

**Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts**

Annex 1: Business case core checklist

**November 2016**

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Guidance for use

This checklist, prepared by the Department of Health (DH), NHS Digital (formerly the Health & Social Care Information Centre (HSCIC)), NHS England, NHS Improvement and other stakeholders, is for use by both NHS trust and foundation trust project teams and NHS Improvement in reviewing and providing assurance on capital investment and property transaction business cases. It comprises a ‘core’ generic checklist. NHS Improvement has added a bespoke clinical quality checklist – this should be completed for all business cases with a patient-facing or clinical aspect.

It should be noted that the format and content of the core checklist may vary in practice to suit the needs of the individual reviewing organisation. However, the core numbers and items in this core checklist will be common to all business case checklists.

Project teams should treat the checklist as a combination of guidance on material which must be included in a business case, and advice on various issues. For example, a business case should be submitted by the senior responsible officer (SRO) (checklist reference 1.1.2 in the checklist below), to show project ownership. If guidance is needed on any point, the project team should consult its case reviewer/approver lead.

Note that the checklist represents the **minimum** content of a business case. HM Treasury’s [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf)[[1]](#footnote-2)and related five case model guidance should be used to produce a complete business case.

The checklist should be submitted with the business case, filled in to indicate whether or not a requirement has been complied with and where it is referenced.

Business case reviewers should then use the checklist in one or both of two ways:

* at the start, to check that the necessary basic material is present
* when the review work is complete, as a formal sign-off of the case, using Table 1 below.

**Table 1: Checklist control table**

|  | **Name** | **Initial check (date)** | **Case submission/review complete (date)** |
| --- | --- | --- | --- |
| Submitting organisation |  |  |  |
| Reviewer |  |  |  |

Assurance summary

This section should highlight where further assurance is required and should be linked to the NHS Improvement recommendation report (Table 2).

**Table 2: Assurance summary**

|  |  |  |
| --- | --- | --- |
| **Business case** | **Areas where further assurance is required** | **Recommendation** |
| Strategic case |  |  |
| Economic case |  |  |
| Commercial case |  |  |
| Financial case |  |  |
| Management case |  |  |
| Clinical quality |  |  |
| Completed by: |  |  |

1. Strategic case

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Approvals and support** | | | | | | | |
| ✓ | ✓ | ✓ | 1.1.1 | Has the business case been approved by the relevant board or governing body? | Provide minutes of the board/governing body meeting approving the business case.  The board/governing body has approved all parts of the business case, eg strategic fit and the financial/operational impact. |  |  |
| ✓ | ✓ | ✓ | 1.1.2 | Has the business case been submitted by the senior responsible officer (SRO)? | If there is more than one SRO/approving body, then the senior or lead responsible officer should take responsibility for submitting the case. The business case should go initially to the ‘junior’ approving body, eg NHS Improvement, if both NHS Improvement and DH are involved. It is important at this stage that the SRO shows ownership and formally signifies the start of the review/approval process. |  |  |
| **Rationale and objectives** | | | | | | | |
| ✓ | ✓ | ✓ | 1.2.1 | Has a clear rationale for the scheme been set out? | What requirement is being met, or what risks or problems are being solved? Is the proposed scheme sufficiently large and standalone to form a project or would it be more sensibly undertaken as part of another programme or project?  The rationale should include the strategic priorities and alignment with clinical, workforce and estates strategies where relevant. The link between the rationale and activity, financial and workforce assumptions should be demonstrated. |  |  |
| ✓ | ✓ | ✓ | 1.2.2 | Have SMART objectives for the proposed investment/spending been identified? | SMART = specific, measurable, achievable, realistic and time bound. Objectives should be consistent with the benefits identified in the strategic and economic case and should be included in benefits realisation plans as appropriate. |  |  |
| ✓ | ✓ | ✓ | 1.2.3 | Are the investment/spending objectives clearly linked to associated benefits? |  |  |  |
| ✓ | ✓ | ✓ | 1.2.4 | Is it clear what health service needs are supported by the objectives? |  |  |  |
| ✓ | ✓ | ✓ | 1.2.5 | Is there evidence of how the lead commissioning organisation has engaged its patients and/or users, stakeholders, wider public/  population and governors (as appropriate) in setting the clinical and service priorities that led to the scheme design and objectives? | For build projects, the case should show that patient group(s) are actively involved in informing development of the plans. For IT projects, [discovery and alpha phases](https://www.gov.uk/service-manual/phases/discovery.html) will precede the SOC and inform the direction of the project.  For service change and reconfiguration proposals subject to the NHS England assurance process described in the NHS England guidance [*Planning, assuring and delivering service change for patients*](https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf), has the SOC been informed by sufficiently mature analysis contained in the pre-consultation business case (PCBC) and the decision-making business case (DMBC)? |  |  |
|  | ✓ | ✓ | 1.2.6 | Have there been any changes to the original scope or objectives? | Are the previous case spending objectives and planning assumptions still valid? Do the services to be procured/does the recommended deal still provide synergy and best fit with other parts of the organisation’s business strategy? Cost changes from those presented at OBC stage should be disclosed and explained. |  |  |
| **Strategic and policy context** | | | | | | | |
| ✓ | ✓ | ✓ | 1.3.1 | Has the strategic context been documented? | Where relevant, an organisation overview with details of structure, financial position, services provided, population and commissioners served could be useful. This should also take account of the wider context in which the organisation sits, eg the local health system (for builds), the UK as a whole (for national IT projects). |  |  |
| ✓ | ✓ | ✓ | 1.3.2 | Has the impact on existing service configuration and the wider health economy been assessed? Is the rationale consistent with local/regional strategic priorities? | This applies primarily to builds, eg the organisation’s vision, strategic priorities, clinical strategies and/or commissioning intentions (where appropriate) should be checked against what is known about service configuration priorities and other health priorities.  Full details should be given of the consequences for other services, clinical networks and the local health system/health organisations. |  |  |
| ✓ | ✓ | ✓ | 1.3.3 | Is there evidence of support from other relevant bodies, eg project sponsors and commissioners (where applicable)? | The project sponsor and/or commissioners should provide written approval of the business case (if applicable).  Commissioners or other relevant bodies with a material interest in the scheme should provide written confirmation supporting the future activity and financial assumptions (if applicable), these being consistent with those of the investing body.  The local health and wellbeing board should be consulted and written evidence provided of its support (if applicable). |  |  |
| ✓ | ✓ | ✓ | 1.3.4 | Is the rationale consistent with government policy and strategic priorities? Any specific policies/  priorities should be listed. |  |  | |
| ✓ | ✓ | ✓ | 1.3.5 | Did the project comply with relevant Carter efficiency recommendations? | The case should refer to Lord Carter’s 2015 report: [*Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf), and identify the recommendations being delivered by the project. |  |  |
| ✓ | ✓ | ✓ | 1.3.6 | Is the rationale consistent with the organisation’s strategic priorities? | These should be aligned as needed with key external bodies, eg trusts with clinical commissioning groups (CCG). |  |  |
| ✓ | ✓ | ✓ | 1.3.7 | Where local sensitivities and/or opposition have been identified, have possible mitigating actions been considered? |  |  |  |
| ✓ | ✓ | ✓ | 1.3.8 | Is there evidence of the extent to which the proposal promotes integrated working between health, social care and public health? | If parallel investments are necessary or being made in other organisations, these should be shown as a dependency. |  |  |
| ✓ | ✓ | ✓ | 1.3.9 | Does activity and capacity planning in the investment proposal demonstrate consistency with related service planning? | Activity/capacity modelling and assumptions should be consistent with the activity requirements of the local health system and wider capacity plans, including alignment to workforce plans, organisational service developments and efficiency programme (if applicable).  For build schemes, a utilisation schedule should be included to justify the scale of the proposed investment. This should provide evidence of the use of the facility (frequency of use in relation to days per week, hours per day/by speciality/user). The method for establishing this need should be included, as well as evidence of how utilisation targets have been arrived at. |  |  |
| ✓ | ✓ | ✓ | 1.3.10 | Does the scheme support greater patient choice on where and how to access care, and/or improved quality and safety of service provision? | See [*Operational guidance to the NHS extending patient choice of provider*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216137/dh_128462.pdf) |  |  |
| ✓ | ✓ | ✓ | 1.3.11 | Is there confirmation that any equality and diversity impact has been assessed and addressed? | The proposal must pay due regard to the public sector equality duty in line with the principles and requirements of the NHS Constitution and with current legislation and guidance. |  |  |
| ✓ | ✓ | ✓ | 1.3.12 | If the scheme involves changes to services, have the four key tests for service reconfiguration been met? Evidence of this should be provided. | The four key tests for service reconfiguration were set out in the NHS England guidance [*Planning assuring and delivering service change for patients*](https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf)published in November 2015. These are:   * strong public and patient engagement * consistency with current and prospective need for patient choice * clear, clinical evidence base * support for proposals from commissioners.   This guidance is a good practice guide for anyone involved in service change or reconfiguration proposals, including trusts. The guidance sets out the required assurance process commissioners should follow when service reconfigurations are being considered. |  |  |
|  | ✓ | ✓ | 1.3.13 | If there have been any strategic or organisational changes, have these been adequately explained and their effects on the investment described? Are the demand assumptions in support of the size and scope of the investment still valid? | Does the recommended solution still provide all the required services – both current and future? |  |  |
|  | ✓ | ✓ | 1.3.14 | Has a post-project evaluation relating to the current service been attached? | This applies where the business case is for a reprocurement or further development of an existing service. Any evaluation that has been carried out should be appended, and referred to in the case. In particular, it should show how:   * it has informed objectives * lessons learned have informed the development of options * lessons learned have informed management. |  |  |
| **Risks, constraints and dependencies** | | | | | | | |
| ✓ | ✓ | ✓ | 1.4.1 | Has the strategic case summarised the main risks of the proposed investment project? |  |  |  |
| ✓ | ✓ | ✓ | 1.4.2 | Has the business case identified the main constraints and dependencies of the proposed investment project? | This is particularly important if there are any interdependencies, especially benefits, with other investments/procurements. |  |  |

**Strategic case: Build schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ✓ | ✓ | ✓ | 1.5.1 | Is there evidence of a board- or governing body-approved estates strategy (or equivalent) that articulates the need for this capital investment? | The estates strategy should cover a defined period in the future. The starting point for developing the strategy is to identify the current and future healthcare service needs of the local population and the current condition of the healthcare estate. An estates strategy cannot be developed in isolation from service planning and should integrate with local commissioning and service strategies. The estates strategy should also address the backlog maintenance and costs in relation to the existing estate. The business case must show and quantify how the proposal put forward will contribute to reducing the backlog maintenance for the buildings involved and the NHS estate as a whole.  See the DH 2005 best practice guide [*Developing an estate strategy*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144226/Developing_an_Estate_strategy.pdf). |  |  |
| ✓ | ✓ | ✓ | 1.5.2 | Does the estates strategy contain board or governing body-approved development control plans (DCP) for the developments proposed in that strategy? | The business case should include a health organisation board or governing body-approved DCP if the site development is complex. For less complex developments, site plans detailing access and relationships with other properties may suffice. |  |  |
| ✓ | ✓ | ✓ | 1.5.3 | Is the rationale consistent with the mandatory [government construction strategy](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61152/Government-Construction-Strategy_0.pdf)? |  |  |  |
| ✓ | ✓ | ✓ | 1.5.4 | Is there evidence of a board or governing body-approved sustainable development management plan which sets out clear milestones to measure, monitor and reduce direct carbon emissions? | This will include the impact of new build and refurbishment projects associated with the estates strategy. For further guidance, see [*Sustainable development in the NHS*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147978/Sustainable_Development_in_the_NHS.pdf)*.* |  |  |

**Strategic case: IT schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ✓ | ✓ | ✓ | 1.6.1 | Is there a summary of the organisation's current IT capability? Does this identify the starting point for development of the IT scheme? | An annex may include, for example, the configuration of current systems, existing level of integration, extent of paper-based systems and level of IT (information processing) expertise. |  |  |
| ✓ | ✓ | ✓ | 1.6.2 | Is the ‘gap’ in IT provision – between the current position and the identified objectives supporting health service delivery – known? |  |  |  |
| ✓ | ✓ | ✓ | 1.6.3 | Does the programme demonstrate awareness of the relevant government standards and policies for technology? How does it ensure these will be met? | The Technology Code of Practice and Digital by Default Service standard always apply. |  |  |
| ✓ | ✓ |  | 1.6.4 | Is the options analysis of the delivery approach supported by adequate analysis of user, as opposed to stakeholder, needs? | Services that are driven by policy without appropriately meeting user needs are far less likely to deliver the claimed benefits due to low adoption rates. |  |  |
| ✓ | ✓ |  | 1.6.5 | Has the programme established the criteria to be met by the minimum viable product (MVP)? | The MVP is the minimum IT support necessary to deliver a service. If the MVP is undefined, then scope-creep and consequent negative impact on value for money (VfM) in particular are more likely. A service that is unable to articulate MVP criteria is unlikely to have completed sufficient analysis of user needs. |  |  |
| ✓ | ✓ | ✓ | 1.6.6 | Is the programme or any component within the scope of service assessments? If so, at what stage and what were the outcomes? | Service assessments are mandatory at alpha, beta and live stages of programmes. Failure to pass these can prevent the programme continuing to the next stage or even live deployment. |  |  |
| ✓ | ✓ |  | 1.6.7 | Do the options analyses consider technical decisions and justify the preferred option? | Buy versus build, proprietary versus open source, co-location or in-house provision versus cloud hosting, etc. |  |  |

1. Economic case

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Options appraisal** | | | | | | | |
| ✓ | ✓ |  | 2.1.1 | Has a wide-ranging, long list of options (including ‘do nothing’ or ‘do minimum’) for achieving the investment objectives been drawn up? | Options should be identified using a range of parameters. Suitable parameters may include scope, implementation approach, timing, scale. Use of a feasibility study is recommended. See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.17–18. |  |  |
| ✓ | ✓ |  | 2.1.2 | Have the critical success factors/criteria/steps for options appraisal been identified? | Critical success factors should be identified. These should be essential (rather than just desirable) factors and set at a level which does not exclude important options.  All criteria should be clearly derived from the SMART (specific, measurable, achievable, realistic and time bound) objectives set out in the strategic case. The reasons for their relative weightings should be set out. |  |  |
| ✓ | ✓ |  | 2.1.3 | Is the preferred way forward outlined? This should comprise a shortlist of options with sound reasons for their inclusion. | Options should be clearly weighted, scored and ranked in line with [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) guidance. A SWOT (strengths, weaknesses, opportunities, threats) analysis is recommended. |  |  |
|  | ✓ | ✓ | 2.1.4 | Has the preferred option been described sufficiently well to enable a quantified assessment of costs, benefits and risks? Can wider impacts be assessed, eg sustainability, competition, regulatory impact? | If, unusually, there is more than one preferred option, the reason for this should be explained. |  |  |
| **Costs** | | | | | | | |
|  | ✓ | ✓ | 2.2.1 | Have all relevant capital and running costs been identified and properly assessed? | The costs should cover the whole life of the investment for all IT projects and most build projects, where possible. They should take into account (if appropriate): lifecycle costs (building-related and equipment/IT replacements), residual values, monitoring and evaluation costs, health organisational development costs, opportunity costs, second- round effects, avoided costs and costs borne by others. Care should be taken not to double-count costs. See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.20–23.  Cost sources should be identified for all costs, including where these are estimates.  Note that costs must be assessed on a ‘bottom-up’ basis: that is, the case must show the total costs of each option, not just costs incremental above existing levels of expenditure.  Descriptions of how all costs have been quantified should be available along with supporting spreadsheets. |  |  |
|  | ✓ | ✓ | 2.2.2 | Have all key assumptions underlying the costs analysis been stated? | For example, the assumptions about the life of an asset. Reference the source documents underpinning these assumptions. |  |  |
|  | ✓ | ✓ | 2.2.3 | Are costs shown in real term, constant (uninflated) prices, with the base year clearly specified and the current year shown as Year 0? Has the correct discount rate been used? | See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.25–28 |  |  |
|  | ✓ | ✓ | 2.2.4 | Have sunk costs, transfer payments, VAT, capital charges, depreciation and other non-resource costs been excluded from the net present costs (NPC)? | Sunk costs are those already incurred, eg project management. Transfer payments include redundancy payments, VAT and local authority rates.  Only income from non-government (third-party) organisations should be included. |  |  |
|  | ✓ | ✓ | 2.2.5 | Is the appraisal period appropriate to the life of the asset generated by each option? | A view from the technical advisor should give the economic life of the asset generated by each option and must be stated. Where the appraisal period is different for alternative options, discounted costs must be expressed as equivalent annual costs rather than NPC. |  |  |
| **Benefits** | | | | | | | |
|  | ✓ ✓ | | 2.3.1 | Have appropriate and credible benefits been identified? | The benefits should be identified through consultation with stakeholders, eg through a benefits workshop. These may include cash-releasing, non-cash releasing or non-quantifiable (qualitative) benefits. See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.21–23.  Benefits should be consistent throughout the case; that is, strategic, economic, financial and management. |  |  |
|  | ✓ | ✓ | 2.3.2 | Have all key assumptions underlying the benefits analysis been stated? | For example, the assumptions about why a benefit might vary from one option to another, or be treated as non-cash releasing rather than cash-releasing. Reference the source documents underpinning these assumptions. |  |  |
|  | ✓ | ✓ | 2.3.3 | Is evidence provided that the benefits are consistent with the SMART objectives identified in the strategic case? |  |  |  |
|  | ✓ | ✓ | 2.3.4 | Have benefits been quantified in line with [HMT’s *Green book*](http://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent)guidance? Non-cash releasing benefits (CRB) should be monetised where possible. Is there a costed profile of benefits? | Care should be taken not to double-count benefits. Non-CRB are very similar to CRB, although the key difference is the former monetises in monetary terms whereas the latter monetises in financial terms (that is, CRB should be considered actual savings, while non-CRB are more usually efficiencies or increases in productivity).  Staff time is a common non-CRB in capital investments, eg for digital pens: time saved typing up patient notes = 15 minutes per day, hourly salary = £15  0.25 x 15 = £3.75 per day productivity saving per employee  If benefits are owned by other organisations, their input should be sought where possible, and their ownership shown (eg of an IT project) in the benefits realisation plan. |  |  |
|  | ✓ | ✓ | 2.3.5 | Where it is not possible to quantify a benefit, is it explained why this is so and have benefits been separately qualitatively evaluated where possible? | Where benefits cannot be valued or quantified, a weighting and scoring exercise should be undertaken. The shortlisted options should then be ranked according to their benefits score. There should be evidence that weights and scores for qualitative benefits have been sufficiently justified for non-quantified benefits. |  |  |
|  | ✓ | ✓ | 2.3.6 | Have quantified benefits been discounted over the period of appraisal? | The discount rate should be 3.5% if benefits are valued in real terms or 1.5% if quality-adjusted life years have been used in valuing benefits. For projects with very long-term impacts (over 30 years), a declining schedule of discount rates should be used (see [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) Annex 6). |  |  |
|  | ✓ | ✓ | 2.3.7 | Have the values of benefits been stated in constant (uninflated) prices and are they consistent with the cost assessment? | See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.25–28 |  |  |
| **Risks** | | | | | | |  |
| ✓ |  |  | 2.4.1 | Have potential risks, constraints and dependencies been identified? | Risks, constraints and dependencies should be consistent with the strategic case – where they should have been described. |  |  |
|  | ✓ | ✓ | 2.4.2 | Have the risks associated with the preferred option been appropriately identified across the whole lifecycle of the project? | These risks should be set out in a risk register (see also management case).  Whole lifecycle refers to the life of the project. This is normally the construction period plus 60 years of operational life for new-build investments. Refurbishment schemes are shorter, typically 25–30 years, depending on the anticipated life of the anticipated buildings.  IT projects tend to be evaluated over a short time period (7–10 years or even less), with allowances to renegotiate or extend the current contract. |  |  |
|  | ✓ | ✓ | 2.4.3 | Have the risks been quantified and costed? These should be presented in a matrix showing:   * which party is responsible for managing risks * the probability of the risk * the impact of the risk * the expected cost of each risk (probability x impact). | A narrative should explain the method for the quantification of risks and how the probability has been derived. |  |  |
|  | ✓ | ✓ | 2.4.4 | Have the assumptions underlying the identification, timing and potential impact of the risks been explained? | These should be covered in the risk register. |  |  |
| **NPV, optimism bias and sensitivity analysis** | | | | | | | |
| ✓ |  |  | 2.5.1 | Is there evidence of the proposed method for the calculation of the net present value (NPV) for shortlisted options, including identification of the required data? | An appropriate discounted cash flow model should be used, such as the GEM (soon to be replaced by the CIA) for build cases, or the NHS Digital (formerly HSCIC) template for IT cases. |  |  |
|  | ✓ | ✓ | 2.5.2 | Have costs, benefits and risks been adjusted for optimism bias? | Optimism bias and mitigation have been assessed in accordance with the optimism bias guidance on DH (NHS build specific) and/or HMT websites.  Adjustments should be empirically based (eg using data from past projects or similar projects elsewhere).  See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.29–30 and the [*Supplementary green book guidance on optimism bias*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191507/Optimism_bias.pdf). |  |  |
|  | ✓ | ✓ | 2.5.3 | Have the costs, quantified benefits and quantified risks been combined to establish the NPV for shortlisted options? Investment proposals should provide evidence of the triangulation of demand and capacity modelling, workforce strategy, service development and efficiency programme across the lifetime of the scheme. | For approval of capital investment schemes greater than £35 million, and service reconfiguration business cases, the valued benefits must exceed risk-adjusted costs by a ratio of 4:1. This represents the absolute VfM threshold in health spending. However, achieving the threshold is not a simple pass/fail test and each business case will be assessed individually basis. DH economists advise that this is not used as a strict benchmark (that is, some cases fall below the 4:1 threshold, but have other important qualitative/strategic benefits). |  |  |
|  | ✓ | ✓ | 2.5.4 | Has an appropriate sensitivity analysis of costs, benefits and risks been carried out? | This should be undertaken to demonstrate either switching values, with the likelihood of the switch explained, or percentages chosen and the basis for selection explained. It should include the worst case scenario.  See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.32–33. |  |  |
| ✓ | ✓ | ✓ | 2.5.5 | Has a cost-to-benefit ratio been calculated for all the shortlisted options, following the formula shown in the guidance? | Formula: Total non-CRB (non-CRB plus societal benefits)/  total opportunity costs (total discounted costs plus retained risks – CRB).  As a minimum, all projects are expected to show a ratio of 1:1; that is, the expected amount in quantifiable benefits is at least equal to the amount being invested.  It should normally be the case that the ratio is higher than 1:1, but this will vary depending on the type of project. The business case should justify the ratio for the project. The quantified benefits used should be credible, with their delivery capable of being assessed.  The 4:1 ratio used by the NICE in assessing new medications should be used as a comparator. Projects which are patient facing are more likely to approach this ratio, and those more concerned with infrastructure are more likely to be further away from it. The ratio achieved should be commented on. |  |  |
| **Summary** | | | | | | | |
|  |  | ✓ | 2.6.1 | Is there a summary of the OBC option appraisal, showing the long and short lists, result of the economic appraisal (including benefits and risks) and sensitivity analysis? If the assumptions, scope or costs have changed since the OBC, does the FBC demonstrate either that the original preferred option remains valid, or that a new preferred option can be demonstrated to be so on VfM grounds? | At FBC stage, the OBC economic appraisal should be reviewed to ensure it is consistent with the FBC. The economic appraisal undertaken at OBC stage needs to be undertaken again at FBC stage if:   * there has been a significant change in the scope of the preferred option and/or * capital costs have increased by more than 5% or revenue costs have increased by more than 10%. |  |  |
|  | ✓ | ✓ | 2.6.2 | Is there a conclusion and clear recommendation for a preferred option? Are the reasons for selecting this option clearly stated? |  |  |  |
|  | ✓ | ✓ | 2.6.3 | Is the preferred option consistent with the results of the cost, benefits and risk appraisals? If not, why not? | The option that generates the lowest risk-adjusted NPC, or the highest risk-adjusted NPV, or equivalent annual cost (EAC) is the preferred (‘best’) option as it represents the most economically advantageous option.  VfM should be based on risk-adjusted cost per benefit point (where best VfM = max NPV) or is there any evidence to suggest that the preferred option was not selected on the basis of the appraisal process? Eg was another option selected solely because it had the lowest cost? See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.37–39. |  |  |
|  | ✓ | ✓ | 2.6.4 | Are there any decisive unquantified costs, non-beneficial areas and/or benefits, and are these assumptions clearly explained? | See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.34–35. |  |  |
|  | ✓ | ✓ | 2.6.5 | If distributional analysis is needed to highlight who benefits and who pays, has it been completed? | See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) pp.24–25. |  |  |
|  |  | ✓ | 2.6.6 | Has the high level assessment and valuation of benefits and risks in the OBC been fully developed for the preferred option in the FBC, including a detailed risk log/register and benefits realisation plan? | See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) p.44 (benefits realisation) and pp.80–82 (risk register log). |  |  |
|  | ✓ | ✓ | 2.6.7 | Is all supporting evidence (eg in annexes) consistent with the results in the main text? |  |  |  |

**Economic case: Build schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ✓ | ✓ | ✓ | 2.7.1 | Is the proposal compliant with NHS estates design and costing requirements, including taking account of proposal ‘abnormals’? | Costs to be set out in accordance with the [*Healthcare premises cost guide*](https://www.gov.uk/government/publications/guidance-to-carry-out-cost-estimates-of-healthcare-buildings) (HPCG) on OBC and FBC forms and latest Department of Business, Innovation and Skills (BIS) PUBSEC index (which has superseded MIPS). In addition, there should be:   * a reasoned contingency sum * inclusion of any consequential planning costs, eg s106. |  |  |
|  | ✓ | ✓ | 2.7.2 | Cost indices and regional location factors – cost advisors employed by NHS organisations are required to subscribe to BIS Construction Price and Cost Indices online to gain access to full data and share project data to ensure indices and location factors are sustainable. |  |  |  |
|  | ✓ | ✓ | 2.7.3 | NHS Capital investment manual (CIM) cost forms; 1, 2, 3 and 4.  Only CIM standard cost forms must be used and completed to reflect DH costing method and agreed costing indices, etc. | CIM forms can be found in the [CIM *Business case guide*](http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4119896) pp.46-47. |  |  |
|  | ✓ | ✓ | 2.7.4 | If PF2 is involved, is tax properly treated and is risk transfer clearly achieved? |  |  |  |

**Economic case: IT schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 2.7.5 | Are tax/subsidy treatments non-distorting between options? | Check if there’s any possibility of state aid if there is distortion between options. See [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf) p.56. |  |  |
| ✓ | ✓ |  | 2.7.6 | Have any discovery or preliminary works been carried out? If so, have the relevant spend control approvals and conditions been attached to the case? |  |  |  |

1. Commercial case

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Commercial feasibility** | | | | | | | |
|  | ✓ |  | 3.1.1 | Has a suitable range of procurement options been considered? Is the proposed procurement route appropriate for the project? | For public capital the Open, Restrictive, Competitive Dialogue or Negotiated procedures can be used provided the particular route adopted is justified.  For PFI, Competitive Dialogue must be used.  Has a managed service been considered as an alternative to a capital purchase with a revenue ‘tail’? Does the case demonstrate understanding of the objectives, requirements and implications of a managed service, and is this reflected in the risk allocation matrix and risk transfer mechanisms? |  |  |
|  | ✓ | ✓ | 3.1.2 | Is there confirmation that the organisation and relevant project advisers (eg lawyers) consider the proposal commercially feasible and deliverable? |  |  |  |
|  | ✓ | ✓ | 3.1.3 | Does the proposal allow sufficient time and resources for the completion of all identified procurement tasks, eg completion of necessary procurement documents and supplier negotiations? | A realistic and credible timetable should be provided. The timetable must meet all applicable legal requirements, eg of the Public Contracts Regulations 2015. Legal minimum durations for procurement stages must not be breached.  Procurement documents which may need to be completed include: OJEU, PQQ, ITT/ITPD, evaluation criteria, all output specification schedules for works and services, contract and/or payment mechanisms.  If a call-off from a framework is proposed, then the authority must show that it is entitled to participate in the framework and that its requirements are in scope of that framework. |  |  |
| **Scope** | | | | | | | |
|  | ✓ | ✓ | 3.2.1 | The business case should clearly describe the subject matter of the procurement. For example, has the business case clearly set out the buildings, land, equipment, technology, goods and/or related service streams to be included in the scheme? | The business case should be clear about the output to be procured, including specification of required outputs and requirements to be met (essential outputs, phases, performance measures, quality attributes). The business areas, stakeholders and customers affected by the procurement should also be set out, along with any future possibilities (potential developments and further phases).  The process should be properly classified for the purposes of the procurement rules.  It should be clear that the organisation can afford to commission or run the clinical services that are already in the building. |  |  |
|  | ✓ | ✓ | 3.2.2 | Does the business case include a strategy for any specialised procurement, eg equipment, with a project plan identifying the timeframes and costs? | The equipment strategy should set out:   * any existing equipment to be transferred * new equipment being procured in advance of the scheme * equipment being procured as part of, or in parallel with, the scheme * specialist equipment.   The business case must confirm which organisation:   * procures the equipment * funds the equipment * will own, operate and maintain/replace the equipment. |  |  |
| **Procurement strategy** | | | | | | | |
| ✓ | ✓ |  | 3.3.1 | Has a realistic and robust procurement strategy been identified? | Clear, realistic procurement key milestones and delivery dates should be set out. Supplementary questions could focus on managerial capacity to deliver to timeline. Caution should be exercised in relation to overly optimistic timelines which have no contingency for slippage. The experience of capital procurement processes generally is that they invariably take longer than anticipated. |  |  |
|  | ✓ | ✓ | 3.3.2 | Does the procurement strategy comply with EU procurement law? Assurance of compliance with procurement legislation should be provided by legal advisors, and updated at FBC stage as appropriate. | For example, all procurement stages must be of at least the minimum duration required by law, which depends on the EU process followed.  Where relevant, a copy of the OBC, ITT and draft OJEU advertisement should be included.  The content of any sign off from legal advisors will be assessed. It is unlikely to be an unconditional endorsement. The reviewer will assess the degree of scrutiny that has been applied to the process; if this is considered inadequate, then the legal assessor will comment accordingly. |  |  |
|  | ✓ |  | 3.3.3 | Has the procurement strategy been chosen because it can provide an outcome that delivers VfM? | Consideration should be given to how to incentivise those involved with the scheme to provide VfM. This should be reflected in the chosen payment mechanism. |  |  |
|  | ✓ |  | 3.3.4 | Has an assessment of market interest been included together with any market soundings to date? Any factors that may have a detrimental impact on market interest are discussed and mitigation strategies included. |  |  |  |
|  |  | ✓ | 3.3.5 | Is there confirmation that no material changes have been made to the procurement strategy? Or if there material changes have been made, have these been detailed and adequately justified? |  |  |  |
| **Procurement process** | | | | | | | |
|  |  | ✓ | 3.4.1 | Was a suitable range of responses/bids elicited in response to the tender process to ensure robust competition? | If, for example, only one or two responses/bids have been received (raising the risk of a poor VfM outcome), this situation must be explained, including how it will be mitigated. |  |  |
|  |  | ✓ | 3.4.2 | Was any shortlisting of supplier responses carried out in the appropriate way, in accordance with the Public Contracts Regulations 2015? | An appropriate assessment of each shortlisted supplier (eg Dunn and Bradstreet reports) should be attached to the business case. This should form part of the wider evaluation of the suppliers which should be documented in the case. |  |  |
|  |  | ✓ | 3.4.3 | Has an adequate summary of the evaluation process and outcome been included? Does it identify and clearly define all the pros and cons of each shortlisted bid, including the preferred bid? Has the selection of the supplier been carried out fairly and in accordance with the Public Contracts Regulations 2015? | The FBC must demonstrate that the appropriate procurement procedures have been followed as required by EC Directives. A copy of the published OJEC notice should be included in the FBC. |  |  |
|  |  | ✓ | 3.4.4 | Is there a clear recommendation for the preferred bidder from the procurement? | The recommendation should be supported by the procurement evaluation report, where relevant. It is good practice to append this report to the business case. The preferred bidder’s offering should be clearly described. |  |  |
|  |  | ✓ | 3.4.5 | Is there a statement of any additional benefits offered by any higher cost supplier? | This is to confirm that the bid with optimal VfM has been selected. |  |  |
|  | ✓ | ✓ | 3.4.6 | Is the accounting treatment of the potential deal set out? | This section should provide details of the intended accountancy treatment for the potential deal and confirm on whose Statement of Financial Position, formerly known as the balance sheet (public, private or both sectors), the assets underpinning the deal will sit.  Where the scheme is novel, contentious or repercussive, or the accounting treatment is unclear, the organisation should obtain written agreement from its external auditors on the proposed accounting treatment. |  |  |
| **Key contractual issues** | | | | | | | |
|  | ✓ | ✓ | 3.5.1 | Is there a summary commentary on all key scheme-specific commercial and legal issues? | As appropriate for OBC/FBC stages of business case development. |  |  |
|  | ✓ | ✓ | 3.5.2 | If the procurement is using a standard contract, have any alterations or derogations been signed off? | The legal reviewer/assessor normally signs these off. |  |  |
|  | ✓ | ✓ | 3.5.3 | If the procurement is not using a standard contract, does the case indicate what contract will be used? Suitable commentary should be provided. Is the rationale for this structure convincing? | Provision of appropriate detail is necessary to enable full scrutiny of the proposed commercial terms. Details should be provided in relation to the duration of the contract, key roles and responsibilities, proposed liabilities, change control, arrangements for remedies for breach (eg due to delays, poor quality, price, etc), treatment of intellectual property, compliance with appropriate regulations, dispute resolution arrangements, operational and contract administration, proposed breakpoints, provisions for contract extension and options/arrangements at the end of the contract. Any derogation from standard form documents should be highlighted.  The contract should tie into the risk analysis.  The DH/Treasury Task Force (TTF) guidance on the contractual provisions for PFI/public private partnership (PPP) deals must be followed. |  |  |
|  | ✓ | ✓ | 3.5.4 | Are there clear and realistic contractual key milestones and delivery dates? | The following examples of different payment mechanisms may be helpful:   * fixed price * reimbursement of costs plus agreed margin * payment on the delivery of agreed outputs.   Any available deductions should be clearly described, eg:   * availability and performance deductions * liquidated damages for delay.   Any incentive payments or gain share arrangements should be clearly described. |  |  |
|  |  | ✓ | 3.5.5 | Has the payment mechanism been clearly set out? Is it appropriate? | The payment mechanism should be appropriate to the type of scheme, eg publicly-funded/PFI.  These examples drawn from PFI-type schemes may be helpful to other types as well. The payment mechanism for the:   * pre-delivery phase could be fixed price/costs or payment on the delivery of agreed outputs * operational phase could be availability payment, performance payment, transaction/volume payment, incentive payment, cost of change or third-party revenues * extension phase (if any) could be technological obsolescence or contract currencies. |  |  |
| **Risk** | | | | | | | |
|  | ✓ | ✓ | 3.6.1 | Has the identified risk (see economic case) been appropriately allocated between public and private sectors? | The business case should include a risk allocation table. The governing principle is that risk should be allocated to the party best able to manage it, subject to relative cost.  For PFI/PPP: there should be a sound risk allocation matrix for the preferred option showing how risks are to be apportioned between the public and private sectors. Shared risks should be excluded.  Ideally, a percentage allocation should be recorded between the categories of public, private and shared risk. If this is not feasible, then a ‘tick’ system can be used at OBC stage.  Has account been taken of potential private sector risks, eg bankruptcy of service provider? |  |  |
|  | ✓ |  | 3.6.2 | Is a timetable set out to revisit and evaluate the risk allocation matrix? |  |  |  |
|  |  | ✓ | 3.6.3 | Is the mechanism for effecting risk transfer described? Are the risks identified as transferable to the suppliers reflected in the contract? |  |  |  |
| **Personnel** | | | | | | | |
|  | ✓ | ✓ | 3.7.1 | Does the OBC state explicitly whether the scheme has any implications for personnel? Does the FBC confirm this? |  |  |  |
|  | ✓ | ✓ | 3.7.2 | Are any staff likely to be transferred? If yes, will TUPE apply? If it does, have all the provisions been complied with? | TUPE – Transfer of Undertaking, Protection of Employment Regulations 2006 (and as updated since). This protects the employment conditions of public sector staff transferring to the private sector. |  |  |
|  | ✓ | ✓ | 3.7.3 | Is there confirmation that plans accord with current guidance and requirements on retention of employment (RoE) as related to pensions, and that there are plans for consultation in accordance with the law/guidance? | TUPE protection does not include pensions, and DH developed RoE to cover these. Its use is now specifically restricted to soft facilities management in PFI schemes. If it applies, a copy of the legal advice received must be provided, as well as whether the health organisation’s HR director accepts or disagrees with it and why. |  |  |

**Commercial case: Build schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org Y/N** | | **Case**  **ref** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 3.8.1 | Have numbered and dated 1:200 (or electronic equivalent in terms of level of detail) drawings been included? | These should:   * include site plans and elevations, where appropriate * be numbered and dated, not loaded and with m2 net internal area (NIA) shown * be consistent with the Schedule of Accommodation/Derogation. |  | |  | |
|  |  | ✓ | 3.8.2 | Have numbered and dated 1:50 (or electronic equivalent in terms of level of detail) drawings been included? | These should be:   * be numbered and dated, loaded and with m2 NIA shown * consistent with the Schedule of Accommodation/Derogation. |  | |  | |
|  | ✓ | ✓ | 3.8.3 | Has a schedule of accommodation/derogation been provided? | This should be in Excel spreadsheet format on a room-by-room basis with any derogation to statutory/mandatory/DH standards highlighted. To support cost forms, drawings and infection control, fire safety, etc certificates of compliance should be attached. See [archive publications](http://webarchive.nationalarchives.gov.uk/20130107105354/https:/publications.spaceforhealth.nhs.uk/?option=com_documents&task=new_pubs&Itemid=1&region=England) and [DH health building notes](https://www.gov.uk/government/collections/health-building-notes-core-elements). |  | |  | |
|  | ✓ | ✓ | 3.8.4 | Detail any land transactions that are necessary to enable the scheme, together with any conditions that are attached to those transactions, including any constraints relating to the site. If there are conditions, are they built into the options appraisal? |  |  | |  | |
|  | ✓ | ✓ | 3.8.5 | Is there confirmation that design/project solutions are appropriate and, in addition, will actively support healthcare outcomes? | This may be achieved using one or a combination of the following design toolkits:   * **Design review: ASPECT**: deals with the way the healthcare environment can impact on the levels of satisfaction shown by staff and patients, and on the health outcomes of patients and the performance of staff. ASPECT can be used as a standalone tool, but should be used to support DQI (see below) and provide a more comprehensive evaluation of the design of healthcare environments. * **Design review: External review panel**: owner organisation should consider external design review panel, particularly for high value/complex projects as it could be related to planning permission requirements or other internal/external influences * **Design review: Design quality indicator (DQI)**: an established design quality assessment method updated for health use with the support of DH to succeed AEDET. DQI focuses on the quality of projects under three headings: functionality, build quality and impact, and engages a wide range of stakeholders.   There are five assessments stages, led by an independent accredited DQI facilitator: briefing; mid design; detailed design; ready for occupation; in-use. Projects must undertake all five stages of assessment to be DQI health accredited. The briefing stage DQI should be held early in the briefing process and must be completed before the end of the SCO. |  | |  | |
|  | ✓ | ✓ | 3.8.6 | Does the scheme demonstrate commitment to the government construction strategy? | Evidence to be provided of commitment to government construction strategy including:   * cost reduction c15% * procurement reform * building information modelling (BIM) * government ‘soft landings’ * benchmarking.   Applies to all construction including local improvement finance trust (LIFT) schemes. |  | |  | |
|  | ✓ | ✓ | 3.8.7 | Has a healthcare planner been appointed to the design team and have they actively contributed to the planning and evaluation process? | The proposal should include a description of the service model backed by plans/drawings demonstrating clinical/non-clinical adjacencies. |  | |  | |
|  | ✓ | ✓ | 3.8.8 | Is there evidence that the design solution complies with relevant DH consumerism requirements for healthcare buildings? | These requirements include:   * acceptable levels of privacy and dignity at all times * gender-specific day rooms * high specification fabric/finishes to reduce lifecycle costs * natural light and ventilation * zero discomfort from solar gain * dedicated storage space to support high standards of housekeeping and user safety * dedicated storage for waste awaiting periodic removal * inpatient bed configurations of >50% single en-suite and >5 bed bays with separate en-suite WC and shower facilities with 3.6-metre bed centres * single-sex washing and toilet facilities * safe and accessible storage of belongings including cash * immediate patient access to call points for summoning assistance * patient control of personal ambient environmental temperatures * lighting at bed head conducive to reading and close work * patient bedside communication and entertainment systems * elimination of mixed-sex accommodation (2011).   There should be formal confirmation from the responsible person that compliance with regard to single-sex accommodation and privacy and dignity is achieved, quoting drawing numbers (where appropriate)/date of review. See [*Adult in-patient facilities: planning and design* (HBN 04-01)](file:///\\irnhsft.local\monitor\Redirected\Lucy.Gardner\Desktop\Capital%20regime\Final\www.gov.uk\government\publications\adult-in-patient-facilities), [archive publications](http://webarchive.nationalarchives.gov.uk/20130107105354/https:/publications.spaceforhealth.nhs.uk/?option=com_documents&task=new_pubs&Itemid=1&region=England) and [DH health building notes](https://www.gov.uk/government/collections/health-building-notes-core-elements). |  | |  | |
|  | ✓ | ✓ | 3.8.9 | Does the scheme comply with health building note (HBN) requirements? | [HBN](https://www.gov.uk/government/collections/health-building-notes-core-elements) give ‘best practice’ guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.  They provide information to support the briefing and design processes for individual projects in the NHS building programme. They should be complied with; however, where they are not, the deviation from guidance should be included in the derogations. |  | |  | |
|  | ✓ | ✓ | 3.8.10 | Does the scheme comply with health technical memorandum requirements? | [Health technical memoranda](https://www.gov.uk/government/collections/health-technical-memorandum-disinfection-and-sterilization) (HTM) give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.  Healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. The HTM series provides best practice engineering standards and policy to enable management of this duty of care. They should be complied with; where they are not, the deviation from guidance should be included in the derogations. |  | |  | |
|  | ✓ | ✓ | 3.8.11 | Does the scheme comply with the building research establishment environment assessment model (BREEAM) assessment? | DH requires, as part of the business case approval, that all new builds achieve a BRE ‘Excellent’ rating and all refurbishments achieve a [BRE ‘Very Good’ rating](Http://www.breeam.org/about.jsp?ID=66) under BREEAM Healthcare with schemes of value in excess of £2 million (>500 m2).  A BREEAM pre-assessment completed by a registered BREEAM assessor and demonstrating the required target score should be provided at OBC. A BREEAM interim design certificate demonstrating the required target score issued by BRE should be provided with FBC/stage 2 submissions. |  | |  | |
|  | ✓ | ✓ | 3.8.12 | Does the scheme comply with the Fire Code? | Formal confirmation that [Fire Code](https://www.gov.uk/government/publications/suite-of-guidance-on-fire-safety-throughout-healthcare-premises-parts-a-to-m) compliance is achieved should be provided by the person in the organisation responsible for fire precaution compliance, quoting drawing numbers/date of review. |  | |  | |
|  | ✓ | ✓ | 3.8.13 | Does the scheme comply with infection control? | Letters of compliance should be provided by a consultant microbiologist and/or infection control lead.  Healthcare buildings must be designed with appropriate consultation with specialists to ensure the design facilitates good infection prevention and control (IPC) practices and has the quality of design (including finishes and fittings) that enables thorough access, cleaning and maintenance to take place.  See [HBN 00-09: *Infection control in the built environment*](https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment). |  | |  | |
|  | ✓ | ✓ | 3.8.14 | Does the scheme meet DH energy and sustainability targets? | Evidence is provided to show that the submitting organisation has applied the revised energy drafting and principles in accordance with DH’s principles paper (final version issued February 2005) or (if the energy plant at the new facilities is expected to be regulated by the recent CRC Regulations) the submitting organisation has adopted drafting which reflects similar principles and has been approved by a private finance unit (PFU).  Alternatively, if there is a project-specific reason why neither of the above approaches is suitable (eg there is already a long-term contract with an existing energy management supplier), the treatment of energy issues in the draft contract has been approved by PFU.  See also [HTM 07-02,](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/148488/Encode_2006.pdf) [DH health building notes](https://www.gov.uk/government/collections/health-building-notes-core-elements) and [Sustainable Development Unit](http://www.sduhealth.org.uk/policy-strategy/)*.* | |  | |  |
|  | ✓ | ✓ | 3.8.15 | Is there confirmation that the NHS facility is resilient to a range of threats and hazards? | Resilience is the ability of the building and its services to withstand the impact of an incident or emergency. [H](https://www.gov.uk/government/collections/health-building-notes-core-elements)BN 00-07provides:   * a strategic approach to resilience planning * technical guidance on measures to enhance resilience. |  | |  | |
|  | ✓ | ✓ | 3.8.16 | Does the scheme comply with the relevant health organisation travel plan? | Evidence of the current board- or governing body-approved travel plan. |  | |  | |
|  | ✓ | ✓ | 3.8.17 | Has a summary of the necessary planning permissions been provided? | The elements of the scheme that require [planning permission](https://www.planningportal.gov.uk/wps/portal/genpub_LocalInformation?docRef=LocalInformation&scope=202&langid=0) or [change of use](https://www.gov.uk/planning-permission-england-wales/when-you-need-it) approval should be detailed. If no permission is needed, a statement to that effect should be included to show that planning has been considered. |  | |  | |
|  | ✓ | ✓ | 3.8.18 | Has outline planning permission been obtained for all the developments described in the business case? | Outline planning permission should be sought to identify any issues relating to planning. Early involvement of the planners can avoid the need for costly redesigns during later stages of development.  On schemes where, exceptionally, planning permission cannot be achieved at OBC, the organisation submitting the OBC must be able to demonstrate that planning authorities have no major objections to the scheme. The form of that assurance will be considered on a case-by-case basis. Evidence which may be considered/required includes:   * evidence of sign off from the organisation’s planning advisors * the strategy to engage the local planning authority to minimise forward risks * the impact of any significant conditions included in the planning permission or communications with the planning authority * details of any additional planning requirements. |  | |  | |
|  | ✓ | ✓ | 3.8.19 | Is a copy of the planning application, letter of approval from the local authority and schedule of any planning conditions and costs provided? | An FBC will not be approved without planning approval (where this is required) or change of use approval (where this is required).  Evidence must link with risk register and cost forms for affect/compliance with s106, s278, etc requirements.  This item should also include reference to any judicial review period that may apply and NHS England’s expectation that works will not commence until any judicial review period ends. |  | |  | |
|  | ✓ | ✓ | 3.8.20 | Does the business case identify any acquisitions or disposals associated with the proposed development? | The business case contains the details justifying the disposal/acquisition in line with the recommendations found in the NHS estate code. |  | |  | |
|  | ✓ | ✓ | 3.8.21 | For P21+ schemes, is there assurance that the requirements set out in the ProCure 21+ guide and detailed selection process have been properly observed? | P21+ should be the default option for construction projects. |  | |  | |
|  | ✓ | ✓ | 3.8.22 | If procurement is via a call-off contract from a framework agreement, including but not limited to P21+, identify that the framework agreement evidences:   * your entitlement to call-off * that what is being called off falls within the framework agreement’s scope * that the call-off procedures of that framework agreement have been followed. | Although calling off from a framework agreement is an alternative to running an EU procurement law compliant-specific process, this is only so if the provider is entitled to call-off from the framework, the call-off is within the scope of the framework and the call-off procedures of the framework are followed.  The call-off requirements are likely to be the most problematic. Most multi-operator frameworks will require mini-competitions between all capable providers on the framework. Such mini-competitions can face many of the same problems of fairly distinguishing between bidders as a full competitive process. |  | |  | |
|  | ✓ | ✓ | 3.8.23 | For P21+ schemes, have repeatable rooms been used? If not proposed, this needs to be justified. | P21+ [repeatable rooms](http://www.procure21plus.nhs.uk/standardisation/) provide evidence-based high quality design as part of a standardised solution. They represent significant cost reduction and therefore must be considered in all cases. They are available to all NHS organisations, irrespective of the use of the ProCure21+ framework. |  | |  | |
|  | ✓ | ✓ | 3.8.24 | For P21+ schemes, have standard components been used? If not proposed, this needs to be justified. | P21+ [standard components](http://www.procure21plus.nhs.uk/standardisation/) are exclusive to P21+ schemes and should be specified on the basis of significant cost reduction with justification if not. All components are compliant with current HBN or have approved derogation. |  | |  | |
|  | ✓ | ✓ | 3.8.25 | Where P21+ is not used, has sufficient justification been provided as to why, as this alternative approach contributes to the aims and outcomes of the government construction strategy? | If Procure21+ is not the preferred option, the reason for this must be given in the options appraisal. |  | |  | |
|  | ✓ | ✓ | 3.8.26 | Any capital development commissioned for primary/community care and procured under LIFT using a lease plus agreement (LPA) or land retained agreement (LRA) should be tested for VfM against the LIFT procurement process. Where LIFT is deemed best VfM, LIFT procurement should be followed. | Go to [Community Health Partnerships](http://www.communityhealthpartnerships.co.uk/news) for latest NHS LIFT documentation. |  | |  | |

**Commercial case: IT only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 3.9.1 | Is any IT provision in line with DH policies? | Evidence to be provided that IT provision is in line with DH policies. A project plan should identify the timeframes and costs, and any critical IT with reference to the relevant organisation’s IT strategy (or equivalent). |  |  |

1. Financial case

| **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | | | **Case ref** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Affordability** | | | | | | | | | |
| ✓ | ✓ | 4.1.1 | Is a clear statement of capital and revenue affordability for the procuring organisation included in the business case, with any key assumptions highlighted? | This should be presented in nominal terms (taking into account inflation) and show the normalised position once the scheme is complete.  A ‘bridge’ statement should be provided indicating how it is proposed the incremental cost of the scheme for the first full year of the operation is funded (eg efficiency saving, capital charges savings, application of existing budgets, etc).  A clear statement should be provided describing the impact of the project on the organisation’s ability to meet statutory financial duties.  Has the organisation clearly stated the financial implications of not continuing with the project? This statement should include an assessment of any project costs incurred ahead of business case approval at the organisation’s own risk.  Have the cash and revenue impacts of any double running costs or decant costs associated with the scheme been considered?  Have significant financial risks associated with the project been clearly stated and any mitigating actions considered? Eg where assumed savings are not delivered. |  | | |  | |
| ✓ | ✓ | 4.1.2 | Does the business case show the sources of the costing data and how these have been built up? |  |  | | |  | |
| ✓ | ✓ | 4.1.3 | Have any of the financial models used been appropriately quality assured? | The National Audit Office's ([NAO) *Framework to review models*](https://www.nao.org.uk/report/framework-to-review-models/) provides guidance on quality assuring modelling. |  | | |  | |
| ✓ | ✓ | 4.1.4 | Have different funding options and their implications been considered? | The cost of any funding option should be included. |  | | |  | |
| ✓ | ✓ | 4.1.5 | Is there evidence that a source of (capital and revenue) funding has been confirmed? | The proposal must quantify and identify the (a) type of capital funding and (b) source of funding. This must be confirmed by all relevant parties, along with their agreement with the need to invest and with the preferred solution. |  | | |  | |
| ✓ | ✓ | 4.1.6 | Have any elements to be funded from external sources been identified, with the profile of funding/spend by year? | External sources include borrowing, public dividend capital, charitable, external grants and other non-provider sources. Confirmation in writing by the external provider of the funding must be evidenced. |  | | |  | |
| ✓ | ✓ | 4.1.7 | Where borrowing is assumed, has the amount of loan, assumed loan term, assumed interest, prudential borrowing assessment and repayments been clearly stated? | A statement showing the effect of the loan on the organisation’s financial position and (where appropriate) financial risk ratings before and after the loan need to be modelled and should be included in the business case. |  | | |  | |
| ✓ | ✓ | 4.1.8 | Are any efficiency savings as a consequence of the scheme based on reasonable assumptions? | Relevant assumptions include those relating to income, expenditure, cost improvement programmes (CIP), quality, innovation, productivity and prevention (QIPP) savings, other efficiency savings, inflation, growth and any reductions in backlog maintenance. Details of the organisation’s performance at delivering its CIP plans for the previous two years, analysed between recurrent and non-recurrent schemes, should be shown.  On the income side, the review will be based on payment by results (PbR) tariff assumptions (national/local, including primary and community care sector pricing) versus activity levels. PbR assumptions should be consistent with commissioner assumptions, and activity assumptions/commissioning intentions should be valid.  On the expenditure side, the validity of the efficiency assumptions through new ways of working, eg clinical safety and acceptability, will be checked.  The measures proposed should be sanctioned by the relevant board and responsibilities for delivery should have been assigned. |  | | |  | |
| ✓ | ✓ | 4.1.9 | In summary, is there evidence that the scheme is affordable year on year and in total to the procuring organisation? | Has the scheme been included in the organisation’s financial plan, as appropriate? For NHS schemes there should be evidence that the scheme is affordable within the health system. Is it included in the DH/CCG/NHS England financial plan and/or is it consistent with commissioning plans and/or aligned with local/regional QIPP plans (as appropriate)?  It must cover the capital and revenue consequences (including recurrent and non-recurrent consequences) over the life of the project.  Financial interdependencies with other projects are identified and explained.  Where the organisation/local health system is in financial deficit, the business case must explain how the scheme will contribute to the recovery plan. The recovery plan should be robust and supported by the relevant authorities.  Where QIPP savings are required to deliver affordability or recovery arrangements are required to ensure robust finances:   * the measures proposed have been sanctioned by the relevant board * responsibilities for delivery have been assigned and likely amounts quantified * monthly outturn on existing programme is provided.   Contingencies should also be identified. |  | | |  | |
| **Statement of Comprehensive Income/Statement of Financial Position** | | | | | | | | | |
| ✓ | ✓ | 4.2.1 | Has a projected Statement of Comprehensive Income (I&E) been provided for the procuring organisation? This should cover the underlying/normalised financial position for the past two years, the current year’s forecast and at least a five-year projection. | The year-on-year impact of the investment on the organisation’s cash flow, Statement of Financial Position (SoFP) and Statement of Comprehensive Income (SoCI) over the whole life of the investment should be included in the business case.  The accounts should be accompanied by appropriate commentary and notes which cover all key underlying assumptions, including inflationary assumptions, and income and activity assumptions. These accounts should fully include all anticipated operational developments.  Non-recurrent support, income and costs should be identified and correctly accounted for. Sources of income need to be clearly described (including non-recurrent, transitional, third-party, provider resources, land sales, etc).  SoCI (I&E account) projections should be shown gross and net of any one-off impairment charges, so that the underlying financial performance is clear.  Ongoing maintenance commitments should be included, as well as any impairments, deferred assets and residual interest charge.  Workforce implications are clearly described and costed in £ and work-time equivalents (WTE).  Any CRB included in the accounts should be clearly described, including how it has been derived, its value and how it is phased over different financial periods to show its impact on the organisation’s SoCI. | |  | |  | |
| ✓ | ✓ | 4.2.2 | Has the incremental impact of the proposal on the procuring organisation’s cash flow, SoFP and SoCI been included? | The costs profile in the business case should be compared with the existing baseline costs.  A projected cash flow statement is provided for the same period as for the SoCI and demonstrates there is sufficient cash flow to cover running costs and debt servicing in the transition/double running period and beyond. | |  | |  | |
| ✓ | ✓ | 4.2.3 | Is the anticipated SoFP (balance sheet) treatment of the scheme set out, showing impact on the procuring organisation? Any unusual risk factors should be fully analysed and discussed. | Where alternative accounting treatments are possible, evidence should be provided of adherence to the relevant accounting standards to justify the approach taken. This should be supported by written confirmation of agreement to the treatment from the organisation’s external auditors. | |  | |  | |
|  | ✓ | 4.2.4 | Where assumed accounting treatment is open to interpretation, is there written confirmation from the director of finance, the procuring organisation’s external auditor and the organisation’s financial adviser stating that (in their opinion) the assumed treatment is correct? |  | |  | |  | |
| **Technical checks** | | | | | | | | | |
| ✓ | ✓ | 4.3.1 | Is the split of costs between revenue and capital in line with the current capitalisation policy? |  | |  | |  | |
| ✓ | ✓ | 4.3.2 | Where the business case includes the purchase or creation of capital assets, is it clear which organisation will own the assets and whose asset register they will sit on? |  | |  | |  | |
| ✓ | ✓ | 4.3.3 | Are there recharges to other organisations as a result of the business case? If so, has the recovery of costs or income being generated been factored into the case? Are the mechanisms for these recharges clear? |  | |  | |  | |
| ✓ | ✓ | 4.3.4 | Have the procurement costs been clearly set out, including the basis for internal costs of the project team and the costs of advisers and technical support? | These should be included in the forward I&E projections. Any funding provided by commissioners or others for these should also be included in the SoCI. There should be commentary on the sources of funding, the agreements to provide funding and any conditions attached. | |  | |  | |
| ✓ | ✓ | 4.3.5 | Where leases are being purchased, have these been correctly accounted for as finance or operating leases in accordance with the applicable accounting standards? |  | |  | |  | |
| ✓ | ✓ | 4.3.6 | Has the treatment of VAT been clearly set out? | Appropriate independent expert advice should have been sought on the treatment and impact of VAT, VAT on land, etc on the scheme. This should be clearly laid out in the financial models and spreadsheets.  For some larger schemes, a ruling from Customs and Excise confirming recoverability of VAT may be required at FBC stage. | |  | |  | |
| ✓ | ✓ | 4.3.7 | Have all contract resources been split out from staff costs and shown as separate line items with correct treatment of VAT? |  | |  | |  | |
|  |  | 4.3.8 | Is the treatment of stamp duty, corporation tax or any other taxes compliant with relevant legislation? |  | |  | |  | |
| ✓ | ✓ | 4.3.9 | Is the indexation assumption accurate and appropriate? | The choice of the most appropriate index will depend on what is being indexed. The business case should explain the choice of the index/indices used. | |  | |  | |
|  | ✓ | 4.3.10 | Has the financial analysis been updated to take account of any changes in costs, and to show the effect of the proposed contractual payments? |  | |  | |  | |
| **Contingencies** | | | | | | | | | |
| ✓ | ✓ | 4.4.1 | Are contingency plans described, eg for alternative sources of funding, if assumptions turn out to be wrong or insufficient? Is there flexibility to fund any additional revenue requirements or to absorb any affordability gap? Are there any contingent liabilities? | There should be adequate proposals for managing a shortfall. There should be written stakeholder support for the plans where relevant. For example, if the commissioners are covering the gap, is this cover clearly shown, including amount and timing? Is there evidence that the commissioners understand what the organisation is doing? | | |  | |  |
| ✓ | ✓ | 4.4.2 | Have the assumptions underlying the financial appraisal (including cost of risk mitigation) been analysed for their robustness? |  | | |  | |  |
| ✓ | ✓ | 4.4.3 | Has sensitivity analysis been carried out on the relevant variables in the affordability analysis? | Sensitivity analysis has been carried out on the relevant variables in the affordability analysis that may have an impact on the overall commissioning plan, eg PbR modelling from an activity and price perspective.  Switching analysis on the following key variables should be completed to assess the maximum and minimum for each under which the scheme remains affordable (keeping other variables as per the base case):   * activity charges * efficiency gains * cost improvements * income/PbR parameters * pay costs * drugs and other running costs * construction inflations. | | |  | |  |
| ✓ |  | 4.4.4 | Is optimism bias set at the correct level, in accordance with the HMT [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf)? | Individual elements may be non-applicable or replaced by specific risks. | | |  | |  |
|  | ✓ | 4.4.5 | Have all elements of optimism bias been replaced by specific risks and set to zero if appropriate? |  | | |  | |  |

**Financial case: Build schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 4.5.1 | Has a costed equipment schedule been provided? | Information must be consistent with costs provided in the business case and cost forms. |  |  |
|  | ✓ | ✓ | 4.5.2 | Does the business case demonstrate that, where appropriate, the organisation has considered the option and potential for releasing any surplus land in line with the central government requirement? | Accelerating the Release of Public Sector Land for Development for housing is a central government initiative announced in 2011.  [*Disposal of surplus public sector land and buildings protocol for land holding departments*](https://www.gov.uk/government/publications/disposal-of-surplus-public-sector-land-and-buildings-protocol-for-land-holding-departments)  [*Accelerating the release of surplus public sector land*](https://www.gov.uk/government/publications/accelerating-the-release-of-surplus-public-sector-land) |  |  |
|  | ✓ | ✓ | 4.5.3 | Are any land transactions necessary to enable the scheme (disposal/acquisition) detailed, together with any conditions attached to those transactions? Have costs of those transactions been incorporated into the case? | The business case contains details justifying the disposal/  acquisition in line with the recommendations found in HBN 00-08: [*The efficient management of healthcare estates and facilities*](https://www.gov.uk/government/publications/guidance-for-nhs-organisations-on-management-of-land-and-property). In some instances, this may require a separate business case if funding/timescales cannot be aligned to the main business case. Risk around funding/cost and timescale should be clearly identified and costed in the risk section. |  |  |
|  | ✓ | ✓ | 4.5.4 | Where land sale proceeds are to be used, does the business case set out the valuation basis, timing for sale and a contingency for downward market movements? | Has the valuation been based on the advice of a suitably qualified and experienced valuation surveyor? Use of land sale proceeds should be agreed with all relevant parties, eg NHS Property Services, DH.  Any cost benefits or non beneficial aspects to the sponsoring NHS organisation(s) linked to the acquisition or disposal of land as part of the business case must be clearly stated, and the net financial impact on them made explicit in the financial modelling and affordability analysis.  See Annex 3 (Land and buildings) of the [*Green book*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf). |  |  |
|  | ✓ | ✓ | 4.5.5 | Has the organisation taken appropriate advice regarding asset impairments? |  |  |  |

**Financial case: IT schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ✓ | 4.6.1 | Have the costs of implementation and business as usual (BAU) been included in the analysis? Over what timescale? |  |  |  |

1. Management case

| **SOC** | **OBC** | **FBC** | **Ref** | | | **Item** | **Guidance** | | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Project plan** | | | | | | | | | | |
|  | ✓ | ✓ | 5.1.1 | | | Is there a project plan with delivery plans, dates and detailed milestones? | The project plan should cover key milestone dates, including approvals, future contract management and operational plans. It could take the form of, or be accompanied by, a management control plan. | |  |  |
|  | ✓ | ✓ | 5.1.2 | | | Is there a robust contract management plan? |  | |  |  |
|  | ✓ | ✓ | 5.1.3 | | | Are other workstream milestones and their interdependencies with the proposal clearly set out? | Other workstreams may include workforce, equipment, training, benefits delivery. Clear delivery dates and detailed milestones should be provided. | |  |  |
|  | ✓ | ✓ | 5.1.4 | | | Is an Office of Government Commerce (OGC) gateway risk potential assessment (RPA) attached? | The outcomes of the RPA should be shown. In some cases, eg when required by HMT, it may be appropriate to include the full report. | |  |  |
|  | ✓ | ✓ | 5.1.5 | | | Once the OGC gateway RPA has been completed, are there clear arrangements for peer reviews? | Confirmation should be provided that recommendations, in particular high priority recommendations, are being addressed.  Schemes with high RPA scores of 41+ will require a gateway review. Medium scoring schemes may be subject to gateway review at the discretion of the SRO. | |  |  |
|  | ✓ | ✓ | 5.1.6 | | | Are plans and a budget in place for post implementation monitoring and post-project evaluation (PPE)? | Is there a clear definition of the scope of the PPE, approaches to be adopted (eg the Magenta Book), timescales and specific milestones reviews? Plans should be consistent with the benefits identified in the economic case and in line with overall objectives. What is the resource for this? Are costs for PPE included in the project cost?  Participation in wider aggregate research may also be appropriate and beneficial.  Note: a Stage 5 in-use design quality indicator (DQI) assessment is classified as an element of PPE. The DQI PPE supports the benefits realisation PPE requirement of the CIM and government mandatory BIM ([Building Information Modelling](http://www.bimtaskgroup.org/government-soft-landings-videos)) ‘soft landings’ process for 2016 ([government soft landings](http://www.bimtaskgroup.org/wp-content/uploads/2013/05/Government-Soft-Landings-Section-1-Introduction.pdf)). | |  |  |
| **Project management** | | | | | | | | | | |
|  | ✓ | ✓ | 5.2.1 | | | What is the project management budget? | A breakdown of the budget should be provided. The budget should incorporate appropriate contingencies (and provide a rationale for these) and be consistent with the financial case. | |  |  |
| ✓ | ✓ | ✓ | 5.2.2 | | | Is there a summary of the project management structure? |  | |  |  |
|  | ✓ | ✓ | 5.2.3 | | | Does the project structure give assurance that the project has sufficient backing and commitment from senior executives and user groups to underpin a successful project? Has the chief executive or equivalent signed off the PBC/SOC, OBC and FBC, and is board support explicit? |  | |  |  |
|  | ✓ |  | | 5.2.4 | Has the project management method been defined? | | The recommended project method is PRINCE 2 (Projects IN Controlled Environments), which is the de facto standard in use in the public sector in the UK. | |  |  |
|  | ✓ |  | | 5.2.5 | Is the membership of the project team set out? | | Details of the following should be set out. For large schemes/builds, it would be appropriate to see all of:   * the amount of dedicated project/programme resource, that is, number of full/part-time staff and their roles * roles and responsibilities of team members * a management structure indicating communication links and reporting responsibilities * evidence that the extent of senior management and clinical time has been assessed and factored into resource requirements * CVs of the project manager and ‘benefits and change manager’ (or job descriptions if not yet appointed).   For smaller schemes, the first four items on the above list can be useful for providing assurance of competence in these key posts. In IT schemes in particular, it is important to have an adequate resource for benefits management and skilled personnel. | |  |  |
|  | ✓ | ✓ | 5.2.6 | | | Is there sufficient and adequately skilled resource available to successfully manage the procurement, implementation and operational stages? | The skills set of the team and any skills gaps are identified. Plans are set out on how skill gaps are to be filled, including any plans to use advisers.  Who will be responsible for contract management? How does their work fit into the overall project management structure?  The role of advisers is set out, including the terms on which they have been appointed, confirmation of the breadth of their appointment, and arrangements to manage their fees. | |  |  |
|  | ✓ | ✓ | 5.2.7 | | | Have adequate management arrangements been put in place to manage the bids, preferred bidder appointment and contract? | These should be clearly set out. | |  |  |
| **Project reporting and monitoring** | | | | | | | | | | |
|  | ✓ | ✓ | 5.3.1 | | | Have the reporting structure and monitoring arrangements been set out? | This should identify who is involved in reporting and monitoring, when and how this takes place and the anticipated cost. | |  |  |
|  | ✓ | ✓ | 5.3.2 | | | Does the plan include full details of the membership and terms of reference of the project board and subgroups in the project management structure? | The case should include an organogram or other representation of the project structure and governance (including links to the organisation’s board). | |  |  |
|  | ✓ | ✓ | 5.3.3 | | | Has the senior responsible owner been identified? | The SRO is the person who is made ultimately accountable for the success of the programme by the lead/procuring organisation and is usually a member of the management team of that organisation. | |  |  |
| **Benefits management** | | | | | | | | | | |
|  | ✓ | ✓ | 5.4.1 | | | Is there a benefits realisation table and plan? | | At OBC stage the benefits strategy should be outlined. At FBC stage a detailed plan should be included. These should cover all benefits, CRB and non-CRB, and should reconcile with the economic benefits identified and valued in the economic case. The benefits should be quantified and measurable.  There should be a clear plan to ensure monitoring and evaluation of the quantified benefits. This needs to include a timeframe and accountable owner, and ensure that the criteria for measurement have been identified. |  |  |
|  |  | ✓ | 5.4.2 | | | Is it clear what benefits are to be realised by whom, eg suppliers, stakeholders, etc.? | | Responsibility for monitoring and achieving benefits delivery should be assigned to named postholders. How will delivery of benefits by suppliers be monitored? |  |  |
|  |  | ✓ | 5.4.3 | | | Does the detailed benefits realisation plan separate CRB from non-CRB and identify how qualitative benefits are to be measured? | | The case should demonstrate how cash is to be released and efficiencies achieved, and should identify which budgets will be impacted. |  |  |
| **Change management** | | | | | | | | | | |
|  | ✓ | ✓ | 5.5.1 | | | Has the organisational and cultural impact of the preferred option been considered/described? Have the necessary measures been put in place to manage the organisational and cultural changes arising from the impact of the scheme? | | For example, the identified impact of deployment should be consistent with wider organisational strategies such as human resources, estates or clinical services. |  |  |
|  |  | ✓ | 5.5.2 | | | Is there a detailed, resourced and robust change management plan which also shows interdependencies? What is the resource for this? | | The change management plan should include a transition plan and details of any necessary training programmes. |  |  |
|  | ✓ | ✓ | 5.5.3 | | | Does the business case demonstrate that users fully support the project and are committed to it? Does the business case include detailed plans for user involvement in the planning and implementation of the project? | |  |  |  |
| **Risk management** | | | | | | | | | | |
|  | ✓ | ✓ | 5.6.1 | | | Is there a comprehensive, costed risk register/log? | | The business case should set out at least the top ten highest risk items for delivery of the preferred option. The full risk register should be appended. Is the nature of the risks clearly explained, together with their timing and their potential service and financial impact? Is understanding of their implications demonstrated? |  |  |
|  | ✓ | ✓ | 5.6.2 | | | Has a risk management plan been provided in which risks are appropriately identified, mitigated and managed? | | Contingency plans should be set out and risks allocated to the most appropriate party. Potential cost overruns are provided for in the affordability analysis. |  |  |
|  |  | ✓ | 5.6.3 | | | Is updated information provided about the nature of the risks, their timing and their potential service and financial impact? Is the risk management strategy sufficiently comprehensive and detailed, covering all identified risks? | |  |  |  |
| **Other** | | | | | | | | | | |
|  |  | ✓ | 5.7.1 | | | Arrangements are in place to make the FBC and any addendum public within a month following FBC approval, with the executive summary (at least) available on the relevant health organisation’s website. | | Publication of the case should be borne in mind from the start so that, for example, the project team is clear about what areas may be commercially confidential (seeking legal advice as needed) and bidders are aware that the case will be published. Care should therefore be taken in organising the case and in its wording. |  |  |

**Management case: Build schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 5.8.1 | Where applicable, external advice on design, build, health and safety, the Fire Code, estate issues and information technology has been sought and evidenced in the business case. |  |  |  |
|  | ✓ | ✓ | 5.8.2 | Is the business case submission accompanied by a completed NHS premises assurance model (PAM) standard assessment questionnaire for the health organisation and evidence to demonstrate that this has been approved by the organisation’s board or governing body? | The [NHS PAM](https://www.gov.uk/government/publications/nhs-premises-assurance-model-launch) promotes the sharing of best practice and lessons learned across NHS providers with the aim of improving the performance of premises. PAM 2014 allows NHS organisations to better understand the efficiency, effectiveness and level of safety with which they manage their estate, and how that links to patient experience and is compliant with relevant legislation and guidance. It provides a single method that is nationally consistent, peer comparable and aligned with the wider NHS management landscape. |  |  |

**Management case: IT schemes only**

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ✓ | ✓ | 5.9.1 | Is there an outline training programme for all relevant staff, both users and project team members? | Detail should be provided about whether the organisation already has a training infrastructure, how training will be developed and who will develop it. |  |  |
|  |  | ✓ | 5.9.2 | Has a detailed, costed and resourced training programme been worked up, covering the training requirements of all relevant staff, both users and project team members? | Detail should be provided about how training is being developed and delivered, and by whom. |  |  |
|  | ✓ | ✓ | 5.9.3 | Does the programme have a delivery plan incorporating the transition to live running/BAU? |  |  |  |
|  | ✓ | ✓ | 5.9.4 | Is there evidence that security and confidentiality have been addressed in accordance with information governance principles? |  |  |  |

1. Clinical quality (see Annex 2 for guidance)

| **SOC** | **OBC** | **FBC** | **Ref** | **Item** | **Guidance** | **Org**  **Y/N** | **Case ref** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Clinical strategy and commissioning intentions** | | | | | | | |
| ✓ |  |  | 2.1 | Describe how the scheme will support the delivery of the organisation’s clinical strategy and is aligned to commissioning intentions. | See strategic case – checklist reference 1.2.1. |  |  |
| **Design and buildings** | | | | | | | |
|  | ✓ | ✓ | 2.2 | Describe the purpose of the building and the suitability of the design and layout to the proposed scheme, with particular attention to patient, staff and visitor needs.  Have the following clinical quality aspects been considered in the purpose, design and layout of the proposed scheme (see clinical quality – checklist reference 2.2.1–2.2.8 below): | Describe the purpose of the building and the suitability of the design and layout to the proposed scheme. Provide a description of the service model, backed by plans/drawings demonstrating clinical/non-clinical adjacencies.  There is evidence provided of ongoing engagement with patients and frontline staff in designing the model of care and the environment(s) in which it will be delivered?  Confirm that the health organisation has appointed a healthcare planner as part of the design team and this person has actively contributed to the planning and evaluation process.  Refer to the HBN appropriate to service type.  [DH publications](https://www.gov.uk/government/publications?keywords=HBN&publication_filter_option=all&topics%5B%5D=all&departments%5B%5D=department-of-health&world_locations%5B%5D=all&direction=before&date=2013-05-01)  [DH health building notes](https://www.gov.uk/government/collections/health-building-notes-core-elements) |  |  |
|  | ✓ | ✓ | 2.2.1 | Use of the facility:   * model of care * patient need * privacy and dignity * workflows and logistics * adaptability * security. | There is evidence that consideration has been given to future proofing the investment/facility/capacity/  capability.  Will the design be appropriate for patient need?  Has the importance of privacy and dignity to individuals been considered? |  |  |
|  | ✓ | ✓ | 2.2.2 | Describe and set out the access requirements for patients, staff and visitors. | Consider way finding and signage, patients with disabilities, parking, goods and vehicle separation, and pedestrian access and exits. |  |  |
|  | ✓ | ✓ | 2.2.3 | Describe space in the facility – patient space standards. | Describe and set out the arrangements for public clinical areas. |  |  |
|  | ✓ | ✓ | 2.2.4 | What is the impact of estates derogation on clinical care? | Derogations must be approved by the medical and nurse directors of the organisation. |  |  |
|  | ✓ | ✓ | 2.2.5 | What is the impact of clinical adjacencies in the scheme design?  What consideration has been given to the impact of clinical and non-clinical adjacencies in the scheme design? | Confirm that the health organisation has appointed a healthcare planner as part of the design team and this person has actively contributed to the planning and evaluation process.  Describe the service model, backed by plans/drawings demonstrating clinical/non-clinical adjacencies.  [DH publications](https://www.gov.uk/government/publications?keywords=HBN&publication_filter_option=all&topics%5B%5D=all&departments%5B%5D=department-of-health&world_locations%5B%5D=all&direction=before&date=2013-05-01)  [HBN core elements](https://www.gov.uk/government/collections/health-building-notes-core-elements) |  |  |
|  | ✓ | ✓ | 2.2.6 | What consideration has been given to:   * provision of carer and parent accommodation * meeting needs of staff and patients. |  |  |  |
|  | ✓ | ✓ | 2.2.7 | Have frontline staff and patients been involved in the design of the care environment? | How have patients, the public, staff and other stakeholders been involved in shaping proposals? |  |  |
|  | ✓ | ✓ | 2.2.8 | Describe how the capital scheme proposal will improve the organisation’s patient-led assessment of the care environment (PLACE scores). | PLACE assessments give patients and the public a voice on local standards of care. |  |  |
|  | ✓ | ✓ | 2.3 | Does the IT system integrate with other systems for the purposes of patient quality and safety?  There is evidence that the organisation has considered:   * system integration * impact on patient safety and clinical quality * clinical engagement * clinical knowledge and use of the system * clinical benefits realisation. | Demonstrate how the IT system will integrate with other systems for the purposes of patient quality and safety.  Describe and present the findings and outcome of the risk assessment and the impact on quality, including risks identified and the mitigation plan?  Present the added clinical benefits of the new system.  Provide evidence of clinician engagement and involvement in the project governance process. |  |  |
| **Leadership and stakeholder engagement** | | | | | | | |
|  | ✓ | ✓ | 2.4 | Can the organisation demonstrate engagement with clinical leaders, frontline clinical and non-clinical staff, and other key stakeholders in shaping investment proposals. The business case and supporting evidence demonstrates the aspects described in clinical quality – checklist reference 2.4.1 to 2.4.3. | Describe how executive clinical leaders, frontline clinical and non-clinical staff, and other stakeholders have been involved in shaping and influencing proposals, including eliciting and acting on patient feedback. |  |  |
|  | ✓ | ✓ | 2.4.1 | Describe stakeholder engagement:   * involvement * shaping developments * high level of engagement with clinical staff. |  |  |  |
|  | ✓ | ✓ | 2.4.2 | Clinical leadership, engagement and oversight:   * oversight from executive clinical leaders * oversight of planning and ensuring clinical quality and business continuity * leadership resource and capacity to deliver * engagement with patients, the public, staff and other key stakeholders * engagement with appropriate experts, clinical or other stakeholders * clinical experts are involved in shaping proposals. | Has the organisation met its duties under s242 of the NHS Act 2006 to involve and where necessary carry out a full public consultation with patients, the public and other stakeholders?  The outcome of this involvement has been considered and where appropriate has informed the business case. |  |  |
| **Design and building** | | | | | | | |
|  | ✓ | ✓ | 2.4.3 | Describe the interface with community partners and development/  understanding of patient pathways. |  |  |  |
| **Patient experience and safety** | | | | | | | |
|  | ✓ | ✓ | 2.5 | The organisation describes how the project will improve the quality of care and the experience of patients. The organisation has carried out a full quality impact assessment using a nationally approved tool and can evidence that the proposal will enhance the quality of patient care and experience. Where any negative impact has been identified, measures to mitigate this have been included in the business case (see clinical quality – checklist reference 2.5.1 to 2.5.7 below). | Describe specifically how the scheme will benefit patients, that is, improve patient experience as a consequence of the new build.  Describe how the organisation intends to continue to involve people in shaping the scheme’s development.  Describe how tools/methods or approaches have been selected by the trust to ensure proposals improve safety, clinical outcomes and patient experience.  Describe how the design of the building will aid therapeutic objectives, engender wellbeing and raise patients’ and visitors’ spirits?  Describe arrangements for business continuity during the build period, eg access for staff, patients and the public takes account of the major incident policy and emergency planning. |  |  |
|  | ✓ | ✓ | 2.5.1 | Quality, safety and affordability:   * there is a clear and credible approach to enhancing the delivery of patient care, quality of care and care outcomes * are the quality, safety, productivity, affordability and VfM considerations robust? |  |  |  |
|  | ✓ | ✓ | 2.5.2 | Patient experience:   * How specifically will the scheme benefit patients, that is improve patient experience as a consequence of the new build? eg: * aiding recovery * quality of environment * patient involvement. |  |  |  |
|  | ✓ | ✓ | 2.5.3 | Consideration has been given to the safety, design and flow of the building, including the use of patient safety indicators – safe design. |  |  |  |
|  | ✓ | ✓ | 2.5.4 | Does the design optimise infection prevention and control?  Has the organisation demonstrated compliance with HBN 00-09: *Infection control in the built environment*. | [HBN 00-09: *Infection control in the built environment*](https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment). |  |  |
|  | ✓ | ✓ | 2.5.5 | Where the capital scheme involves medicines ensure:   * pharmacist involvement and senior pharmacist sign off of plans * involvement of the medicines optimisation lead. |  |  |  |
|  | ✓ | ✓ | 2.5.6 | Describe what facilities have been made available for carers, including consideration of carers’ requirements, including those caring for others with learning disabilities, mental health and long-term conditions. |  |  |  |
|  | ✓ | ✓ | 2.5.7 | Describe the business continuity during the build period, eg major incident policy and emergency planning. |  |  |  |
| **Workforce** | | | | | | | |
|  | ✓ | ✓ | 2.6 | How have national drivers for workforce been incorporated in the proposal, including:   * 7-day services * safer nursing care tool, safer staffing tool and NICE guidance * technology advance and utilisation * workforce-to-patient ratios * Francis report and response from the government’s *Hard truths* report * learning from the staff survey * appraisal and pay progression – opportunity for improving workforce and rewarding success * weekend workforce and mortality * attraction and retention of staff * evidence of national benchmarking and use of workforce analytical tools to meet current and future delivery * training and development in new ways of working. | Describe how national drivers for workforce have been considered and incorporated into the proposal?  Describe arrangements for training and development in new ways of working. |  |  |
| **Sustainability** | | | | | | | |
|  | ✓ | ✓ | 2.7 | Have sustainability, demand and capacity modelling been carried out across the lifetime of the scheme? |  |  |  |
| **Learning and continuous improvement** | | | | | | | |
|  | ✓ | ✓ | 2.8 | Does the organisation have arrangements in place to evaluate lessons learned and opportunities for continuous improvement? | Describe how the effectiveness of the scheme will be evaluated and shared as lessons learned for future scheme developments. |  |  |

1. [www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent](http://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent) [↑](#footnote-ref-2)