned by purchaser.
BOARD, marker, magnetic whiteboard, 600H 900W	18	2	
CLIP, spring, 32mm dia. 3, mounted on a wooden batten, wall mounted	2	2	
CLOCK battery, wall mounted	13	2	
CUPBOARD, secure lockable tambour units, adjustable shelves, freestanding, 1000W 450D, Height TBC.	2	2	
DISPENSER, paper towel roll, wall mounted	2	2	
DISPENSER, barrier cream, disposable single cartridge, wall mounted	10	2	
DISPENSER, paper towel, wall mounted	19	2	
DISPENSER, toilet paper, dispense individual sheets, wall mounted	5	2	
DISPENSER, Medical hand sanitizer, lever action, wall mounted	13	2	
DISPENSER, soap, disposable single cartridge, lever action, wall mounted	19	2	
DISPENSER, disposable gloves set of 3 and disposable apron, wall mounted	9	2	
LOCKER, freestanding, 300W 300D	2	2	
NAPPY CHANGING UNIT, countertop, safety straps, 560 (D) x 780mm (W)	1	2	
OVEN, microwave, capacity 18 litre, build in, (suitable for CUP259)	1	2	
PROJECTOR, multi-media, ceiling mounted	1	2	
RACK, leaflet/pamphlet, 4 sections, with adjustable dividers, wall mounted, 300H 805W 215D	3	2	
RACK, magazine, 3 shelves, floor standing, fixed to the wall, 1400H 900W 300D	1	2	
SHELF, raised edge, non-breakable, 500W 200D	5	2	
SHELF, raised edge, non-breakable, 300W 150D	3	2	

SHELF, raised edge, non-breakable, 200W 150D	4	2	
SHELF, specimen shelf, 800 x 200	2	2	
SHELVING FRAME, modular storage, 1 bay, with 5 shelves, 2130H 1000W 465D	12	2	
SHELVING FRAME, modular storage, 1 bay, with 5 shelves, 2130H 1000W 665D	2	2	
TELEVISION monitor, colour, flat panel, large, wall mounted	2	2	
VENDING MACHINE, sanitary towel with coin slot	5	2	
BIN, sanitary disposal, sealed, operated with one hand, nominal 420H 155W 490D	5	3	Purchased by NHSE/Tent, installed by contractor, operated and maintained by tenant and owned by purchaser.
BIN wheelie, 240 litre, 1060H 600W 730D	1	3	
BIN wheelie, 1100 litre, 1470H1370W 1115D	1	3	
BOARD, flip chart, height adjustable, freestanding	1	3	
CABINET, filing, 4 drawer, 1320H 465W 620D	9	3	
CHAIR, upright, with arms, upholstered, stacking	10	3	
UNIT CHAIR/SETTEE, 2 seater, easy, with arms, fully upholstered	2	3	
CHAIR, swivel, height adjustable, medium back, with arms	4	3	
CHAIR, easy, low back, with open arms, upholstered, wipeable	2	3	
UNIT CHAIR, 3 seater, with arms, upholstered, wipeable	7	3	
UNIT CHAIR, 5 seater, with arms, upholstered, wipeable	2	3	
SELF CHECK-IN, touchscreen computer, freestanding form.	2	3	
SCRUBBING/POLISHING MACHINE, single brush, 110v machine	1	3	
CLEANER VACUUM, dry suction, tub, with accessories, filtered air exhaust	1	3	
CONE, warning, 'wet floor'	6	3	
COUCH, examination/treatment, (2 section), with paper roll holder, variable height, retractable wheels	5	3	
COUCH, examination/treatment, (3 section), variable height, retractable wheels, with paper roll holder	2	3	
CUPBOARD, steel, 2 adjustable shelves, 2 door, lockable, 900H 900W 420D	1	3	
CUPBOARD, flammable material, metal, adjustable spillage tray and	1	3	

sump, lockable, 712H 355W 305D			
DRAWER UNIT, 3 drawer, lockable, on castors, desk height 715H 430W 600D	2	3	
HOLDER, sack, small, freestanding	7	3	
HOLDER, sack, with lid foot operated, medium, freestanding, 875H 430W 385D	27	3	
HOLDER, sack, with lid foot operated, large, capacity 120 litre, mobile	1	3	
HOLDER, sharps box, up to 7 litre capacity, rail/trolley hang or wall mounted, 170H 125W 100D	8	3	
LOCKER, 4 compartments, 1800H 300W 450D	5	3	
RACK, metal, 1 bay, 4 shelves, 1980H 1000W 300D	10	3	
REFRIGERATOR, capacity 160 litre refrigerator, under bench, 550W 600D	1	3	
TROLLEY, modular storage, single open frame, including handle and worktop, with up to 5 sets of runners for 600 facing inserts, 850H 730W 450D	7	3	
STOOL, surgeon/anaesthetist, height adjustable, includes anti-static seat pads	2	3	
TABLE, 710H 900W 600D	1	3	
TABLE, circular, 710H 900mm dia.	1	3	
TABLE, occasional, square, 415H 610W 610D	7	3	
TABLE, 720H 1200W 700D	8	3	
FLIPTOP TABLE, Modular fliptop table with lockable linking mechanisms. Rectangle for centre of meeting table. 1350 x 675mm.	1	3	
FLIPTOP TABLE, Modular fliptop table with lockable linking mechanisms. Half round table for ends of meeting table. 1350mm diameter.	3	3	
CURTAIN, corner to shower area, as shown on plan	1	3	
TROLLEY, cleaners, mop bucket, 3 shelves tray and waste sack holder, 980H 1170W 550D	1	3	
TROLLEY, dressing/instrument, stainless steel, buffered, 870H 750W 450D	2	3	

Table 27 – Equipment responsibility matrix

5.8.4 IMT Strategy

5.8.4.1 Infrastructure

The CCG's GP IT support team will maintain systems within the new building. It is expected that the system will have standard N3 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.

5.8.4.2 Digital Road Map

The General Practice Forward View 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). Coventry and Warwickshire have completed their LDR (Appendix 15).

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

5.8.4.3 Hardware/software

Tenants will be responsible for 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 existing caretaker 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 caretaker practice.

5.10 Planning consent

Planning consent for the land at Bow Fell has been granted with a number of conditions. These conditions are set out in table 28 below, this table shows the condition and the mitigation against each condition as well as the date each item was submitted or is due to be submitted, these dates are included in the project plan. The consent letter is available (appendix 14).

Condition number	Condition	Mitigation
1	The development to which this permission relates must not be begun later than the expiration of three years from the date of this permission	This date will be 15th June 2020. The plan will be to start construction in 2018, this is well within the limit of the condition. Construction Works as per key milestone schedule to start late October 2017
2	The development shall not be carried out other than in accordance with the plan numbers received by the Local Planning Authority 10th 2017 Plan numbers: 1279-DB-XX-ZZ-DR-A-053 – Site location plan (appendix 16) 1279-DB-XX-ZZ-DR-A-047 P1.1 – Roof plan (appendix 17) 1279-DB-XX-XX-DR-A-028 P1.3 – Proposed elevations (appendix 18) 1279-DB-XX-XX-DR-A-046 P1.1 – Planting plan (appendix 19) 1279-DB-XX-XX-DR-A-027 P1.2 – Photomontage (appendix 20) 1279-DB-XX-XX-DR-A-023 P1.4 – Landscape General arrangement (appendix 21) 1279-DB-ZZ-XX-DR-A-037 P1.2 – Illustrative site massing (appendix 22) 1279-DB-ZZ-XX-DR-A-038 P1.1 – Illustrative approach (appendix 23) 1279-DB-XX-XX-DR-A-026 P1.2 – Illustrative Masterplan (appendix 24) 1279-DB-XX-ZZ-DR-A-015 P1.7 – Ground Floor Plan (appendix 25) 1279-DB-ZZ-XX-DR-A-016 P1.7 – first floor plan (appendix 26) 1279-DB-XX-XX-DR-A-023 P1.2 – Existing Site plan (appendix 27) 3D plan sheet 1 (appendix 28) 3D plan sheet 2 (appendix 29)	If minor changes did occur, they should not be significant in nature therefore could be dealt with by means of a "Non-Material Amendment" application.
3	No development shall commence unless and until	Materials submitted with planning application. Samples

Condition number	Condition	Mitigation
	full details of the colour, finish and texture of all new materials to be used on all external surfaces, together with samples of the facing bricks and roof tiles have been submitted to and approved in writing by the Local Planning Authority. The development shall not be carried out other than in accordance with the approved details.	will be submitted when contractor appointed.
4	Full details of any refrigeration or air handling plant, flues or other equipment to be located externally to the building, to include proposed measures for acoustically treating such equipment, shall be submitted to and approved in writing by the Local Planning Authority prior to such plant being installed. Equipment shall then be installed in accordance with the approved details.	M&E design completed on basis of condition, final details will be submitted when Contractor appointed
5	No development shall take place until a Construction Management Plan has been submitted to and approved in writing by the Local Planning Authority and Local Highway Authority. The Construction Management Plan must include details to prevent mud and debris being passed onto the highway; wheel washing facilities; vehicle routing plan; and parking and loading/unloading of staff/construction/delivery vehicles	Contractor to complete when appointed
6	Details of any external lighting proposed for the development hereby permitted shall be submitted to and approved, in writing, by the local planning authority prior to the commencement of the development hereby permitted. The external lighting shall thereafter be installed in accordance with such approved details, unless otherwise approved in writing by the local planning authority.	M&E design completed on basis of condition, final details will be submitted when Contractor appointed.
7	In order to reduce the likelihood of local residents being subjected to adverse levels of noise annoyance during construction, work on site must not occur outside the following hours: - Monday – Friday 7.30am – 18.00pm Saturday 8.30am – 13.00pm NO WORK ON SUNDAYS & BANK HOLIDAYS If work at other times is required permission should be obtained from the local planning authority.	Contractor restrictions included in tender prelims.
8	In order to reduce the likelihood of local residents being subjected to adverse noise annoyance the opening hours of the community facility hereby arrive should be: Monday – Sunday 06.00 – 23.00pm NB: The above is made with the exception under a temporary event notice (a maximum of 15 TEN applications can occur in a year for the provisions of sale of alcohol, regulated entertainment and selling hot food after 23:00).	Rugby Borough Council

Condition number	Condition	Mitigation
9	All windows and doors should remain shut when amplified music (recorded or live) is being played in the community venue	Rugby Borough Council
10	Prior to the commencement of the development hereby approved, full details of the location a bat and/or bird box scheme shall be submitted to and approved in writing by the Local Planning Authority. Thereafter and prior to the occupation of any building the bat and/or bird boxes shall be installed on the site in accordance with the approved details.	Bat and bird box scheme and detail completed ready for submission when contractor appointed
11	The landscaping scheme, as detailed on the approved plans, shall be implemented no later than the first planting season following first occupation of the development. If within a period of 5 years from the date of planting, any tree/shrub/hedgerow is removed, uprooted, destroyed or dies (or becomes in the opinion of the LPA seriously damaged or defective), another tree/shrub/hedgerow of the same species and size originally planted shall be planted at the same place, unless the LPA gives its written consent to any variations	Full landscape scheme submitted and approved with planning application. Final detail to be submitted when contractor appointed.
12	The accommodation for car parking and loading and unloading of vehicles, shown on the approved plan 1279-DB-XX-XX-DR-A-06 P1.2 shall be provided before the occupation of the development hereby permitted and shall be retained permanently for the accommodation of vehicles of persons working in or calling at the premises and shall not be used for any other purpose.	This will be for the CCG to manage; the CCG are aware of this condition.
13	The applicant shall submit a Green Travel Plan to promote sustainable transport choices to the site, the measures proposed to be carried out within the plan to be approved by the Planning Authority in writing, in consultation with the County Council as Highway Authority. The measures (and any variations) so approved shall continue to be implemented in full at all time. The plan shall: Specify targets for the proportion of employees and visitors travelling to and from the site by foot, cycle, public transport, shared vehicles and other modes of transport which reduce emissions and the use of non-renewable fuels; Set out measures designed to achieve those targets together with timescales and arrangements for their monitoring, review and continuous improvement; Identify a senior manager of the business using the site with overall responsibility for the plan and a scheme for involving employees of the business in its implementation and development.	Attached (Appendix 30) and section 5.10.1
14	No works or development shall take place until a specification of all proposed tree planting has been approved in writing by the LPA. This specification will include details of the quality, size, species,	The Design Buro will issue the pertinent details as described to the Local Authority for approval to discharge this condition.

Condition number	Condition	Mitigation
	position and the proposed time of planting of all trees to be planted, together with an indication of how they integrate with the proposal in the long term with regard to their mature size and anticipated routine maintenance. In addition, all shrubs and hedges to be planted that are intended to achieve a significant size and presence in landscape should be similarly specified	

Table 28 – Planning conditions summary

In addition to the above conditions, the Council have also issued a number of 'informative' points to be considered during or prior to construction, these are mainly focused around wildlife and planting. The full details are available (appendix 14)

5.10.2 Contractors responsibilities

As part of the Employers Requirements the Contractor is responsible for discharging the planning conditions and costs associated. The exception, Condition 13 - a Green Travel plan has been completed by NHS PS. The CCG will ensure that the incoming APMS contractor is familiar with their obligations in terms of operating the building and the Travel Plan requirements will be circulated with the APMS tender documents.

5.10.3 Site Surveys

NHSPS are satisfied that the appropriate site surveys have been completed and mitigated in line with the LA planning requirements. NHSPS confirms that all surveys have been carried out and reviewed, this has informed the Planning approval/Design and completion of the Employers Requirements to ensure a robust tender price. A copy of the Flood Risk Assessment is included (appendix 42). NHSPS confirm the recommendations in this document are included in the design.

5.10.4 Travel Plan

Guidance on the use and preparation of Travel Plans is presented in the BREEAM Scheme Documents under Section 7 Travel. The following main objectives for a BREEAM Travel plan are included:

- To reduce the traffic generated by the development to a significantly lower level of car trips than would be predicted for the site without the implementation of a travel plan;
- To promote healthy lifestyles and sustainable, vibrant local communities;
- To encourage good urban design principles that open up the permeability of development for walking and cycling linked to the design and access statements.

A BREEAM Travel Plan has been commissioned by NHSPS scheme (appendix 30). The plan outlines a number of benefits, including:

- Reducing the need to travel by private car and aim to cut congestion on the local highway network from the new development;
- Improving accessibility by ensuring that walking, cycling, goods delivery and public transport issues are considered by the relevant authority;
- Reducing social exclusion by identifying that a wide range of transport options are easily available for new residents, including those with disabilities, and that amenities are accessible;
- Helping to reduce greenhouse gas emissions by promoting alternative sustainable travel options. This will help address the increased emphasis of tackling climate change and reducing the impact on the local environment;
- Improved health, less stress and better quality of life can be enjoyed by residents. Financial savings can be achieved through identifying a greater travel choice;
- Bringing new choices of modes of transport to a wider community with the promotion of car sharing schemes.

5.11 Schedule of Accommodation

A schedule of accommodation was developed for the scheme at OBC stage (Appendix 31) based on using concept design only and accommodating a list size of 10,000 patients. The schedule was then updated as the design was shaped and the new Schedule of accommodation (Appendix 32) created and used to build the planning application pack, this schedule of accommodation is summarised in table 29.

NHSPS have confirmed that there are no derogations from HTM's in the scheme, this also applies to *after* the VFM exercise was undertaken.

Activity space	Primary care centre	
	Quantity	Total area m2
Public spaces, Entrance, reception, waiting, WC's	9	103.3
Clinical spaces, consulting rooms and treatment rooms	7	112
Support spaces, clean and dirty utilities, stores, plant room, cleaners room, specimen WC and IT hub	10	95
Staff spaces i.e. office areas	2	51.4
Staff support areas i.e. record stores, changing rooms etc.	8	86.8
Net Internal area (NIA)		**448.5***
Gross Internal Area (GIA) GF		**444.6**
Gross Internal Area (GIA) FF		**179.5**
Total GIA		**624.1**

Table 29 – Schedule of Accommodation FBC

* The NIA in the district valuer's report is 522.6m2 as per RICS guidance note 60 with the Total GIA remaining at 624.1m2

5.11.2 Capital Costs

A set of standard FB forms have been produced (Appendix 41) based on the Schedule of Accommodation (Appendix 31). These have identified the costs shown in table 30.

Cost Item (Summary)	Cost
Departmental costs (FBC2)	£108,0810.24
On-Costs (FBC3)	£107,827.62
Works Costs total at BIS PUBSEC 195	**£1,188,637.86**
Provisional location adjustment	£0
Sub – total	**£1,188,637.86**
Fees	£356,561.51
Non-Works Costs (FBC4)	£228,967.13
Equipment costs (FBC2)	£0
Planning contingency	£0
Total	**£1,774,166.50**
Optimism Bias	£0
Sub total	**£1,774,166.50**
Inflation adjustment	327538.43
Forecast Outturn Business Case Total	**£2,101,704.93**

Table 30: Capital costs from FB forms

* Contractor costs held until 30 November 2017

5.11.3 Design Principles

5.11.3.1 Drawing/design considerations

The following considerations have been taken into account when finalising the design for the new Brownsover facility

- 1:50 scale designs (Appendix 25 and 26) for a primary care health centre have been developed based on the SoA (Appendix 32).
- Clinic Rooms have been sized generically as laid out in HBN11-01 to allow considerable flexibility of clinical use.
- The design has been developed using a modular dimensional approach, including clinical and non-clinical spaces. The overall GIFA is below the original OBC SoA. All rooms are 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 admin areas are in an open plan space with six desk areas of 6.6m2. Partitions could be included.

- The accommodation remains arranged over two floors with dedicated Staff accommodation on the First floor. All Patient/Clinical areas are provided on the Ground Floor. This allows best utilisation of the site, and retains some site area for future expansion.
- The design continues to be targeted to achieve a BREEAM Excellent rating. NHSPS have employed Scott White & Hookins to compile and manage a BREEAM tracker. This tracker is continuously reviewed to ensure that the targeted credits exceed the 70% threshold to achieve "Excellent", the design stage evidence is being complied and the BRE submission will be undertaken as soon as practicably possible. The design stage certificate will not be available before the Full Business Case is submitted for approval however, NHSPS will make this available as soon as it is produced. A copy of the detailed BREEAM tracker is available (Appendix 33). Please note, this is a working document and therefore this has been baselined at 6.11.17. The current summary is:

Current Targeted' Rating Total:	70.91%
Equating to BREEAM:	Excellent
Total if all 'Additional Potential' Credits are also achieved:	75.26%
Equating to BREEAM:	Excellent
Current Evidence Received Total	65.33%
Equating to BREEAM:	Very Good

Table 31 gives details of the advisors to the project in respect of BREEAM

- BIM - A Digital Model has been developed for the Brownsover Surgery development in accordance with PAS 1192-2. NHSPS are developing their 'Employers Information Requirement Document' (EIR) that determines the key technical, management and commercial requirements. When issued, a 'BIM Execution Plan' would have been developed to set out project specific standards, delivery strategy, goals/milestones and competency. Notwithstanding the absence of the 'EIR' the Design Team have developed a Digital Model to enable graphical and non-graphical data to be derived from the 3D Model together with 2D information, including asset information."
- The FBC estates standards are based on compliance with HBN 11-01 - 'Facilities for primary and community care services', and HBN00-09 Infection Control (see notes from the infection control lead (Appendix 34)) in the Built Environment.
- The FBC estates standards are based on compliance with HBN 11-01 - 'Facilities for primary and community care services', the design is compliant with this guidance. The design is compliant with HBN11-01. Given the scale of the project, the proposals are designed to Building Regulations as this was deemed more appropriate by the Fire Officer. Minutes of a fire strategy review meeting are available (appendix 36). HTM 05-02: Firecode has been prepared in order to provide specific guidance for healthcare premises to demonstrate compliance with Part B of Schedule 1 of the Building Regulations. NHSPS have confirmed that the building has been designed in order to comply with the applicable requirements as set out within HTM 05-02: Firecode.
- The administrative area is compliant with the SoA presented for the FBC design.
- The agility ratio of 8 desks per 10 people has been applied to the SoA.

Consultant	Service	RIBA work stage engagement
Scott White & Hookins	BREEAM Assessor	1 to 7
RBA Acoustics	Assessment of Acoustic Performance	4 to 5
JMS Consulting Engineers Ltd	Travel Plan	4 to 5
Middlemarch Enviro Ltd	Ecological Surveys	4 to 5

hrs Services Ltd	Renewable Energy Feasibility Study	4 to 5
Additional Surveys for BREEAM	TBC	4 to 5

Table 31 - BREEAM advisor team

5.11.4 DH Consumerism compliance

In addition to the good design principles it is important that the design is compliant with DH consumerism requirements for healthcare buildings. NHSPS have created a Consumerism Standards document that outlines the design compliance with these requirements (Appendix 36). This is summarised in table 32

Consumerism requirement	Compliance example
A design that provides acceptable levels of privacy and dignity at all times	Space for visitors to sit with patients, with adequate space between chairs. In respect of acoustics, NHSPS appointed RBA Acoustics Ltd appointed to provide design assessment and recommendations to ensure compliance with HTM-08. Recommendations incorporated into tender documents and acoustician retained by NHSPS for validation of construction performance prior to Practical Completion. Copy of acoustic report attached (appendix 43).
High specification fabric and finishes to reduce lifecycle costs	External finishes compliant with HBN 'core Element' standards, internal finishes compliant with HBN guidance for durability and infection control purposes
Natural light and ventilation	Large, double glazed, and thermally efficient windows, natural ventilation has been provided wherever possible.
Zero discomfort from solar gains	Careful internal planning has reduced the possibility of discomfort from solar gains
Dedicated storage space to support high standards of housekeeping and user safety	A number of store rooms have been provided to the rear of the clinical area, easily accessible and secure
Dedicated storage for waste awaiting periodic removal	Provided to the rear of the clinical area
Single sex toilet facilities	Provided in the design
Immediate access to patients to call points for summoning assistance	Individual treatment rooms and sanitary rooms provided with emergency call systems
Patient control of personal ambient environmental temperatures	Provided wherever possible
Gender specific day rooms	N/A
Inpatient bedroom configuration requirements	N/A
Bedhead and bedside requirements	N/A
Elimination of mixed sex accommodation	N/A

Table 32 - consumerism standards compliance

5.11.5 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 this 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 a workshop on 22nd April 2016.

A workshop for detailed design was held in February 2017.

Both events were well attended, and good feedback given. A full report of the event and the attendance list is available for both of these events (appendix 4 & 8).

5.11.5.1 Outputs from the mid-term session

The DQI report for the mid-term session produced a number of graphical outputs. Figure 31 shows a spider diagram of the outputs in relation to the function, form and performance elements of the design. This graph shows a clear balance across all of these elements.

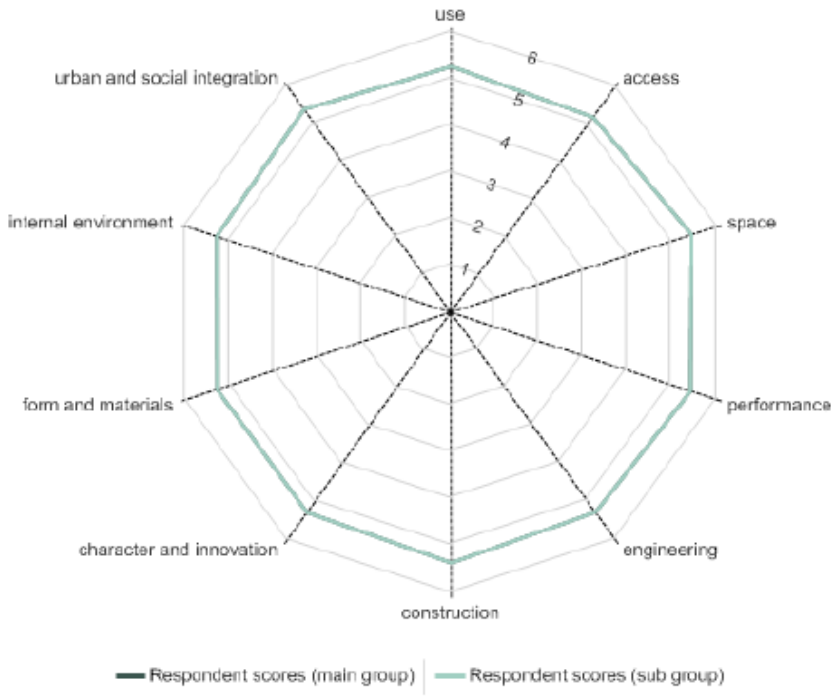


Figure 31 - Elements of function form and performance outputs detailed design DQI

Figure 32 is a representation of the 10 sections under the main scoring headings in the DQI session. This graph shows the popularity of each of the sections.

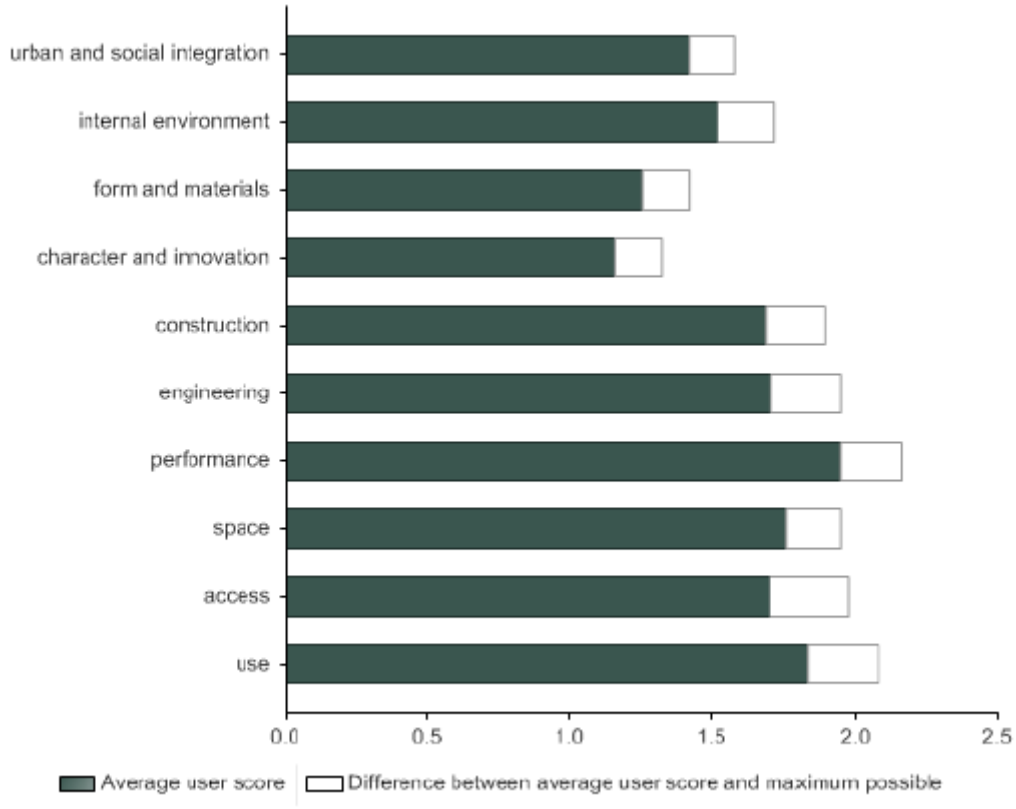


Figure 32 - Popularity of the ten elements of the DQI session

Figure 33 shows the summary of the DQI overall and is scaled between 0% and 100%. The graph shows the maximum possible score against the actual score.

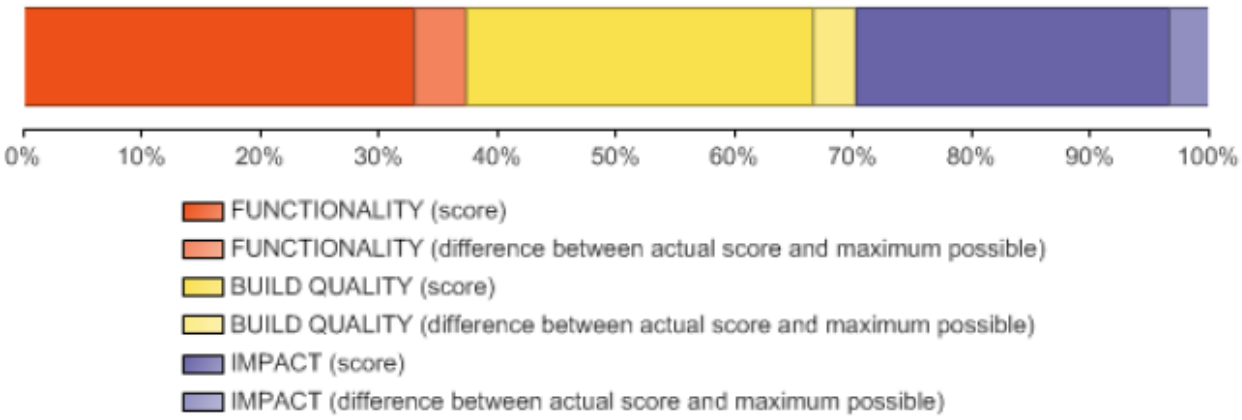


Figure 3 Maximum score v actual score for DQI overall elements

5.11.6 VOA checklist

As part of good practice and assurances a Valuation Office checklist was completed for the outline business case.

DVS (part of the Valuation Office Agency) fulfils an essential and key role in the primary care development process. The role, acting on behalf on the NHS, 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, Health Authority, Health and Safety Executive, HM Government and other applicable guidance and requirements, room sizes and efficiency of layout.

This document is to assist identification of the key areas of compliance during the development of the premises.

A completed VOA checklist for the scheme is attached at appendix 5. At the time of the OBC this checklist could not be populated fully because the detailed architectural, mechanical and electrical design for the building had not been worked up. The VOA checklist has been revisited for this FBC and populated fully (appendix 5). An analysis of the changes is shown in section 1.5.10 in table 13.

5.11.7 Project synergies with the Foleshill scheme

The Brownsover OBC was a joint document with the Foleshill scheme on account of the similarity between the two schemes. By working up a joint document a number of synergies could be achieved;

- Standardisation of the concept design
- Ability to use the same advisors
- Ability to share development costs

The projects have now split and the FBC's taken forward separately. The gap in time development wise is now considerable making further savings through joint working too challenging. There is still prudence in using lessons learned from the Brownsover scheme to help to shape the Foleshill scheme moving forward and it will be the application of these lessons that will drive any benefit for Foleshill.

6. The finance case

6.1 Introduction

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. It looks at the revenue and capital implications of the project and how these will be funded and by whom.

6.2 Sources of Capital Funding

The current capital costs of the scheme excluding VAT are as set out in table 33 and is supported by the FB forms attached as appendix 41

	£
Capital Cost	**2,101,704**
Comprised of:	
*Tendered construction contract	£1,408,078
Professional fees including legals	£ 231,324
Land cost (Community Hall)	£ 271,238
Sub total	**£ 1,910,641**
NHSPS developers charge	£ 191,064
Total	**£ 2,101,704**

Table 33 Capital funding costs

*Held until 30 November 2017

6.3 Cost comparison OBC and FBC

At the time of the OBC production, there was no detailed design, only an idea of what the building could look like as prepared for the DQI stage 1 and 2 review. In addition the final procurement route had not been agreed and although there was an idea in principle no firm agreement had been made around the land and costs with Rugby Borough Council. A Public Sector Comparator (PSC) was therefore used to estimate the capital costs of the scheme. The OB forms reported this as £4.6m. NHSPS had calculated the cost of the scheme themselves and in parallel on a capital funded option at £2,100,611. After the confirmation of the procurement route, the final answers around the land apportionment and agreements and the work up of detailed design and firming up of procurement route the difference between NHSPS' initial cost estimate and the final cost at FBC is £1,094.

The expected cost of the lease at that time was £98,000, very much in line with the DV's report on Value for money in this FBC.

6.4 Overall revenue affordability

6.4.1 VFM – District Valuer

The District Valuer sent her report on 25th October 2017 (Appendix 40). The report sets out the following summary points:

- I have considered the information made available to me together with my Value for Money (VFM) recommendation regarding the proposed project

  In respect of the proposed lease to the GP Practices, I have set out my assessment of the estimated "Current Market Rent" (CMR) recommended for reimbursement in accordance with, and as defined in:

  National Health Service, England

  The NHS (GMS – Premises Costs) Directions 2013

- I understand the developer is seeking a rent of £98,000 pa plus VAT on a tenant's full repairing and insuring lease (FRI) for 25 years with 3 year rent reviews. This is above my opinion of lease rent which is £97,625 pa plus VAT.

NHSPS have agreed to the annual rental figure of £97,625 and this business case is reflective of this amendment throughout.

In this instance, the comment by the DV and the breakdown below is relevant and supports the project.

"I am of the opinion that a rate of £181m2 (FRI) on the net internal area and £275 per car parking space (FRI) is appropriate for the proposed subject premises and have therefore valued accordingly".

The breakdown of costs in the report is as follows:

Ground + First floor: 522.60 @ £181.00 per m2		£94,591
11 car parking spaces @ £275 each		£3,025
Total		£97,616
	Say	**£97,625 pa (FIR)**

This assumes a valid practical completion letter is issued within 2 years of the date of the report.

6.4.2 Clinical costs

The clinical costs for the project remains as at present and will do so until the procurement of the APMS providers for the scheme. A separate business case will be produced at the time of the appointment of the new APMS provider to demonstrate the affordability and value for money.

6.4.3 Cost comparison current costs/new costs

The new Brownsover Health Centre will be procured by NHSPS through NHSPS Customer Capital. The property will be leased by NHSPS directly to the GP Practice on a lease coterminous with the APMS contract. The lease will be a full repairing lease with the GP's being responsible for FM services under the tenancy.

NHS England have agreed and approved the additional rent reimbursement and associated costs payable to the GP Practice under Primary Care Premises Costs Directions as set out in Table 34. This 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.

	Current Costs £	New Costs £	Difference £

	Current Costs £	New Costs £	Difference £
Cost of occupation			
Transport	27,000	0	-27,000
Rent (Reimbursement level)	35,000	97,625	62,625
Rates	15,000	25,000	10,000
Water and clinical waste	5,100	10,000	4,900
Total Cost	82,100	132,625	50,525
Funded by			
NHSE under PCD	82,100	132,625	50,525 *

Table 34: Recurrent Revenue Affordability. Source and application of funds

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. The VAT charged to GPs is currently irrecoverable for medical practices.

This represents an increase in the revenue cost of the building of £50,525 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 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.

CRCCG 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 will be met by the GP Practice and funded from the service contract payment they receive from commissioners.

The agreement for lease rent will be based on a fully insuring and repairing lease, FM services do not form part of this agreement. An FM service can be provided but there is no obligation for the Tenants to utilise this service. Costs have been provided to NHSE and the CCG by NHSPS

There also a number of transitional, non-recurrent costs for the scheme as detailed in table 35.

* This figure is £375 less than quoted in the approved OBC due to the application of the DV report content to the FBC

	£'000
Non-recurrent costs	
Stamp Duty Land Tax	36,500
Legal Costs	10,000
Sub total	46,500
Funded by NHS England	46,500

Table 35 – Non-recurrent costs

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

6.5 VAT Treatment

NHSPS has opted to tax and the necessary confirmation issued to HMRC.
The benefit to all parties of opting to tax is that the capital cost of VAT is recovered and not included in the development costs.

6.6 Project Costs

Project costs from approval of the FBC through to commissioning of the building will be paid by NHSPS.

7 The Management Case

7.1 Introduction

This Section of the FBC explains how the Brownsover scheme will continue to 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 facilities.

7.2 Project management arrangements

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

- Design and construction of the new Brownsover primary care centre with all associated clinical and non-clinical support services; and
- Relocation of primary care centres into the new facilities

The Brownsover project is led by Coventry and Rugby CCG, who are working with NHSPS. NHSPS have a proven track record of developing Primary Care estate, since its formation in 2011.

The project will be structured using PRINCE2 methodology. The reporting organisation and the reporting structure for the project is shown in figure 34

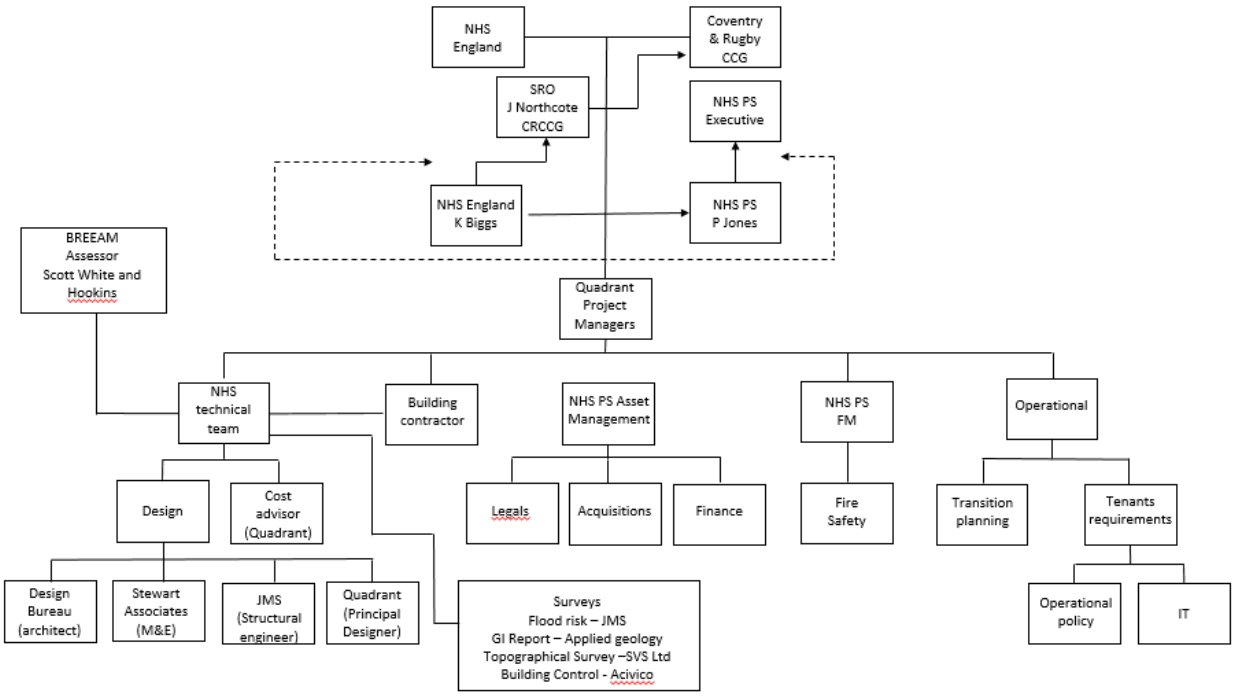


Figure 34 Project Management structure

7.3 Management of project phases – responsibilities

Item	Resource	Requirements	Outputs
Procurement process	NHSPS, Design team	Tender documents, contract documents	Contractor appointment
Construction Phase	Aftercare Team for defects period, NHSPS	Defects reporting system, Facilities Management	Building signed off at end of Defects Period. Maintenance of Building and Servicing
Operational phase – Hard FM		[Awaiting information]	Managed Soft FM services
Operational phase – services	APMS provider	APMS contract	Patient services
Operational phase – Soft FM		Tenant responsibility – Full repairing internal lease	Managed Soft FM services
Operational phase – movement of staff into building		Tenant responsibility – Full repairing internal lease	Managed Soft FM services

Table 36 – project phases responsibilities

7.4 Project plan

A project plan has been drawn up and agreed by the project team (appendix 7), the key milestones are shown in table 37.

Milestone	Target period
Planning consent	10/05/17
Procurement of contractor	September 2017
FBC review	05/11/17 - 30/11/17
CRCCG Primary Care Committee approval	22/11/17
Contractor price expires	30/11/17
Financial Close	30/11/17 – 7/12/17
Site set up	08/12/17 – 26/1/18
Construction period	26/01/18 – 08/11/18
Commissioning and handover	09/11/18 – 23/11/18

Building Operational	26/11/18
Post Project Evaluations commence	03/12/18

Table 37: Project Plan key milestones

7.5 Project Costs

The total cost of NHSPS fees associated with the delivery of the Brownsover scheme is £356,561.51.

This covers the following:

- Legal and financial transaction advice
- Development of information for the FBC
- Development of the detailed design
- Technical advice
- DQI assessment inputs
- Cost advisor

In respect of the CCG's costs, the following support items are acknowledged by the CCG:

- DQI stages 4 and 5 assessments
- Ongoing cost advice including site inspections throughout the build
- Any unaccounted costs for removal and delivery of IT equipment from existing premises to new premises

7.6 Benefits realisation plan –

The Benefits Realisation Plan (BRP) (appendix 37) 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 38

Benefit	How benefit will be delivered
Strengthen capability of current service provision across core and non-core services	Provide a modern facility that meets 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 a modern facility that meets modern standards to ensure current services are being delivered to a high standard.
Improved quality of care	Reconfigure services and staff teams to reflect new models of care in a new facility
Clean and modern building	Design of new facility 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 a facility that encourages the integration of health and social care, allowing for new working	Improve functional relationships/adjacencies and increase operational efficiency to deliver better quality care.

Benefit	How benefit will be delivered
practices and subsequently providing working efficiencies	Unsure size will allow for commissioning intensions 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	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 facility meets 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	Facility 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 facility provides 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. 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 '- Link with other services such as Adult Social Services, Children's Social Services and the nearby schools and the Children's Centre. Link 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 and have a sense of ownership	Good use of facility by community, positive feedback from users

Benefit	How benefit will be delivered
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

Table 38 – key benefits (BRP)

7.7 Advisor team

Table 39 gives details of the advisors to the project

Project team member	Company
Project Manager	Quadrant Surveying Ltd
Architect	The Design Buro (Coventry) Ltd
M&E Advisor (including heating and ventilation)	Stewart Associates
Structural advisor	JMS Consulting Engineers Ltd
Civil engineer	JMS Consulting Engineers Ltd
QS/cost advisor	Quadrant Surveying Ltd
BREEAM Healthcare Assessor	Scott, White & Hookins LLP
Principal Designer	Quadrant Surveying Ltd

Table 39 project advisors

The cost of this support will be picked up by NHSPS as part of their service.

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 register;
- 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; and
- 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 (appendix 38)

The Risk Register will follow the structure as set out below:

- 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 will be reviewed on a regular basis by the Project Teams. Risks will also be assessed and discussed at various meetings such as site meetings, project team meetings, project board meetings where required. Risks will be scored as per a risk scoring matrix; risks of a pre-mitigation score of 16 or above will be escalated to the Programme Board on a monthly basis.

At present the key risks (scoring 10 and above) for the scheme, the mitigation plan and the score post mitigation are:

A risk register has been developed which identifies the key risks for the Brownsover scheme. A mitigation plan, and where possible estimated financial impact has been developed for the high risk items. This continues to be reviewed on a regular basis and the review dates form part of the project plan. The key risks identified in order of severity and prior to and after mitigation plans being applied are shown in table 40

Risk	Score pre-mitigation	Score post mitigation
Proposal does not achieve value for money	20	5
Unable to procure a suitable APMS provider	15	8
Delays due to inclement weather	12	12
Increased construction costs due to unforeseen circumstances	12	2
NHS business case and approvals not in place	12	12
Delay in signing off contract documents	12	12
Risk to public due to location of site	10	5

Table 40 - key risks in order of severity pre and post mitigation

7.8.1 Construction risk and contingency

The scheme, although Design & build under the Contract, has been fully designed to a level that ensures compliance and incorporated within a fully comprehensive set of Employers Requirements.

There are a small number of defined Provisional Sums adequately costed. All associated surveys and fees have been completed and included, this includes post-novation. The scheme has been competitively tendered, and a full analysis concluded to ensure a fully compliant contract price. Based upon this procurement strategy and risk review it was agreed with NHS PS that no construction contingency was necessary. The contractor has highlighted a contingency sum within his CSA to cover items of design development and risk, both price and construction related. Should the CCG request significant design changes, a DCR process will be adopted where the implications will be determined and any increase in revenue cost via a “supplemental” rent would be agreed prior to issuing the instruction to the contractor. NHSPS will make a notional £50K of capital funding available in the event that the client may want to issue

design changes. This contingency sum is outside of the current capital modelled in determining the rental of £97,625pa supported by the DV.

7.9 Arrangements for change management

Due to the fact that there will be only one service provider in the building Change Management is unlikely to cause any issues, therefore there is no formal arrangement in place in this instance.

7.10 FBC CRCCG approval and publication

This Full Business Case will be sent for approval to Coventry and Rugby CCG's Primary Care Committee for approval on 22nd November 2017. CRCCG are aware that a letter confirming the approval should be sent to NHS England, NHS Property Services and NHS England Central 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's website within one month from date of 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's website. A stakeholder briefing will also be issued to key stakeholders including CCG, NHS Property Services, Local Authority, MPs etc which will also include a link to the FBC on NHS England's website. Stakeholders such as the CCG will be asked to publish information on their websites as well, again with the link to the FBC on NHSE website.

7.11 Energy Certification

A DEC (Display Energy Certificate) and EPC (Energy Performance Certificate) will be completed prior to handover by the Contractor. This forms part of the contractor's proposals.

7.12 Arrangements for post project evaluation

7.12.1 DQI, BIM, VOA, BRE, NHS Improvements

Figure 35 shows post project evaluation at a glance through the various stages of the project.

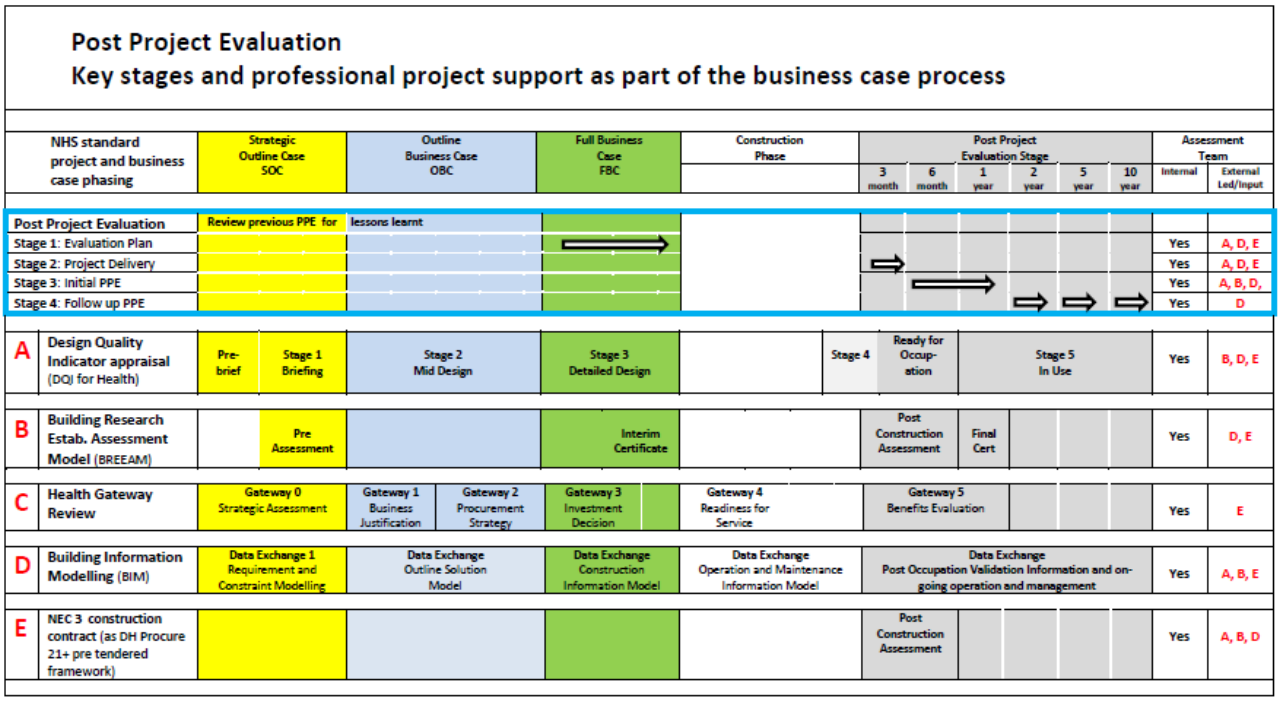


Figure 35: Post project evaluation at a glance

The CCG and NHS England 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. The CCG have confirmed that their own internal audit team can provide unbiased reviews to the project board to support the process to practical completion and beyond into Post Project Evaluations.

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. 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. (appendix 5)
- **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. A DQI event was held with key stakeholders on 22nd April 2016, with a further 3rd stage review in February 2017. (Appendix 4 and 8)
- **NHS Improvements post project evaluation –** To be completed 6 months after the completion of the project and signed off by the CCG board. (Appendix 44)

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

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

It is proposed that this stage of the evaluation be undertaken between six and twelve months after the completion of the primary care centres, in order that many of the lessons learned are still fresh in the minds of the stakeholders. This stage of the evaluation will also encompass the evaluation of the scheme whilst in construction.

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

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 facilities.

The objective of this stage will assess how well and effectively the projects were 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 evaluation process will be managed by the NHS England Project Director.

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.

The costs of the final post project evaluation, once the service is fully established, are not included in the costs set out in this FBC as it is assumed that this work will be undertaken in-house as part of the Project Director's role.

7.13 Gateway review arrangements

The impacts/risks associated with the Brownsover project have been scored against the risk potential assessment (RPA) for projects (appendix 39).

- further consideration to be given to governance arrangements to ensure involvement of NHS England, the CCG, NHSPS and other key stakeholders
- final agreement to the scope of the project
- the project will deliver significant benefits and is a significant investment for the system
- Regular project meetings to review the business case arrangements and ensure governance is in place

7.14 Contingency plans

In the event of this project failing to proceed, primary care will be delivered from the former GP branch surgery; this will be a temporary measure on lease terms, and is restricts enabling modern healthcare services to be provided. The NHS would be unable to meet the increased demand for general medical services in this area.

8 Appendices

Appendix No.	Appendix Name	Appendix No.	Appendix Name
1	OBC approvals NHSE	25	Ground floor plan
2	OBC approval CCG	26	First floor plan
3	Fully costed equipment schedule	27	Existing site plan
4	DQI report and attendance list – OBC – stages 1 and 2	28	3D view sheet 1
5	VOA Checklist	29	3D view sheet 2
6	Generic Heads of Terms	30	Green Travel Plan
7	Project plan	31	Schedule of accommodation OBC
8	DQI report and attendance list – Feb 2017	**32**	Schedule of accommodation FBC
9	Estates Strategy	**33**	BREEAM tracker baselined 5.11.17
10	Communications plan	**34**	Evidences of comments from infection control
11	OBC option appraisal notes	**35**	Minutes from fire strategy meeting
12	OB forms	**36**	Consumerism standards
13	Planning application	37	Benefits realisation plan
14	Planning consent letter	38	Risk register
15	Local digital roadmap (LDR)	39	RPA
16	Site location plan	40	Valuation report from DV
17	Roof plan	41	FB forms
18	Proposed elevations	42	Flood risk assessment
19	Planting plan	43	Acoustic report
20	Photomontage	44	NHSI Post Project Evaluation form
21	Landscape general arrangement	45	CCG letter of support
22	Illustrative site massing	46	NHS England Director of Finance letter of support
23	Illustrative approach	47	CCG FBC approval letter
24	Illustrative masterplan	48	NHS England FBC approval letter