NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	Governing Body	Agenda Item: 7.3
Date of Meeting:	25 June 2020	
Paper Title:	Catterick Integrated Care Campus – Outline Business Case Approval (UPDATED VERSION)	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead	Report Author and Job Title
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Purpose (this paper if for)

Decision	Discussion	Assurance	Information
X			

Has the report (or variation of it) been presented to another Committee / Meeting?

Executive Summary

This paper provides the Governing Body (GB) of NHS North Yorkshire Clinical Commissioning Group (the CCG) with a summary of the Outline Business Case (OBC) for the Catterick Integrated Care Campus (CICC) proposal and asks for approval by the Governing Body to submit the OBC to NHS England (NHSE) for approval.

It was first proposed in 2015 that, due to the state of disrepair of the primary care estate for both the NHS & the MoD on the Catterick Garrison site and the proposed influx of new residents under the Army's 2020 rebasing scheme, there was a significant opportunity for both organisations to come together and, for the first time, provide medical services in a fully integrated way.

Over the subsequent five years we have worked in partnership with the MoD to develop the proposal for the CICC which will deliver a cultural shift in the way health and care services are designed and provided by putting the principles of personalisation, co-production, prevention, self-care and wellbeing at the heart of the model. This new model of care will engineer an innovative approach between the NHS and MOD to deliver an integrated service offer to MOD personnel, their dependents and local residents in Catterick and the surrounding area which is fit for the future.

The CICC is the first of its kind, a truly transformational scheme between the NHS and MOD to cater for a significant rebasing of personnel and their dependents between 2021 and 2031, as well as the expected growth in the general population. The scheme will be the blueprint for how services can be delivered across health and care economies and builds upon the principles of the Primary Care Home (PCH) model of care whilst addressing the very discrete needs of this cohort of the population; military personnel, their dependents and veterans, to move away from fragmented and reactive care to holistic and preventative care which is truly person and family centred.

The population of Catterick is due to rise from 20,624 in 2019 to 29,164 in 2031, this represents a movement of 8,540 over an 11-year period. The MOD and CCG with its partners have sought to design a future model of care which will not only address this population spike but also shift the traditional service model and organisational boundaries and create a valued asset in the

local community.

Politically, there is acute national interest in the development, particularly related to the responsibilities detailed in 'The Strategy for Veterans' (2018 – Ministerial Covenant and Veterans Board) for better healthcare for veterans, in integrated services and in public services working together to serve populations with greater efficiency.

A joint governance structure is in place across the programme to provide appropriate management and oversight to ensure the overall integrity of the programme, with approval routes and processes aligned to ensure synergy between the MOD and CCG to enable business case progression. A programme plan is in place to manage the scheme to build, mobilisation and go live in 2023/24.

The total capital cost of the preferred option is circa £55.32m (including VAT and inflation) of which £42.63m will be MoD Capital and £12.69m will be NHS Capital. The source of the NHS capital funding is to be formally confirmed by NHS England & Improvement following approval of the OBC but for the purposes of the OBC it is assumed that the scheme will be publicly funded.

The preferred option is to transfer the NHS capital allocation to the MoD under Section 2 (NHS Act 2006) agreement. The asset would be held by the MoD with the NHS entering into a contract giving the NHS use of the agreed floor areas at a peppercorn rent for an agreed period (40years).

The recurring revenue costs of the preferred option attributable to the CCG are estimated as circa £556k per annum, circa £329k more than current expenditure. The CCG expects to support this funding gap by cash releasing savings delivered through CCG transformational schemes and/or accessing primary care transformation funding through the ICS.

The additional £329k cost will not be incurred until 2024 when the building is complete but we have already begun the task of identifying where savings might be made and have thus far identified c.£120k of savings.

These calculations have taken into consideration VAT, inflation, released costs and increase in practice income related to increased population.

A Comprehensive Investment Appraisal (CIA) financial model has also been developed to support the OBC. As well as the capital and revenue implications above, risks and benefits of the scheme have been considered in the CIA to give an economic and value for money evaluation. The financial modelling section of the OBC is subject to final refinement and representational change following final approval.

We have already submitted, and had approved by NHSE, a PID and Post PID Options Appraisal. The Outline Business Case (OBC) is the 'gateway' document which will enable us to access the capital required for the scheme and progress to completion of a Full Business Case. We anticipate completing this element of the work by Autumn of this year.

Appendix 1: Catterick Integrated Care Campus Outline Business Case

Recommendations **The Governing Body is being asking to:** Approve the progression of the OBC for submission to NHSE for approval and confirmation of capital funding.	
Monitoring Both organisational and joint governance structures are in place to provide monitoring, management and oversight and to ensure the overall integrity of the programme.	
Any statutory / regulatory / legal / NHS Constitution implications	All statutory, regulatory, legal and constitutional implications have been successfully considered, assessed and managed through the NHSE/I service change assurance process.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	Press release to be issued – June 25th – following Governing Body decision.
Financial / resource implications	Additional £329k costs per year above existing cost of primary care provision in Catterick. To be offset by primary care transformation schemes and additional primary care funding through HCV ICS. Significant reputational risk of not proceeding with high profile scheme.
Outcome of Impact Assessments completed	Impact assessments completed as part of OBC – scheme contains significant benefits for disadvantaged groups.

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NHS
North Yorkshire
Clinical Commissioning Group

Catterick Integrated Care Campus

Outline Business Case

May 2020

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Executive Summary

The seamless integration of health and care services is a fundamental premise of both the national policy agenda and the local strategic direction across England, with the aim of; promoting good health and wellbeing, delivering better outcomes for the local population, promoting ease of access and ensuring a sustainable and financially viable health and care system for the future.

This is the case in North Yorkshire, with local health commissioners, the Ministry of Defence (MOD) and providers; as well as the independent, voluntary and community sector coming together to design and deliver holistic, person and family centred care and support with an unreserved focus on prevention, self-care and early intervention.

This ambition will ensure local patient/service users, their carers and families have access to the right care, at the right time, in the right setting, delivered by the right professionals to enhance their wellbeing and independence, and improve their overall quality of life.

It is widely acknowledged that the current model of health and care service delivery is unsustainable considering the challenging policy and fiscal environment, coupled with the increasing demand and expectations placed on local health and care economies. New models of care are being incubated throughout England which is looking to shift the current paradigm and remove the reliance on secondary care, with an increased role for primary, community and social care integration with the wider voluntary and community sector.

This is further evidenced in the NHS Long Term Plan with the specific ambitions that every area across England is covered by an Integrated Care System (ICS) by 2021; the evolution of Integrated Care Partnership sub-systems (ICPs) and the establishment of Primary Care Networks (PCNs) on a locality spatial footprint of 30-50k populations with a central role for General Practice.

The Catterick Integrated Care Campus (CICC) is firmly rooted within this approach and philosophy. Previously as Hambleton, Richmondshire and Whitby CCG (HRW CCG) and now as North Yorkshire CCG (NYCCG) local commissioners have developed, in collaboration with the MOD, local healthcare providers, broader public sector partners and the voluntary and community sector, a new integrated model of care. The CICC model of care describes a cultural shift in the way health and care services are designed and delivered and is steeped in the principles of personalisation, co-production, prevention, self-care and wellbeing. The new model of care will engineer an innovative approach between the NHS and MOD to deliver an integrated service offer to MOD personnel, their dependents and local residents in Catterick and the surrounding area over the next 10 to 15 years which is fit for the future.

The CICC is the first of its kind, a truly transformational scheme between the NHS and MOD to cater for a significant rebasing of personnel and their dependents between 2021 and 2031, as well as the expected growth in the general population. The scheme will be the blueprint for how services can be delivered across health and care economies and builds upon the principles of the Primary Care Home (PCH) model of care whilst addressing the very discrete needs of this cohort of the population; military personnel, their dependents and veterans, to move away from fragmented and reactive care to holistic and preventative care which is truly person and family centred.

Politically, there is acute national interest in the development, particularly related to the responsibilities detailed in ‘The Strategy for Veterans’ (2018 – Ministerial Covenant and Veterans Board) for better healthcare for veterans, in integrated services and in public services working together to serve populations with greater efficiency.

The CICC scheme has been in development for a number of years and represents the vision and ambition of a series of system leaders and associated organisations to realise a new and innovative model, which moves away from disease treatment and management to seamless person and family centred care and support in the community.

The MOD and CCG have been instrumental in this design process and have provided the space to think creatively to address the forecasted influx of MOD personnel and dependents due to the rebasing and associated significance of the Catterick Garrison to the MOD, as well as Local Authority projected housing growth. The population of Catterick is due to rise from 20,624 in 2019 to 29,164 in 2031, this represents a movement of 8,540 over an 11-year period. The MOD and CCG with its partners have sought to design a future model of care which will not only address this population spike but also shift the traditional service model and organisational boundaries and create a valued asset in the local community.

A feasibility study was commissioned in 2017 which culminated in the development of a project initiation document (PID) for the NHS and the subsequent need for respective business cases for the scheme at both a MOD and CCG level with separate but inextricably linked approvals processes. The Outline Business Case (OBC) is the NHS requirement and the target audience is the CCG and NHSE/I. The MOD have also commissioned a detailed independent Assessment Study which represents a key technical milestone in the scheme’s development.

A joint governance structure has been established across the programme to provide appropriate management and oversight to ensure the overall integrity of the programme, with approval routes and processes aligned to ensure synergy between the MOD and CCG to enable business case progression. A programme plan is in place to manage the scheme to build, mobilisation and go live in 2023/24

This campus will be a national exemplar of best practice in integrated military and civilian healthcare and in new ways of working and all partners across the NHS, MOD, our providers and our communities remain committed to delivering this new facility and to turning the vision into a reality.

1. Introduction and background

1.1 Introduction to the Business case

Key areas of focus in the Business Case

The Outline Business Case (OBC) will explore, analyse and make recommendations on the following key areas:

- Whether the proposed scheme and new model of care can deliver improved health and wellbeing outcomes for patients, service users, carers and local residents; including both MOD personnel, their dependents and the wider registered/ resident population within Catterick;
- Whether the proposed scheme and new model of care can maintain or improve the quality of care in terms of safety, patient/ service user experience and clinical effectiveness;
- Whether the proposed scheme and new model of care can provide a sustainable solution in light of the financial and policy challenges facing the health and care economy;
- Whether the proposed scheme and new model of care can provide a sustainable solution to the MOD personnel and dependent rebasing over the period to 2031; following the site identification as a Super Garrison; and
- Whether the proposed scheme and new model of care can provide a blueprint and proof of concept for the design and delivery of integrated armed forces health and care with the NHS and its partners, which is replicable across England.

The OBC for the scheme builds on the feasibility study undertaken in 2017 (Appendix 1), the production of the Project Initiation Document (PID), Assessment Study and post PID options appraisal (PPOA) to confirm the preferred option/solution which offers optimal value for money and sets out the proposed delivery strategy. The realisation of the scheme will see the relocation of services and will be subject to formal public consultation in line with statutory duties. This will be confirmed prior to the Full Business Case (FBC) and discharged as part of the communication and engagement strategy and overall programme plan.

The FBC will be developed following NHSE approval and will set out the formal investment case for the scheme; building on the OBC, providing the final detailed costing, benefits and return on investment (ROI) as well as the chosen commercial route and detailed plans for implementation and delivery.

Approach to writing the Outline Business Case

The OBC has been prepared using the agreed standards and format for business cases, as set out in the HM Treasury publication 'The Green Book: Appraisal and Evaluation in Central Government'[1] and the NHSE/I Project Appraisal Unit (PAU) business case guidance. The Green Book explains the importance of the business case as follows:

[1] https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

“Policies, strategies, programmes and projects will only achieve their spending objectives and deliver benefits if they have been scoped robustly and planned realistically from the outset and the associated risks taken into account.

A business case in support of a new policy, new strategy, new programme or new project must evidence:

- That the intervention is supported by a compelling case for change that provides holistic fit with other parts of the organisation and public sector– *the Strategic Case;*
- That the intervention represents best public value – *the Economic Case;*
- That the proposed model and method of integrated working is attractive to the healthcare economy; can be secured; is aligned to NHS guidance on Competition and Patient Choice and Public Sector Contract Regulations; and is commercially viable – *the Commercial Case;*
- That the proposed spend is affordable – *the Financial Case;* and
- That what is required from all parties is achievable – *the Management Case*.”

There are three key stages in the evolution of a business case: the Strategic Outline Case (SOC), the Outline Business Case (OBC) and the Full Business Case (FBC), as set out below:

1. Strategic Outline Case (SOC) - scoping the proposal;

- Making the case for change;
- Exploring the preferred way forward; and
- *Gateway 1: Business justification.*

2. Outline Business Case (OBC) - planning the scheme;

- Determining potential Value for Money (VFM);
- Preparing for the potential deal;
- Ascertaining affordability and funding requirement;
- Planning for successful delivery; and
- *Gateway 2: Delivery strategy.*

3. Full Business Case (FBC) – Securing the solution;

- Securing the VFM solution;
- Securing the model of care;
- Ensuring successful delivery; and
- *Gate 3: Investment decision.*

The level of detail and the completeness of each of the five dimensions of the Case are built up at different rates during the business case development process, as set out below:

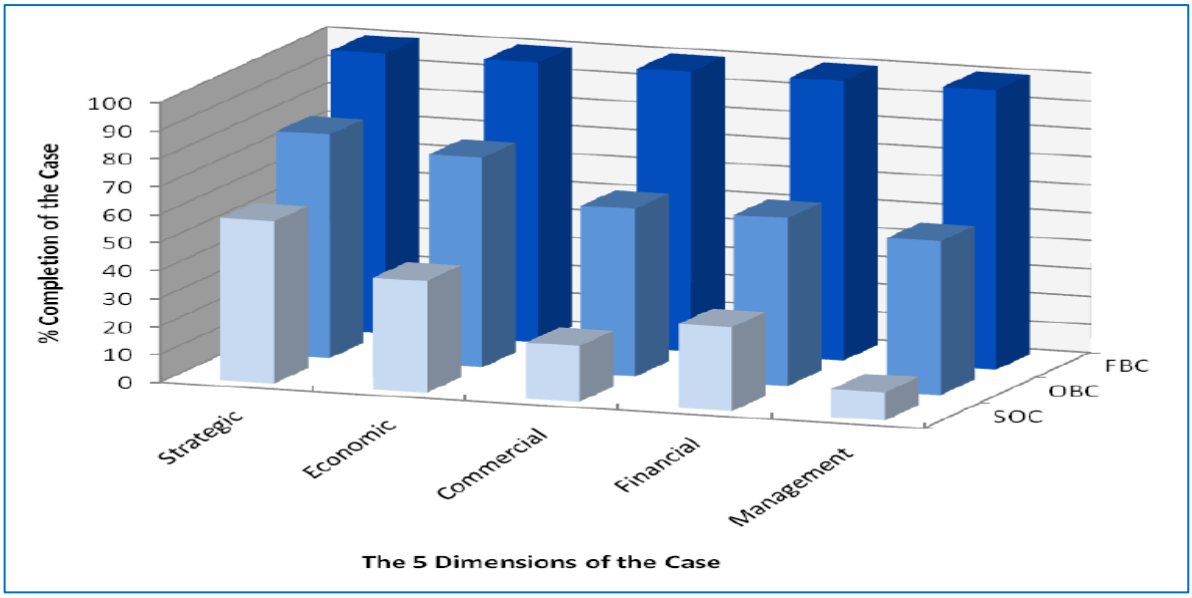

Figure 1: Business Case Phase Development and Composition

Format of the Outline Business Case

In line with the guidance described, the OBC follows the approved format i.e. the Five Case model, with the following key components:

- **The Strategic Case -** This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme and new model of care;
- **The Economic Case -** This demonstrates that a preferred way forward has been selected which best meets the existing and future needs of the population and is likely to optimise value for money (VFM);
- **The Commercial Case -** This outlines the commercial deal and procurement route required to realise the scheme and model of care;
- **The Financial Case -** This highlights likely funding and affordability issues associated with the scheme and new model of care; and
- **The Management Case -** This demonstrates that the scheme and new model of care is achievable and can be delivered successfully in accordance with accepted programme and project management methodologies and best practice.

Following the production of the NHS OBC and the MOD OBC and subsequent gateway approvals, it is envisaged that the NHS FBC and MOD Main Gate Business Case (MGBC) will be developed to enable the scheme to progress through detailed design and construction to facilitate a go-live date in 2023/24. The programme plan set out in the Management Case details the key milestones and critical success factors on that journey.

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1.2 Background and current healthcare landscape

Richmondshire is one of the largest districts in England, covering an area of just over 500 square miles and has a unique population profile in comparison to the rest of North Yorkshire, due to the sharp contrast between an elderly population living rurally and a density of young people living in more urban areas of the locality:

- 70.6% of the population lives in rural areas
- Of this group, 15.3% of the population live in areas which are defined as 'super-sparse' (less than 50 persons/km)
- 30% live in Catterick town which is the home to Catterick Garrison, the largest army base in the UK.

The uniqueness of the population brings with it a number of health inequalities which are typical of:

- an increasingly ageing, deprived population living in rural areas (isolation, fuel poverty, winter deaths, falls and a high level of social care needs)
- in contrast, a military population, including veterans and forces families and 'camp followers' with health needs characterised by obesity, drug and alcohol abuse, smoking, risky behaviour, chaotic lifestyles, poor lifestyle choices, homelessness
- a young population which has significant deprivation and a high level of dependency, and which therefore places a high level of demand on services for children. This is driven in part by an MOD policy to base families with special needs in Catterick rather than any other army base in the UK

More specifically:

- More than one quarter of children grow up in poverty in the Colburn, Hipswell and Scotton Wards in Catterick (27% of 2623)
- 27% of children from Reception age to Year 6 are obese and this figure is rising
- 60% of adults are overweight or obese
- The rate of people being killed on the road is more than double the English average (nearly 50 casualties annually)
- Winter mortality rates are higher than the rest of England (27% versus an average of 22%)
- More than a quarter of people (28%) have limited access to public transport
- There are a significant number of Veterans living in the area, some with a higher risk of mental illness and suicide and who experience loneliness and isolation, resulting in risky behaviours and poor lifestyle choices
- Richmondshire has the highest rate of homelessness in North Yorkshire as a whole (2.5. per 1,000 household)

Source NYCC JSNA Richmondshire District CCG profile 2019

Catterick has been a garrison town since 1914 and the MOD identified Catterick site as a 'super-garrison' under its 2020 plans which will see a rationalisation of other MOD sites in England and Europe with a consolidation at Catterick. As a result, the town is set to grow significantly over the next 10 years as further military personnel and their dependents are rebased and new housing developments are completed.

Currently, serving personnel receive their care through Defence Medical Services, whilst their families and dependants are cared for mainly by the NHS.

NHS England's responsibilities are to commission directly:

- all secondary and community health services for members of the Armed Forces, mobilised Reservists and their families if registered with Defence Medical Services (DMS) Medical Centres in England;
- specialised services, including specialist limb prosthesis and rehabilitation services for veterans

The CCGs responsibilities are to commission:

- all secondary and community services required by Armed Forces' families where registered with NHS GP Practices, and services for veterans and reservists when not mobilised. The bespoke services for veterans, such as veterans 'mental health services, will be commissioned by CCGs either individually or collectively'
- emergency care services on a geographical basis which can be accessed by anyone present in their defined geographical boundary e.g. accident and emergency services, emergency ambulance services and other emergency health services. Serving members of the Armed Forces and their families (where registered with DMS Medical Centres) will have full access to these services
- health services for these groups stationed overseas who return to England to receive NHS care

Armed forces families, whether they are regulars, reservists, or veterans, or their spouse, partners or children, can have specific health needs, service access issues and additional concerns. These include:

- stress around deployment
- extended and repeated periods of separation from spouses and partners
- social isolation from family and friends
- additional and sudden caring responsibilities

This cohort of patients is often vulnerable and disadvantaged. Their issues include:

- difficulty accessing healthcare,
- discontinuity of care,
- access to screening & immunisation,
- access to diagnostics,
- local variation in commissioning and provision,
- transitional issues,
- young carers issues,
- family separation,
- domestic abuse
- substance abuse and dependence issues

In addition, they may also be dealing with multiple non-health related issues socio-economic issues such as housing, social isolation/moves, education and employment. The right level of support for families of armed forces veterans and serving personnel can often feel limited and difficult to access for both children and adults.

As many as 1 in 4 armed forces partners or family members of service personnel and veterans report that their own mental health and wellbeing has been affected by their loved one's situation. Of these 1 in 8 reports that they would not seek help due to the stigma associated with speaking up as an armed services partner or family member.

It is also the policy of the MOD to base families who have children with special needs in Catterick rather than any other army base in the UK due to the proximity of both primary and secondary 'special schools' which support children with special educational needs (SEN).

The Armed Forces Covenant (2000) was established to remove disadvantage and to ensure that the whole armed forces community, including their families, receive the same health services and outcomes as the civilian community. However, although this provides a sound basis, there is continued evidence that personnel and their families continue to face significant disadvantage.

1.2.1 Primary healthcare in Richmondshire and Catterick

The population of the Primary Care Network covering Richmondshire is 45,804. Approximately, £9 million is spent per annum on primary health care in the area currently.

RICHMONDSHIRE GP Registered Patients Numbers July 2019

GP Practice	Registered Patients	Total Male	Total Female
Aldborough St John Surgery	**3236**	1624	1612
Catterick Village / Colburn Medical Group	**6632**	3223	3409
Central Dales Practice	**4216**	2147	2069
Harewood Medical Practice	**7767**	3397	4370
Leyburn Medical Practice	**6053**	2996	3057
Quakers Lane Surgery	**6324**	3039	3285
Reeth Medical Centre	**1592**	796	796
Scorton Medical Centre	**3668**	1832	1836
The Friary Surgery	**5596**	2771	2825
TOTALS	**45,084**	21,825	23,259

Source shapeatlas.net (full age profile Appendix 2)

However, of the 9 Richmondshire practices, **Harewood Medical Centre** and **Catterick and Colburn Medical Group** tackle the most significant and multiple health issues within their patient lists. These are listed in the table below.

Catterick Village / Colburn	7th on the IMC (2015) deprivation score for HRW CCG (National GP Profiles, PHE)
	Higher than expected rates of smoking - 20% (QOF 2017/18)
	Higher numbers with adult obesity – 15.5% (5% above England and CCG average)
	Significantly higher rates of depression against the national & CCG average – 11.5%
	Higher than CCG and national average of rates of admission to due to injury for those under 18 years – 17.9%
Harewood Medical Centre	Higher than expected rates of smoking – 20.9% (QOF 2017/18)
	Higher rates of depression against the national average – 10.02% – just over national average and above the CCG average
	Higher numbers with adult obesity - 11.4% (2% above CCG and national average)
	Significantly higher than national and CCG average – rates of admission due to injury for those under 18 years – 21.1%
Other issues of note in GP lists where rates are <u>over</u> national and CCG average	Asthma – Leyburn, The Friary
	Adult obesity – Glebe House, Aldbrough St John, Quakers Lane
	Coronary heart disease – The Friary
	Depression – Scorton, Glebe House
	Hypertension – Leyburn, Reeth, Quakers Lane, Glebe House, Scorton
	Smoking – The Friary

1.2.2 Current GP facilities within Catterick

1.2.2.1 Catterick Garrison Health Centre

Harewood Medical Practice is the main primary care service provider for the area. This facility hosts the GP practice and a wide range of other services from multiple providers, including the provision of: community nursing services through South Tees Hospitals NHS Foundation Trust, community dentistry and GP out-of-hours services through Harrogate District NHS Foundation Trust and Extended Access services through Heartbeat Alliance. The facility is currently constrained for space and has limited ability to accommodate even a small increase in patient numbers. It is not suited to the delivery of modern NHS care and provides limited scope for developing new service models and integrated approaches to care with the MOD.

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1.2.2.2 Colburn Medical Centre

Colburn Medical Centre is one of two sites operated by Catterick & Colburn Medical Practice. It is also the local base for mental health services provided by Tees, Esk and Wear Valleys NHS Trust. The property is owned by Assura Medical Properties plc and leased by the practice. The lease ends in November 2026.

The challenges and issues which Harewood Medical Practice faces on an on-going basis will be alleviated by the Practice relocating to the CICC and this is also the case with the Colburn branch site and this move will offer the advantages of working within Multi-Disciplinary Teams and also alongside Living Well and Community Teams.

In a drive to address and significantly reduce health inequalities, the CICC will deliver increased and improved services to both the residents of Catterick Garrison and to those living in the wider Richmondshire area; and it will enable the NHS to provide fully integrated care with colleagues from the MOD for the first time. The CICC programme is fully aligned with the commissioning strategy of the North Yorkshire CCG.

1.3 Project Proposal

The CCG considers that the longer-term solution lies in a much more integrated approach to the delivery of healthcare by the MOD and NHS working together. Having undertaken a high-level options appraisal and initial feasibility study as preparation for completing the PID, the intention is to provide an integrated healthcare facility at Peronne Lines in Catterick Garrison to provide capacity for MOD military healthcare and a projected patient list of 15,222 for the Harewood practice by 2031.

The CICC will meet all of the commissioning intentions of the NHS, with the aim of this development becoming an exemplar of best practise to support future initiatives. The evidence will be borne out of results, measured by health and care outcomes, quality of care, safeguarding and specifically in:

- Reduced number of attendances at A&E and other urgent and emergency services
- Reduced number of admissions to hospital
- Raised awareness amongst healthcare professionals around the relationship between life in the armed forces; and mental health issues amongst families and carers
- Improved continuity of care throughout transition into and out of the armed forces

The proposal to deliver healthcare services through an improved, integrated healthcare model means that the population of Richmondshire will have the direct advantage of:

- advanced primary care
- shortened, more efficient care pathways,
- extended hours of service including Saturdays and Sundays
- walk-in clinics
- a state-of–the-art, modernised, easily accessible building in the centre of Richmondshire offering not just treatment services but also community and social activities and facilities to encourage cohesion, and a sense of belonging and wellbeing

Indirectly, patients will benefit from:

- technology which will enable both MOD and NHS practitioners to have access to patient health records (Project Cortisone)
- technology which will enable primary care service delivery and virtual clinics to patients and associated practitioners in rural parts of the District
- cross-organisational clinicians and practitioners working in Multi-Disciplinary Teams (MDTs)
- a culture of innovation and integration
- a hub point for the Primary Care Network, with links to all GPs in the locality
- It is expected that the Campus will become a centre of excellence and a model of best practice for integrated primary care within our region and nationally.

In addition to clinical rooms for primary care services, the facilities offered initially will be:

- Community pharmacy
- Physiotherapy and rehabilitation
- Community dentistry
- Minor Injuries Unit
- Community market place for health, social care and wellbeing advice and drop-ins with café area
- Clinical training facilities

In later stages, outdoor facilities will be added, including fitness trails, community gardens, play areas and other provisions to promote a wider wellbeing focus at the campus.

The primary NHS provider-occupiers will be:

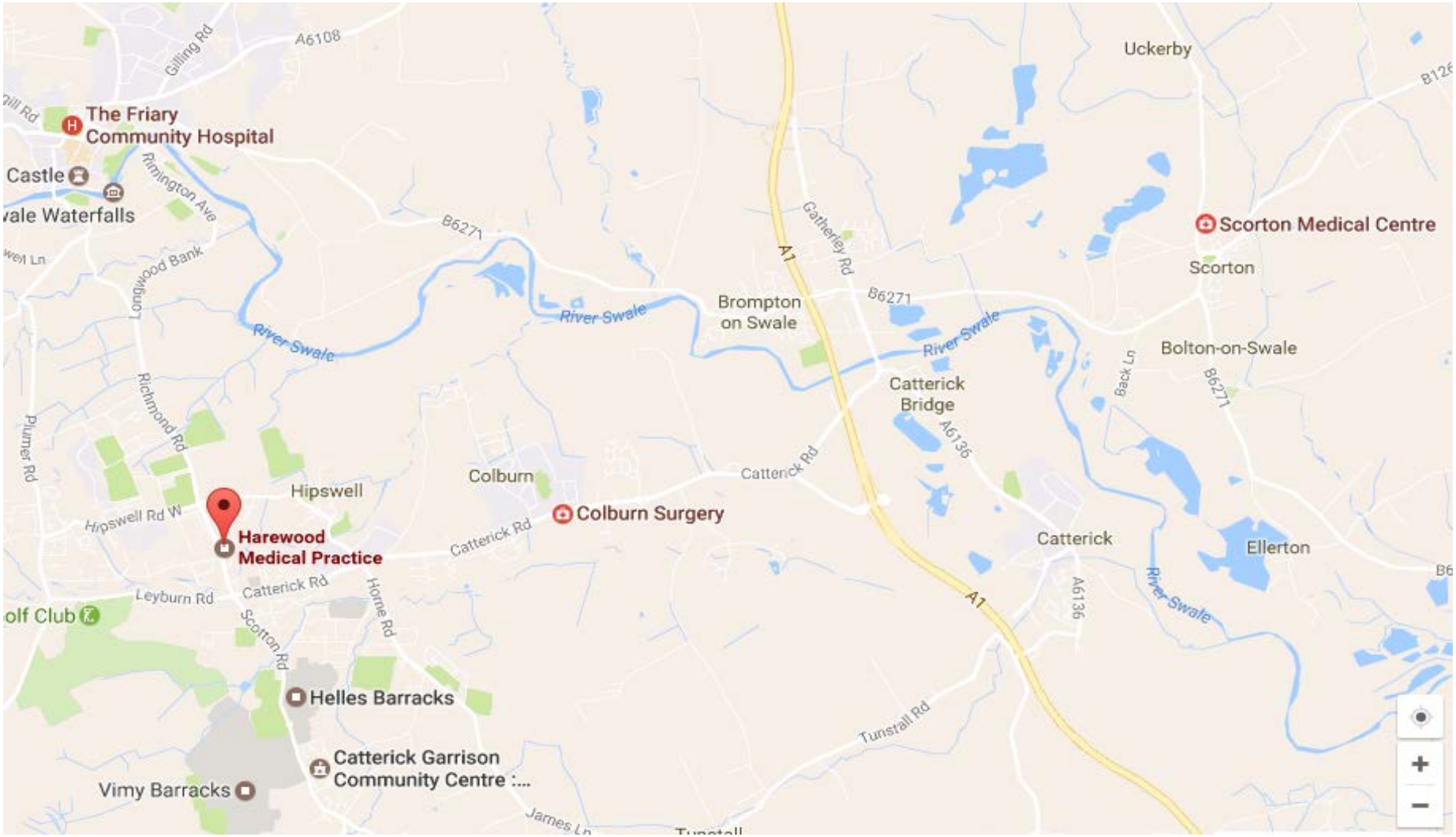
- Harewood Medical Practice – primary care
- South Tees NHS Foundation Trust (STFT) – X-ray, community nursing, physiotherapy
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) – mental health services
- Harrogate and District Foundation Trust (HDFT) – podiatry, community dentistry
- North Yorkshire County Council - social care

The clinical operating model in Appendix 3 describes the clinical outcomes sought and a final list of services to be provided will be included in detail in the FBC.

The whole population of Richmondshire will benefit from services offered at the CICC. Whilst the Harewood Medical Practice patients list will directly transfer into the building, the full scope of services offered will be available to all residents.

1.3.1 Locality Map

The plan below shows the Catterick locality. Harewood Medical Group and Colburn surgery are the two main sites affected by proposals. There is some impact on the current range of services at The Friary which is linked with a separate business case. A summary of space and services is provided in tabular form on page 20.


Uckerby
The Friary
Community Hospital
Castle
Gilling Rd
A6108
Rimington Ave
B6271
River Swale
Brompton
on Swale
A1
Gatherley Rd
Scorton Medical Centre
Scorton
Bolton-on-Swale
Catterick
Bridge
Back Ln
A6136
Catterick Rd
Colburn
Colburn Surgery
Hipswell
Hipswell Rd W
Harewood
Medical Practice
Richmond Rd
Plumer Rd
Leyburn Rd
Scotton Rd
Horne Rd
Helles Barracks
Catterick Garrison
Community Centre :...
Vimy Barracks
Tunstall Rd
Ellerton
Catterick

1.3.2 Summary of NHS services and facilities

Current Premises	Ownership	Floor areas	Remaining lease term	Strategy	Services
Catterick Garrison HC	NHS Property Services long leasehold interest MOD Site	GIA is 985sqm The split of NIA as follows Harewood 437sqm HDFT 104sqm NHSPS vacant (CCG funded) 167sqm	Ground lease expiry date 01/02/2066	Surrender lease by negotiation if CICC scheme proceeds	Harewood Medical Practice (GMS) Community Dental Service and some community space (HDFT) GP Out of Hours Service (HDFT)
Colburn Medical Centre	Assura PLC C&C Medical practice lease sublet to TEWV NHS FT	Catterick & Colburn practice occupy 178m^2 TEWV 178m^2	Ends 24 Nov 2026	If option 5 progresses exit 2023 and commercial sublet or early surrender to landlord (savings unlikely)	Catterick & Colburn Medical Practice (GMS) TEWV Community Mental Health services locality team base
Catterick Village HC	NHS Property Services Freehold	*GIA 650sqm* *The NIA split as follows* *C&C practice 369 sqm* *South Tees FT 47sqm* *HDFT 155sqm*	*N/A*	*This site no longer forms part of the business case consideration as it will remain in all options and will become the sole site for Catterick and Colburn Medical practice who will not be party to the CICC scheme.* *The CCG will consider changes at this site as a separate operational business case arrangement linked to approving a new lease in 2020*	
The Friary	Owned by Nexus Group NHS Property Services leasehold interest for community / inpatient space. Friary Medical Group hold a lease for general practice provision in the same site	NHSPS interest – 1730 GIA Split of NIA as follows South Tees FT 1,346sqm , HDFT 28sqm The Friary Practice Leased areas approved for GMS is 563.84m2 and 9 Spaces	PFI like lease until Mar 2024	*This site will be separately considered by the CCG for separate re- provision and development of a local service hub.*	South Tees are the main occupier and provide community inpatient ward, some outpatient services, allied health services and x-ray. The trust works jointly with North Yorkshire social services to provide an intermediate care facility. Therapy sessions available include dietetics, speech therapy, chiropody, physiotherapy and occupational therapy. Outpatient clinics include: surgical, orthopaedic, medicine, rheumatology, paediatrics, mental health, family planning and audiology. Harrogate NHS FT provides some community services including podiatry and speech language therapy.

1.4 Design principles

Our vision as a CCG is to commission high quality services as close to home as is possible for the people of North Yorkshire. Our strategic objectives for the future of health care in North Yorkshire are to:

- to support the people of North Yorkshire to start well, live well and age well
- to provide high quality and responsive health and care services
- to make the best use of the 'North Yorkshire pound' and live within our financial means
- to reduce health inequalities across North Yorkshire

We will do this by improving quality, improving efficiency, transforming the local integrated service offer and creating a financially and clinically sustainable health system.

The CCG, the MOD and its partners across the health and care system have developed a shared vision for the CICC, as below:

"To deliver a purpose-built, state-of-the-art, health and wellbeing campus which provides high-quality, safe and sustainable primary and community care for the population of Catterick and the surrounding area, and which is able to meet the current and future needs of the Ministry of Defence personnel and resident population."

The new model of care enables GPs, nurses and other health professionals to come together with clinicians from the MOD, social care practitioners and the voluntary and community sector to plan and deliver integrated out of hospital care that leads to better outcomes for local patient/service users, their carers and families.

The campus approach enables personnel, their dependents and local residents to access a portfolio of services in one place - in the community, with a home first principle, allowing hospitals to focus on specialist care for the patient/service users with the highest acuity of need. This will therefore ensure the best use of the limited resources across the health and care system.

The current health and care systems are constrained by organisational and professional boundaries, often resulting in reactive, fragmented and inefficient care which impacts on patient/service user and carer experience and outcomes.

A focus on person centred pro-active and co-ordinated care will:

- support appropriate use of health and care services;
- improve patient/service user and carer experience and outcomes; and
- ensure people live longer with better quality of life.

A significant, sharp increase in the forecast population, reduction in funding across the health and care system, increased pressures on A&E and secondary care services, seven day working, gaps and duplication in workforce and limited focus on patient/service user experience have resulted in a whole system approach and commitment to develop a new model of care for Catterick and the surrounding area.

The ambition of the CICC is that the population will be supported to achieve positive health, care and wellbeing outcomes, whilst maintaining independence at home or as close to home

as possible via a primary care and community care model of integrated working. In meeting these objectives, health and care commissioners and providers across the NHS and MOD expect to achieve several benefits including:

- improved access to routine and urgent appointments;
- better sharing of information between professionals;
- earlier identification of need and support provided to reduce escalation;
- greater patient/service user and carer activation and ownership of their health and wellbeing;
- less reliance on the statutory health and care sector.
- integration of treatment and care pathways,
- improved experience for the patient,
- staff skill-exchange
- increased opportunity for innovation
- promotion of parity of esteem between mental and physical health and reduction of stigma

In order to guide the design and oversee the development of the CICC model of care and subsequent delivery of the scheme, health and care leaders have devised a series of guiding principles which have been co-produced with local health and care stakeholders.

These are set out below:

- Care at (or as close to) home as possible – as the default position;
- Community services wrapped around practice registered and resident populations and Primary Care Network; (PCNs)
- A central operational role for general practice - providing the “expert generalist” and a co-ordinating role;
- Services that are easily navigated by patients/ service users and professionals alike;
- Population and place based – scalable across larger spatial footprints;
- Integrated approach to care – social, physical and mental health – parity of esteem;
- Person-centred proactive and co-ordinated care, that anticipates changing needs and intervenes early;
- Responsive intermediate and urgent care system that is seamlessly integrated with the out of hospital model;
- Focus on prevention and self-care to moderate demand, reduce avoidable pressures and improve patient/service user experience and outcomes;
- Further enhancement of the primary care offer via the PCNs – delivering more specialised services in the community and sharing expert knowledge and skills across the system (i.e. access to sector specialists and consultants); and
- Agile workforce with expert outreach across the health and care system.

It is also important to note that the CICC scheme has been developed within the following context:

- The patient/service user (person) is at the centre of everything;
- The CICC is about building new capabilities and pathways not transferring statutory responsibilities for care between the MOD and NHS;

- The CICC is a proactive, system-wide approach to manage the population spike due to MOD rebasing and housing growth representing a movement of 4,700 by 2031
- Partners have agreed a planning assumption that all MOD dependents will be registered with NHS GMS, bringing a patient list of 15,222 by 2031 which is a doubling of the list size in 2020
- A whole person and family focus not disease specific/condition management – health and wellbeing
- A centre of clinical excellence across the MOD and NHS
- An opportunity to increase the scope of exposure to practice between MOD and NHS clinicians via shared education and training
- An opportunity to integrate early with the Richmondshire Primary Care Network (PCN) via the inclusion of the DMS
- The CICC will be the national blueprint for the design and delivery of Armed Forces care for personnel, their dependents and veterans
- The CICC will be a valuable asset for the local community with wider social and leisure facilities
- The CICC will allow the realisation of an the integration opportunity for Catterick and the surrounding area

Rationale

This is a demand-driven project, combining the NHS and MOD together in partnership and is designed to address:

- the MOD's rebasing exercise which will bring troops and their families back to England from bases throughout Europe, resulting in an unprecedented growth in the population of Catterick
- the imperative need to improve and expand the NHS estates, service delivery and efficiencies in the locality. The latter was to cater for the current and future high levels of dependency and illness resulting from significant social deprivation in the Catterick area
- the imperative need to modernise and expand the MODs medical healthcare facilities and estates to cater for the population growth

A long-term sustainable solution is required to ensure general medical services can be maintained to the existing and expanding population. The population growth is tabled below.

Current Harewood Patient Population 2020 7,767		
Population increase due to:		
Housing Development	3,049	
Net Increase Military Personnel		3,230
Net Increase Military Dependents	1,651	
Catterick Population Increase	**4,700**	
Harewood Population Increase due to:		
Increase in Catterick Population	4,700	
Transfer from Military GP	1,000	
Transfer from Catterick & Colburn Practice	1,700	
Total Impact	**7,400**	
Projected Harewood Practice List by 2031 15,222		

Please see **Appendix 4** for the detailed population growth profile

In 2017, the project was initiated between NHS and MOD clinical and commissioning teams to develop an alternative model of service delivery which has potential to sustain clinical services. The aims and objectives were:

- to ensure that treatment and care pathways offered were integrated, streamlining the healthcare experience for the patient; introducing cost efficiencies into the process and enabling staff skill-exchange, thereby improving the opportunity for innovation
- to de-escalate the marginalisation of mental health care by setting it at the heart of the clinical model, promoting parity of esteem between mental and physical health and reducing stigma
- to develop a campus approach where wellbeing services were delivered alongside mainstream services, promoting the philosophy that prevention of disease was as important as treatment
- to support both partners to recruit scarce clinical personnel and maintain professional skills. Significant improvement in the physical environment would enhance working conditions for all clinical teams and patients

Objectives

Partners have also established a common set of project objectives which are set out in the table below. A series of benefits have been identified for each objective and these are set out in detail at Appendix 5 and included within the Comprehensive Investment Appraisal (CIA).

ID	Drivers	Detailed Driver Commentary
A	An improvement to the health and wellbeing outcomes of the population (both Civilian / Military)	Does the option provide facilities that will allow identified health and wellbeing outcomes to be met
B	A fully integrated health and wellbeing service	Does the option provide full integration of the services being provided and provide links to other services
C	Adaptable and sustainable to the changing needs of the population	Health provision evolves to meet the changing needs of the population being served. Does the option provide a solution that can be adapted to meet these changing requirements
D	Sustainable (environmentally)	Does the option provide an environmentally sustainable solution and have the potential to meet the necessary DREAM and BREEAM requirements
E	Meeting the long-term policy requirements of NHS / MOD	Does the option provide facilities that allow the policy requirements of the NHS / MOD to be met?
F	A resource that adds value to the wider community (where people want to go)	Does the option provide a facility that can be used to meet the wider needs of the community over and above the healthcare needs
G	An environment that attracts and retains staff	Staff retention can be an issue particularly in the NHS. Does the option provide an environment where staff are happy and are keen to work
H	Programme	Does the option meet the programme or provide opportunities to improve on the required delivery programme

1.5 Financial Link to Benefits

The CCG recognises that the population increases will occur by 2031 and have a direct financial impact on commissioning budgets in primary care and community care settings. If no change is made to service models delivery of GMS services will be at risk. The opportunity to deliver an alternative clinical model and the potential efficiencies which could be achieved through an integrated healthcare facility offer some potential to limit the direct cost escalation that will occur.

The CIA includes a mix of non-cash releasing, societal and unmonetisable benefits. The non-cash releasing benefits are linked to the objectives and include the assumptions about changes to service delivery and how they support continued delivery of primary and community care. This is further detailed in the Economic Case.

1.6 Clinical Operating model

The closer integration between health and care is a fundamental part of both the national policy agenda and local strategic direction and commissioning intentions with the aim of promoting health and wellbeing, delivering better outcomes for patient/service users and promoting ease of access. As well as providing support, care and safeguards for those people in the community who have the highest level of need and for their carers and families, good integrated care and support transforms lives for all, enhancing health and wellbeing for all ages and increasing independence, choice and control.

The 5YFV and subsequent NHS Long Term Plan describes a future where patient/service users are empowered to take much more control over their own care and treatment; where the divisions between physical and mental health, health and social care, prevention and treatment are broken down; where services are organised to support people with multiple health conditions, not just single diseases and where far more care is delivered locally.

The CICC clinical operating model, as agreed between the MOD and NHS is the neighbourhood/locality articulation of this ambition. It aligns with the STP/ICS developments across North Yorkshire, the commissioner and provider landscape at a CCG spatial footprint and the rebasing of MOD personnel and dependents in Catterick. The scheme has a significant national profile and will be the proof of concept for how the MOD and NHS can work co-productively to achieve the best possible health and wellbeing outcomes for local people and communities. The scheme has the potential to become a national exemplar with utility across England.

The CICC model of care at a neighbourhood and locality level firmly rooted in primary and community care, PCN development and MDTs are the enablers to bring about this change. It will, via an integrated approach to out of hospital care, provide a place-based response to engineer a safe and financially sustainable health and care system which is fit for the future.

The CICC Integrated Model of Care is set out below:

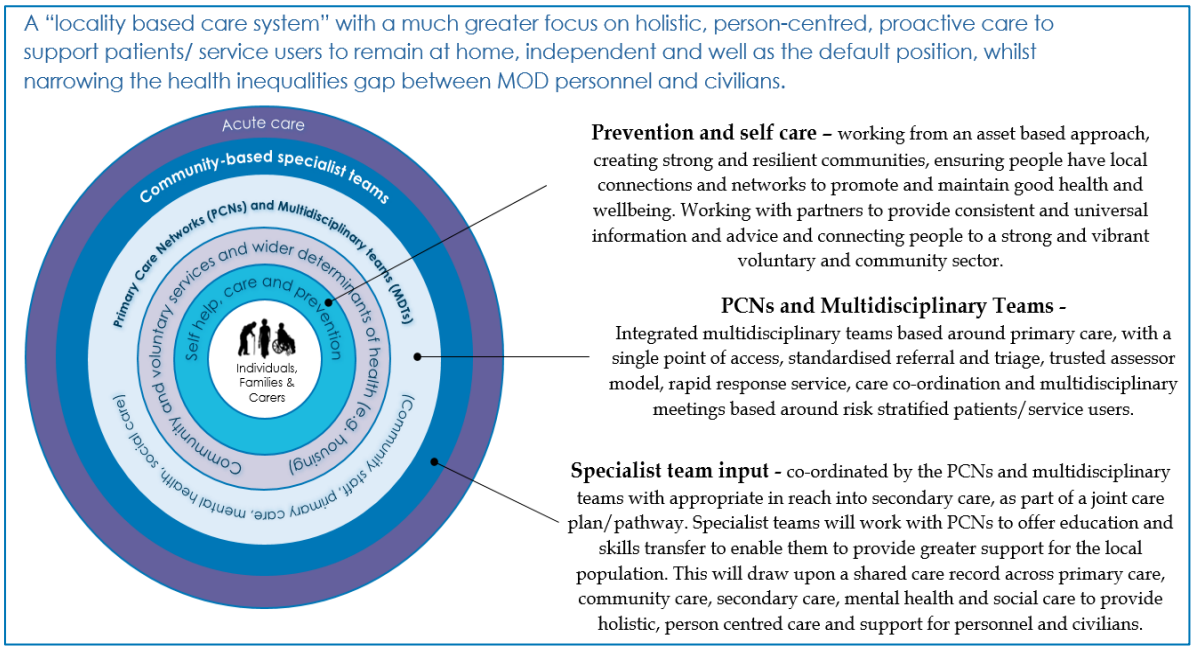


Figure 2: CICC Integrated Model of Care

The direct and indirect benefits of this model of care will be:

Direct:

- a state-of–the-art, modernised, easily accessible building in the centre of the Richmondshire
- treatment *and* prevention services – range and scope of holistic care
- advanced primary care
- shortened, more efficient care pathways,
- extended hours of service including Saturdays and Sundays
- walk-in clinics and improved access
- care navigation and social prescribing
- virtual clinics
- community-based wellbeing activities
- outdoor activities

Indirect

- technology which will enable both MOD and NHS practitioners to have access to patient health records (Project Cortizone)
- technology which will enable delivery to those in rural parts of the locality
- cross-organisational clinicians and practitioners working in MDTs
- culture of innovation and integration
- a hub point for the Primary Care Network, with links to all GPs in the locality

Operationalising the model

To ensure the CICC vision, ambition, outcomes and benefits are achieved, an operating model and associated service portfolio has been co-produced by the NHS, MOD and its partners. The scope of services has been informed by clinicians, service managers, wider professionals and practitioners from across the health and care economy to ensure that its design is as robust and achievable as possible, whist still being ambitious enough to realise the full potential of the opportunity. This is set out below:

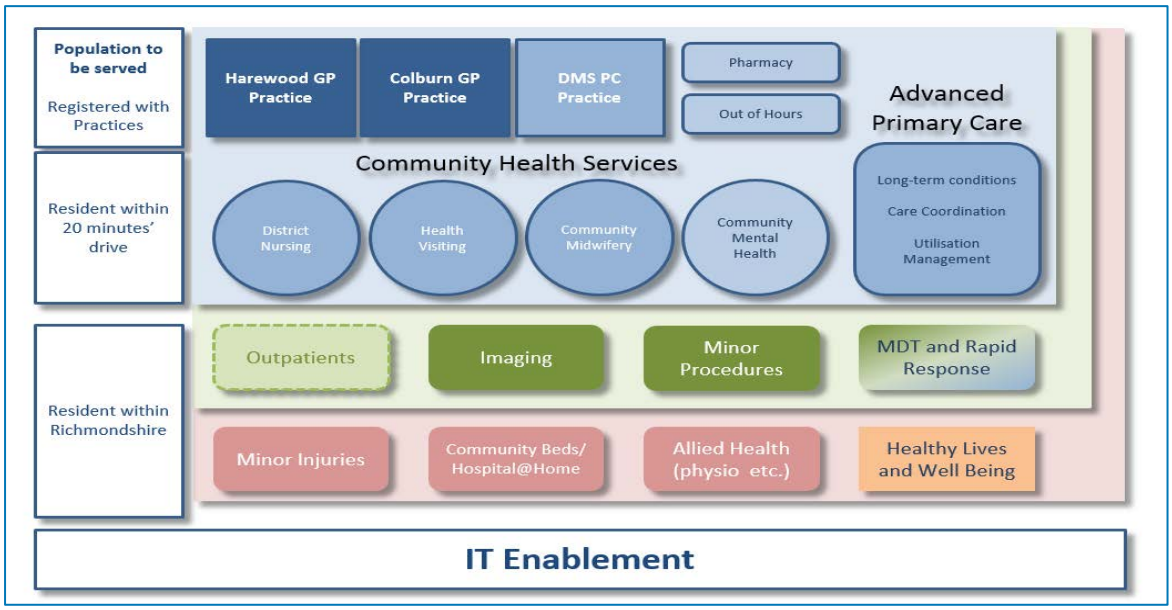


Figure 3: CICC Operating Model and Service Portfolio

It is also important to note that the CICC operating model has been engineered within the following context:

- An opportunity to increase the scope of exposure to practice between MOD and NHS clinicians via shared education and training;
- An opportunity to integrate early with the Richmondshire Primary Care Network (PCN) via the inclusion of the DMS;
- The CICC will be the national blueprint for the design and delivery of Armed Forces care for personnel, their families and veterans;
- The CICC will be a place where people want to be – a valuable asset for the local community with wider social and leisure facilities; and
- The CICC is more than just the sum of its parts – realising the integration opportunity for Catterick.

The CICC operating model consists of the following four pillars:

1. **More effective prevention –** through enhancing community resources and resilience. Delivering proactive care is holistic and preventive, empowering people to play a central role in managing their own care, preventing the onset or decline of care needs or conditions. Bringing health and care services together in one co-ordinated care response that is underpinned by prevention; self-care, early intervention, reablement and rehabilitation can avoid long term treatment and life-long service dependency.

2. **Delivering integrated care more effectively –** enhanced Primary Care will be targeted towards people who have one or more long term health conditions, and who depend on support, but who are not counted among the frailest in society.

3. **A locality-based, community-focused delivery model -** the importance of better co-ordination of care across teams and organisations. The PCN and MDT approach from reactive care to proactive care and support with the central role of general practice.

4. **An approach to care that seeks to maintain stability and prevent escalation to more acute levels of care –** an integrated model of care at the neighbourhood level which results in tangible benefits including a reduction in emergency admissions and A&E attendances for patient/service users identified through a robust and recognised risk stratification process, a reduction in delayed transfers of care and fewer permanent admissions to care homes. The approach will see an increased role for the voluntary and community sector to support local people to remain healthy and well by connecting them to local networks and reducing their need for formal health and care services. The CICC model will address fragmentation, duplication and a lack of co-ordination and will create care pathways which promote personalisation, independence and resilience.

Integration Roadmap

It is widely accepted that the CICC will not be fully integrated once the scheme becomes operational in 2023. It will take a number of years to fully materialise the integration opportunity and needs to be managed over a continuum with clinically safe and sustainable pathway redesign, and the full and active engagement of all stakeholders. Appropriate transitional plans will be devised and implemented to ensure there is no clinical risk to patient/service users throughout this journey. This journey is set out in headline terms below:

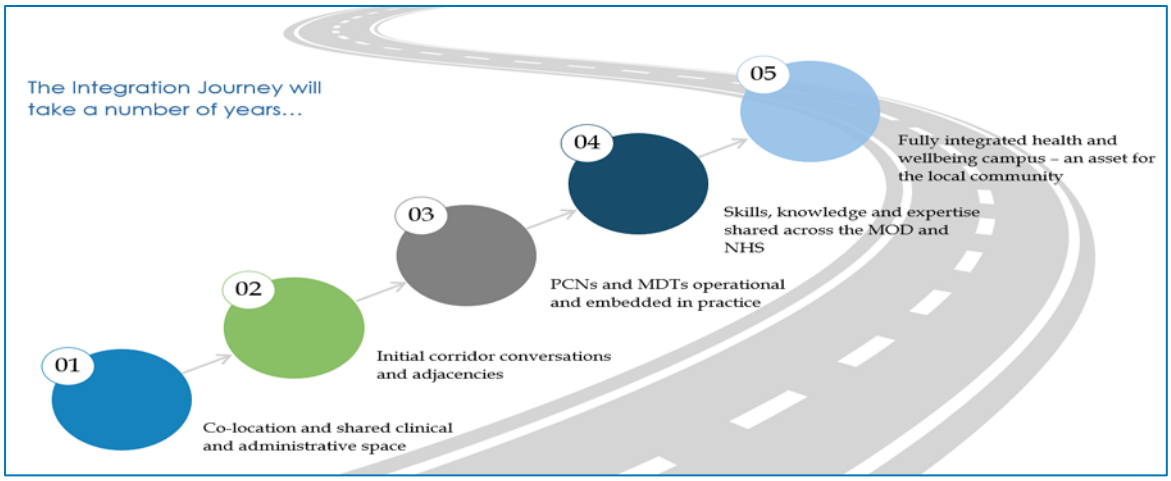


Figure 4: High Level CICC Integration Roadmap

As part of the design and planning for the CICC, the MOD, NHS and partners have identified a number of opportunities for integration. This has resulted in the following services, as depicted below:

- Primary care
- Mental health
- Physiotherapy
- Occupational therapy; and
- Community services

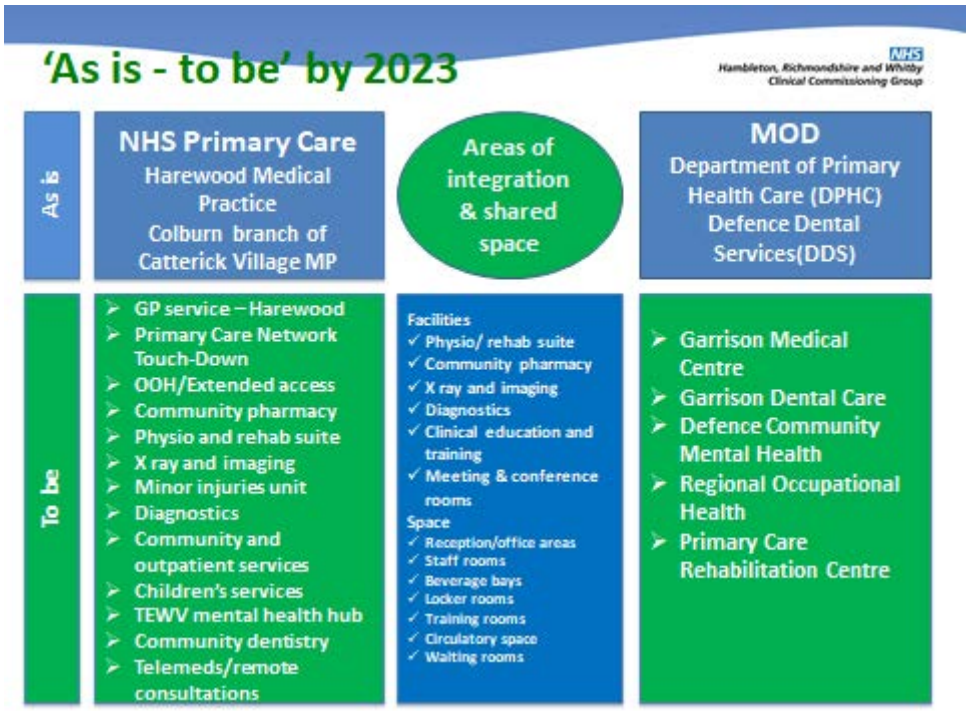


Figure 5: CICC Service Integration Opportunity

As part of this design process, all partners are clear that there is the need to only integrate where it is clinically safe and financially viable to do so, not all services will be integrated across the MOD and NHS. There will continue to be the need for the MOD and NHS to deliver core requirements independently, where it is in the best interest of the patient/ service user and host organisation. It is however important to recognise that due to the services being co-located in the CICC that learning, development, knowledge, skills and expertise will be shared, as appropriate, across sectors to continue to improve patient/ service user care and outcomes.

The following section sets out the level of ambition against each of the services identified for integration over the key milestones of; year one, year three and year five: This will be reviewed throughout the design and delivery phases for the CICC to ensure the building design facilitates the vision and delivery of the integration opportunity, and a demonstrated impact can be measured for patients/ service users and the local health and care system. It is also important to recognise that clinicians from across the MOD and NHS will continue to build on their existing relationships and work together to improve patient/ service user care and outcomes prior to the scheme going live. The intention is for the DMS to join the Richmondshire PCN as a means to provide holistic person and family centred care and support.

Care Pathways

The MDT approach and philosophy is central to the CICC operating model. The fulcrum of which is the needs of the patient/ service user with appropriate health and care professionals brought together to oversee the design and delivery of individualised care and support. As part of the operating model design a series of care classification have been generated and agreed across the NHS and MOD to reflect the patient/ service user and their care journey.

These are set out below:

1. **Acute care** – advice/ attention is required within 24/48 hours;
2. **Routine care** – longstanding symptoms where the patient/ service user does not place an urgency on the need for review; and
3. **Long term conditions** – non-complex and complex. The triage process will determine the specific pathway and inform the MDT response.

It is apparent, following clinician engagement sessions between the MOD and NHS that there are some real similarities and synergies between the operating practices across the MOD and NHS.

The acute care and routine care pathways are largely consistent across the MOD and NHS where there is a digital gateway for patients/service users to access services which is triaged through a navigator to either a routine appointment or signposting to alternative services. The exception is that the triage within NHS GMS is led by the most senior clinician, usually a GP to ensure the patient/service user is triaged through to the most appropriate service. The MOD triage is a nurse led service. This service variance will enable learning and best practice to be shared across the MOD and NHS to inform continuous improvement and service development for the benefits of patients/service users and professionals alike. It is also the intention that minor injuries and out of hours services will be available on site and layout drawings for the scheme will provide appropriate access at the front of the site, with the building design as a key facilitator.

The final category of Long Term Conditions (LTC) represents the greatest opportunity for integration and sharing of skills, expertise and knowledge within the CICC. The clinical practice and approach to this cohort of patients/ service users differs between the MOD and NHS due to the demographic profile of this cohort of the population. From a MOD perspective, this typically represents a younger demographic profile and is focused on the need to ensure personnel are “fit to work” with structured programmes to ensure this is achieved in a timely and clinically safe manner. Whereas, from an NHS perspective, this cohort of patients tend to be of an older demographic profile with a number of health-related conditions. This divergence will enable the sharing of and exposure to clinical practice across the MOD and NHS in a structured and clinically compliant manner to improve the care received by personnel, dependents and local residents, as well as upskilling health and care professionals.

The central point of care in this category is the MDT and the response will be determined by the needs of the patient/ service user. All appropriate health and care professionals will, via a named lead professional responsible for the care of the patient/ service user be convened, as appropriate, with the patient/ service user, or a representative to discuss their care and support needs and put in place an agreed care and support plan. This will be focused around the needs and wishes of the patient/ service user. This approach will put in place actions/ intervention which services to reduce or even stop the need for escalation to higher acuity of care.

The more complex the presenting need, the greater the requirement for timely MDT meetings and these can operate on a single case basis. Whereas non-complex cases or where there is a similarity in the needs of a cohort of patients/ service users then an extended MDT meeting can be convened to manage a number of patients/ service users such as the frail/elderly.

To note:

A final Clinical Operating model workshop had been planned for 19 March 2020, with representation from all partner organisations and the clinical operating model work stream leads, but due to the Covid 19 pandemic that workshop had to be postponed.

The purpose of the workshop was to agree a detailed plan to operationalise this clinical strategy amongst the frontline teams and wider clinical providers.

This workshop will be rescheduled at a later date.

1.7 Approval and Support

NHS Hambleton, Richmondshire and Whitby CCG (CCG) Joint Business and Finance Committee received the PPOA on 5 March 2020 and the Governing Body on 26 March 2020 (previously tabled at the meeting on 23 January 2020) and confirmed their approval for submission.

The project vision has been 'socialised' over a number of years but more recently with providers and stakeholders. Please see the section on Communications and Engagement for full details and **Appendix 6** for the Communication and Engagement plan.

NHS England confirmed their support of the PPOA on 27 April 2020 which enabled us to move on to complete the OBC phase of the work.

This OBC is being presented to the Governing Body of NHS North Yorkshire CCG on 25 June 2020. It is proposed to follow an approvals programme of:

Share with Wendy Balmain (SRO)	NYCCG Directors	Finance Performance & Contracting Committee	NYCCG Governing Body	NHSE Regional	NHSE National
1 June 20	8 June 20	18 June 20	25 June 20	2 July 2020	1 September 20

The Senior Responsible Officer (SRO) for the programme is Wendy Balmain, Director of Strategy and Integration. The SRO for the MOD element of the programme is Surg. Commodore Fleur Marshall.

The full detail of the combined Programme Structure is included in the Management Case for this project.

2. The Strategic Case

The purpose of this section of the Business Case is to explain and revisit how the scope of the proposed scheme fits within the existing business strategies of the system. It also provides a compelling case for change, in terms of the existing and future operational needs of the system.

The Strategic Case demonstrates that the spending proposal provides business synergy and strategic fit and is predicated upon a robust and evidence-based case for change. This includes the rationale of why intervention is required, as well as a clear definition of outcomes and the potential scope for what is to be achieved.

2.1 North Yorkshire CCG

Organisational overview

North Yorkshire is the largest county in England covering over 3,000 square miles. The total population is currently 611,633 people and is set to increase to 620,300 by 2025. It ranges from isolated rural settlements and farms, to market towns and larger urban conurbations such as Harrogate and Scarborough. The health and well-being across North Yorkshire is varied with issues related to an ageing population, some marked differences in life expectancy and defined population health needs such as the deprivation experience by the population of Catterick Garrison.

NHS Hambleton Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) was responsible for planning and commissioning the vast majority of health services across Hambleton, Richmondshire and Whitby areas from 2013 to March 2020. These services include Primary care (GP practices), hospital care, and mental health and community services.

From 1 April 2020 HRW CCG along with the two other North Yorkshire CCGs was disestablished and a single North Yorkshire CCG was created.

The CCG aims to continue to build on the significant benefits delivered to local populations by the three former North Yorkshire CCGs through strong local clinical leadership and collaboration.

There is a strong intention to continue to provide an emphasis on prevention, primary care, mental health and integrated models that organise services around people and communities and ensure value for money for the organisation.

There is an identified need to develop an Integrated Care Partnership (ICP) across North Yorkshire and York to deliver the aspirations of the NHS Long Term Plan, along with the active engagement with the Humber Coast and Vale STP; to share learning and appropriate adoption of service models that reduce variation across the broader geographical footprints.

The CICC aligns with the strategic direction and intentions of the North Yorkshire CCG and is cited as a specific priority for the CCG over the next 3-5 years. The CICC will deliver holistic, person centred care and support, firmly rooted in the foundations of primary and community care, and the central role of general practice. The scheme is the first of its kind between the MOD and NHS and will provide services for the needs of a very distinctive cohort of the population; MOD personnel and dependents as well as local people and communities in Catterick and the surrounding area.

2.2 Impact on local service configuration

The CICC programme is fully aligned with local service reconfiguration and any impact upon and from key local changes relating to the Friarage and Friary hospitals is being managed by interrelated work streams.

The CCG has worked, over the last five years, with our partners across the system to develop a compelling case for change. Clearly our key partner is the MOD and we have a Memorandum of Understanding with them which is currently agreed in principal for future ratification. Expressions of interest have been secured from the key providers who will be based in the CICC.

Prior to the completion of the final business case once costs per square metre have been finalised and full healthcare costs confirmed, formal letters of commitment will be secured from each of our partners including those named and the North Yorkshire Health and Wellbeing Board and the North Yorkshire Scrutiny of Health Committee. So far, letters of support have been secured from each of the provider –occupiers. These are attached to this document at **Appendix 7**.

2.3 Alignment to Policy and Priorities

The CICC scheme is consistent with a broad spectrum of national policy including:

NHS Long term plan: The CICC aligns strategically to the Long Term Plan and its ambitions by providing holistic, person and family centred care and support via a new and innovative integrated model of care between the MOD and NHS which focusses on the development of PCNs and Multidisciplinary Teams (MDTs) to promote out of hospital care in the community.

The CICC will also serve to address challenges in secondary care by affecting change against key system measures such as admission avoidance, delayed transfers of care (DToCs) and excess bed days by embedding a primary and community care focus to neighbourhood working and managing demand and escalation.

The NHS is also required to take action on prevention, invest in new models of care, and help sustain social care and address inefficiency in the health and care system. In doing so, it expects the NHS to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade.

Primary Care Networks: The CICC builds on the philosophy and approach of the PCN model of care and further embeds the principles of the PCNs. This encourages groups of GPs to combine with nurses, other community health services, hospital specialists and

mental health, social care and voluntary sector partners to deliver truly integrated out-of-hospital care. The model is further enhanced for the CICC by bringing together MOD healthcare services to provide a holistic service portfolio for personnel, their dependents and the wider residents of Catterick.

GP Forward View: The GPFYFV stated that the foundation of NHS care will remain as list-based primary care, and that there would be a new deal for GPs given the pressures they are under and the waterfall effect across the health and care system.

The Forward View for General Practice published in April 2016 described that over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased rapidly, with new options to encourage retention, but this will take time to address existing workforce issues. Part of the solution is the need to make general practice more desirable as a profession and with more attractive and appropriate succession routes from University.

The GP Forward View recognises that most observers concur that solutions to the challenges facing general practice lie in a combination of investment and reform and require action from CCGs and practices themselves. It continues to recognise that GPs core role will be to provide first contact care to patients with undifferentiated problems and provide continuity of care where this is needed, but also to act as leaders within larger multi-disciplinary teams (MDTs) working at different organisational levels, for example, their own practice, a neighbourhood of practices (PCNs) and across the local health and care economy.

It emphasises that local systems should encourage and support general practices to work together at scale in a variety of new forms enabling greater opportunities for them to increase their flexibility to make, share, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary sector organisations (PCNs).

The CICC aligns with this agenda and the subsequent Long Term Plan with the central role of GPs in the model of care and development of PCNs and MDTs in primary and community care.

Vision for General Practice: The Royal College of General Practitioners' (RCGP) vision looks to the future of general practice as being key in attempting to reconcile the challenges faced by today's NHS with the aspiration of achieving better outcomes for patients delivered through primary care between now and 2022.

The 2022 GP: A Vision for General Practice in the Future NHS, RCGP 2013. The CICC model of care and philosophy places GPs and primary care at the heart of service delivery. The development of PCNs across the CCG and MDTs will be central to the successful realisation of the scheme.

Forward View for Mental Health: this policy is very much in line with the strategic and transformative approach outlined in the CICC model of care, where MOD mental health and

emotional wellbeing services are provided on the same site as core NHS services and broader voluntary and community support services. This will provide a holistic response to support some of the most vulnerable sections of the community.

Armed Forces Covenant and Personnel in Transition: The CICC aligns strategically to this agenda by placing the person and their family at the centre of the care design and delivery process. The integration of services between the MOD and NHS will ensure that personnel, their dependents and local residents receive seamless health and care services from a single site. The CICC will also build on the positive transition, reservist and service family's work, providing a holistic offer to some of the most vulnerable sections of the community.

Care Act 2014 and Deprivation of Liberty Safeguards (DoLS): The CICC model of care has a truly person-centred approach to the design and delivery of health and wellbeing services for MOD personnel, their dependents and local residents. Health and social care are inextricably linked, improvement in outcomes will require a holistic focus with the full and active engagement of all stakeholders across the health and care spectrum, not least patient/service users, their carers and families. The CICC will provide demonstrable impact against key system challenges such as admission avoidance, DToCs and lengths of stay, as well as step up (to acute/ hospital care) and step down (to community/ GP/ home care) short-term rehabilitation/ reablement designed to prevent escalation to and de-escalation from secondary care services.

2.4 NHS North Yorkshire Strategic Priorities

The strategic priorities of the North Yorkshire CCG are:

The CCGs strategy will only be successful if further improvements in how people experience services. Therefore, the successful delivery of the CCGs strategic objectives and our vision and ambition for the CICC will be measured using the following high-level outcomes:

Person Centred Outcomes:
• People are independent and well for as long as possible
• People live longer and with better quality of life
• High levels of patient/service user and carer satisfaction
• Resilient communities where local people and communities are less reliant on statutory health and care services
• Patient/service users receive the right care, in the right place, at the right time.

System Outcomes:
• The health and care system is more resilient, responsive and financially stable
• Integrated commissioning and provision across health and care (NHS and MOD)
• More sustainable services – particularly primary care
• More accessible services – particularly over tourist periods
• Teams wrapped around GP practices with MDT decision making
• Reduced acute hospital activity (A&E attendance and non-elective admissions)
• Moving investment from acute to community/primary care – shifting activity and cost
• Real time sharing of patient/service user information to provide holistic person-centred care and support
• Better Value from reducing resources - making the best use of the Catterick pound and removing variation and duplication
• Achieving the left-shift: more focus on education, prevention, earlier intervention and admission avoidance
• A replicable and transferable model of care able to be rolled out across England
• More tailored, better value services co-produced by the people who use them and commissioned based on outcomes rather than activity.

If we are able to deliver our vision and the outcomes that it will produce, we hope to significantly improve the health and lived experience of the people of Catterick and Richmondshire, now and for generations to come.

2.5 Local issues and concerns

Any change to NHS services and provision is often viewed negatively by the public. Strategic solutions to addressing the service provision issues in Richmondshire, whilst maximising the opportunities offered by change will require challenging negotiations with all stakeholders.

Careful management of expectations will be required, when taking into account public and political opinion regarding the CICC and its links to the future of the Friary Hospital and wider healthcare provision.

This management will come from the joint CICC Communications and Engagement Group and from the Strategic Engagement & Advisory Group and through implementation of the actions as set out in the terms of reference (please see Appendix 8). Public assurance will continue by enlisting CICC public champions and by ensuring that 'Friends of' groups, Councillors, Healthwatch and other appropriate mechanisms are utilised with the aim of informing and including wherever possible.

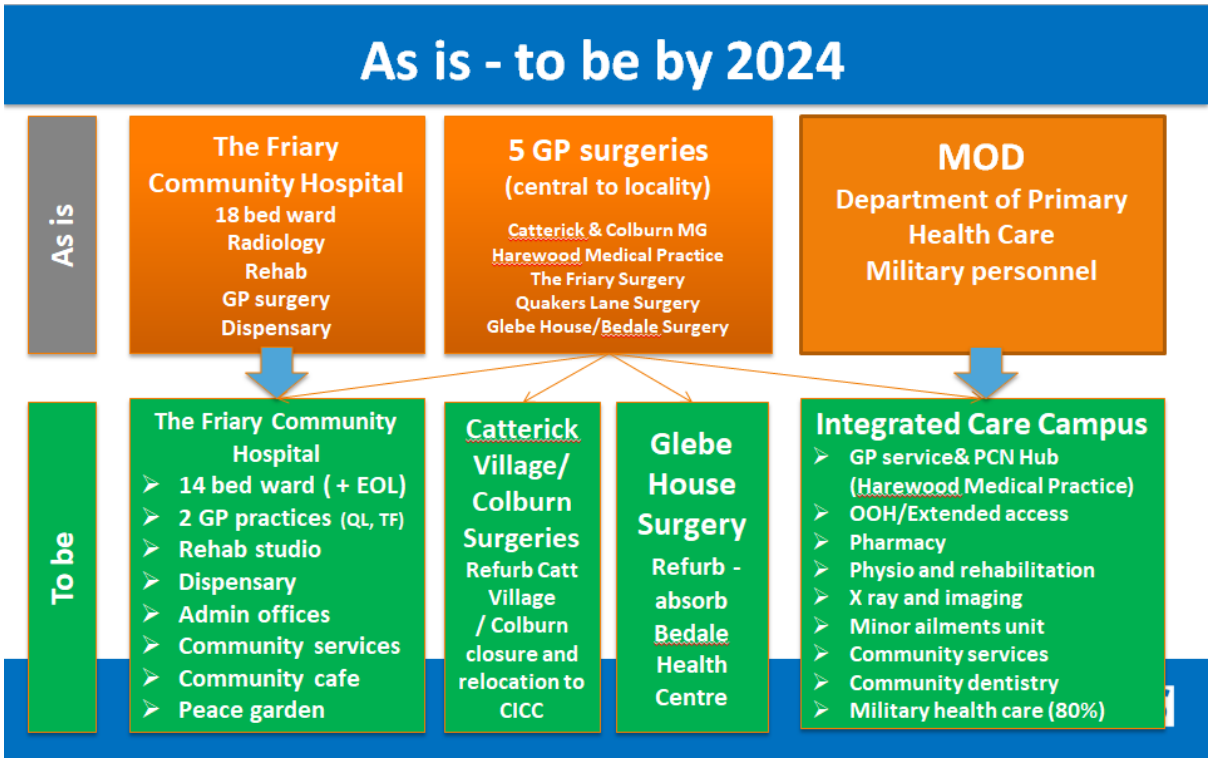
2.6 Integrated Working

The CCG has established a Richmondshire Transformation Programme to address health service and estate challenges through a number of interdependent transformation change projects. The intended outcome is to ensure that healthcare provision is: sufficient for the expected population increase; to address the health inequalities within the population; delivered from estates which are fit- for- purpose and of the modern standards expected by our population; and which is efficient and 'future-proofed'.

The CICC sits within this programme which has three work-streams:

WS 1 – Catterick Integrated Care Campus
WS2 – The Friary Community Hospital
WS 3 – Remaining GP estates

The change programme and services within scope are being regarded together to ensure that estates and facilities are maximised and modernised. A summary of the vision is below:



Friary Community Hospital redevelopment – the hospital is within the centre of Richmond itself and located approximately 6 miles from Catterick. The proposal is to redesign and refurbish The Friary Community Hospital and expand and redirect the focus of services in this facility into a 'speciality unit' for the frail and elderly with rehabilitation services. This will continue to include inpatient bed provision. Currently, the hospital services include bed provision, a GP practice, physiotherapy and rehab, X ray and a dispensary. Agreement has been made for the X-ray facility to be transferred to CICC on opening as well as some of the physiotherapy provision.

Recent discussions have taken place with the building owner, resulting in a development of proposals to retain the building for 100% medical use and with three options for redesign and refurbishment offered to the CCG. The current contract ends March 2024 but should the business case for change be approved, transfer of services will align with the opening of the CICC.

The Richmondshire transformation programme will include work to refurbish, relocate and extend the GP estate where there are significant capacity and demise issues or where they need to accommodate additional services, as follows:

a.	Harewood Medical Centre	New build and relocation as part of the CICC development
b.	Catterick Village Health Centre	Refurbishment
c.	Quaker's Lane Surgery	Relocation into the refurbished Friary Hospital
d.	The Friary Practice	Refurbishment as part of Friary Hospital development
e.	Glebe House Medical Centre	Extension
f.	Leyburn Medical Centre	Extension

Close practice or community service premises once practice developments have been completed:

g.	Colburn Surgery	Patients relocate to CICC/ Catterick Village Health centre
h.	Bedale Health Clinic (approved & commenced)	Services relocate to Glebe House Surgery
i.	Brentwood Care Home (closed) NHS service wing	Services relocate to Leyburn Medical Centre

The remaining practices are considered to be in good repair and are therefore not within scope of estates plans.

Please see Appendix 9 for 'Reshaping Richmondshire'

2.7 Activity and capacity planning

Activity/capacity modelling and assumptions have been aligned with the activity requirements of the local health economy and wider capacity plans, including workforce plans, organisational service developments and efficiency programmes. We completed the majority of this alignment work through collaboratively planning with our partners at Richmondshire District Council and North Yorkshire County Council.

A detailed Schedule of Accommodation has been developed for the NHS elements of the scheme. This is provided in Appendix 10. This has been completed with reference to NHS guidance. A utilisation model has been completed alongside this work and this is included in Appendix 11.

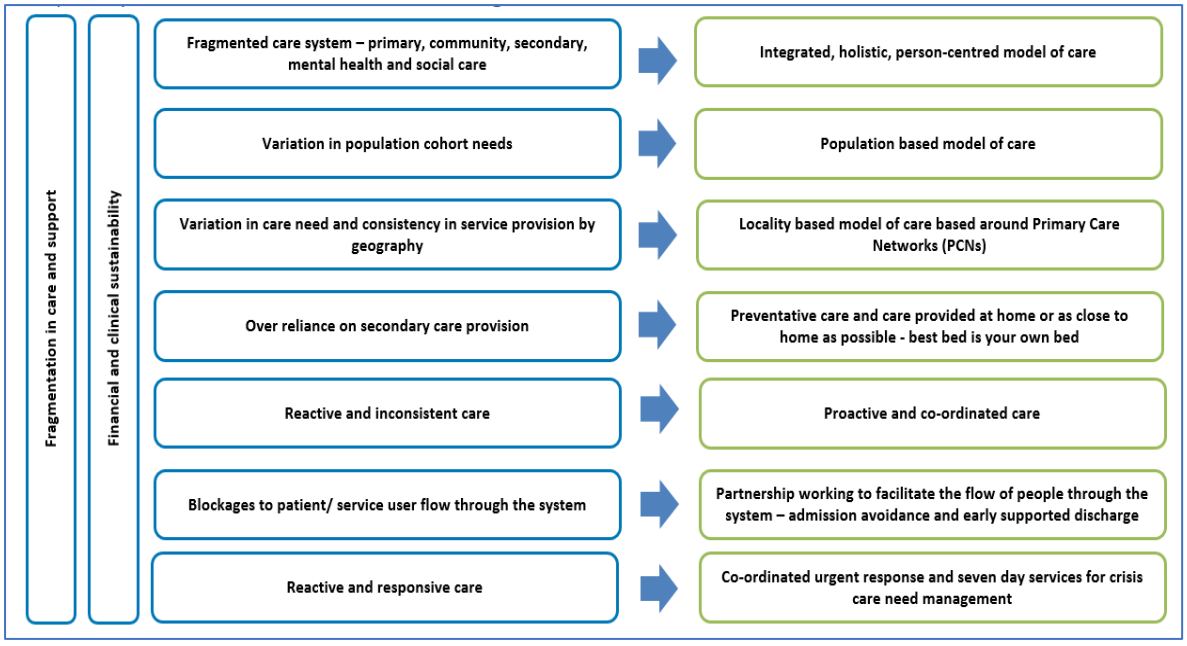
The assessment of the requirement for community mental health space has been modelled by Tees Esk Wear Valleys NHS Foundation Trust on the basis of patient volumes and staff requirements.

The community space requirement is based on current sessional space capacity and dedicated capacity within NHS facilities. This space requirement has been minimised with the expectation of sharing capacity across the facility. This has been based on current understanding of service demand but will be further refined at OBC. Administrative areas have also been minimised and no permanent office space is provided in the facility, instead a hot-desk or touch-down capability will be provided along with shared staff facilities to support interaction.

Opportunities have been explored for sharing of space and facilities and it is anticipated that this will be possible for dental provision as well as for rehabilitation, meeting and training facilities and for circulation and support spaces.

2.8 Patient Choice

Patient choice is integral to the shared vision for the CICC and the benefits that it will bring to patients by enabling access to a wider scope of services in one place. We anticipate that those benefits will be a 'left shift' in care as shown below:



The services which will be 'new' to patients at this facility will be access to X-ray, physiotherapy and rehabilitation suite, a minor injuries unit. Greater access to GP services lies at the heart of the clinical model, with an Out of Hours service and Better Access embedded, enabling access to these services until 8pm weekday evenings and on Saturdays and Sundays.

At the heart of the CICC is a large atrium which will be home to a shared Reception and a marketplace of services which are within and outside of the building, alongside drop-in sessions, advisory bureaus and other services which will encourage self-care and wellness. These services will be run collaboratively by the Voluntary and Community sector, social services and NHS.

The agreement for sharing facilities within the building will allow greater access to services which patients may otherwise have to travel some distance to. NHS patients will have services provided in a new and highly accessible building, with ample car parking facilities, and in conjunction with Richmondshire District Council there will be new bus routes and stops outside the Campus as part of their town improvement programme to cater for the increase in the Catterick population

2.9 Equality & Diversity

The provision of a campus of this size, scope and quality and situated in the heart of the Garrison will assist in addressing the common difficulty which Forces Families experience in not being able to access NHS services quickly and efficiently whilst they move from base to base within the UK and abroad. Situated in the heart of the Garrison, the services will be readily visible and accessible to this itinerant population to ensure that their health, particularly dental health, does not suffer as a result of their status.

There is a sense that the military culture will be positively influenced through integration with NHS patients and public within CICC, in the hope that, culturally, previously stigmatised issues such as mental health, sexual orientation and race will be minimalised and support

the vast change in attitude and opinion which is sweeping through our society and organisational cultures currently.

2.10 Service Change

Our proposals for the CICC predominately bring additional health and care services to Catterick and the surrounding area. We have consulted with engagement and communications colleagues at NHSE/I and currently we understand that there is not a requirement to undertake formal consultation upon these changes.

However, as is good practice, we have and will continue to, engage with our public, patients and partners throughout this process.

In Richmond town there may be a requirement to undertake consultation as the anticipated changes to current service delivery would result in:

- relocation of X-ray
- consolidation of general practice services from two sites to one

We will, of course, continue to consult with our regulatory colleagues and partners and will fulfil all statutory responsibilities relating to this service change.

2.11 Estates Strategy

In 2016, the CCG completed an estates strategy which was approved by the Governing Body. The proposed development of the Catterick Integrated Care Campus is included in that strategy. This document is included at Appendix 12.

In July 2019 North East and North Cumbria ICS refreshed and updated their estates strategy. The CICC is included in the investment requirements included in that document which is included at Appendix 13. NHS North Yorkshire is now in the Humber Coast & Vale ICS area. CCG leadership have briefed the ICS on this key project. For completeness the HCV ICS estates strategy is also included at Appendix 13.

In 2019, HRW CCG produced the ‘Reshaping Richmondshire’ Estates Strategy which lays out the rationale for change, key risks and the position of the CICC programme within this. This strategy will be subsumed by the North Yorkshire CCG Estates Strategy upon merger as of 1 April 2020.

2.12 Engagement - Public and Stakeholder Consultation

The CCG has undertaken a degree of engagement to date in a speculative nature towards the service areas within the scope of the development. On review it is recommended that partners undertake further robust and rigorous pre-consultation engagement and consultation processes to focus around the preferred option. This will be developed as the scheme progresses through the relevant business case gateways.

The Communications and Engagement objectives are listed as:

- To maintain credibility by being open, honest and transparent throughout the process;

- To raise awareness and understanding of why it is important that the NHS and MOD has a plan to deliver sustainable and viable services for the future;
- To monitor and gauge public and stakeholder perception throughout the process and respond appropriately;
- To be clear about what people can and cannot influence throughout the engagement;
- To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement and consultation activities, complaints, compliments etc.;
- To provide information and context about the proposals in clear and appropriate formats that is accessible and relevant to target audiences;
- To demonstrate the NHS and MOD are actively planning for the future; and
- To meet NHS legal duties for engagement, equality duties and best practice engagement and communications.

The current Communications and Engagement Strategy is included at Appendix 14. A detailed Communication and Engagement Plan has been created to run alongside any engagement to ensure outcomes can inform the scheme and the production of the NHS FBC.

Risk

As part of the MOD Assessment Study (Appendix 15) activities a detailed strand of risk assessment activities were undertaken jointly by the project teams. The AS, Reference B, Appendix L contains a Risk Register for each option considered during the AS. Annex D shows the Preferred Option Risk Register which has been developed throughout the lifecycle of the project a Risk Workshop and subsequent reviews, the last of which was held on 20 Apr 2020.

The Risk Register has been prepared in accordance with the relevant MOD guidance documents, the consultants' own information and DIO Business Assurance and Risk (BAR) team advice. The Risk Register, including three-point estimates, Monte Carlo risk analysis in terms of both cost and schedule with separate pre and post mitigation supporting information.

The 50% confidence risk estimate for the preferred option is currently £4.668M in total for the combined scheme. This represents 13.27% of the construction costs (including Main Contractor Preliminaries, overheads and profit). Risk will continue to be managed throughout the next stage and mitigating actions will be applied. This comprehensive approach along with greater certainty to be gained as the design is developed should result in an improved understanding of risk and probable reduction of the risk estimate.

MOD have identified that as the project moves into the next stage, it is pertinent to deploy risk funds to manage risks that have been identified as occurring within that stage which has been calculated as £158,679 excluding VAT Authority risk up to FBC.

An Optimism Bias assessment has been undertaken on the project, and this compares favourably with the 50% confidence risk estimate. The calculated Optimism Bias is 9.85%. This assessment is separate from the optimism bias applied in the CIA model. It is difficult to

assess the direct interaction of overlaying the project level risk work with the NHS use of the CIA model. It has been decided to not apply the construction side risks to the CIA in order to avoid duplication. The CCG have only applied the healthcare direct risks for NHS elements of service delivery.

The top 5 project risks, impact based on costs post mitigation are:

Ser	Risk Description	Mitigation	Probability	Impact	Risk Rating
66	Outcome of the public consultation changes to the NHS requirement	Early engagement with the public consultation can reduce and minimise the amount of changes to the requirement.	M	M	1
54	Lack of availability of skilled labour and materials	A market analysis could be undertaken to reduce the probability of this risk	M	M	2
53	Lack of competition for tenders	A market analysis could be undertaken to reduce the probability of this risk. Use of known Frameworks can ensure competitive tenders are received.	L	L	3
56	Proposed Procurement methodology not agreed between MOD/NHS	No mitigation is possible.	H	M	4
17	Market conditions impact on competitiveness of tenders (Procurement / Construction)	A market research/analysis could be completed before going out to tender to confirm the current market conditions.	L	M	5

The top additional risk for the CCG is the risk of Harewood Medical Group handing back their contract. This risk fundamentally affects the comparison between the ‘do minimum’ and fully integrated facility. The risk is currently mitigated by section 96 funding which is passed through to the practice.

However, it is expected that the CICC would enable the system to care more effectively for the patients of the practice by supporting them to self-care and use prevention in a meaningful way. The model would put self-care, prevention and community support at the forefront of care for these patients and thereby reduce their risky, sometimes reckless and often medical-seeking behaviours.

Regulatory risks such as compliance with the government construction strategy (the proposed delivery route via P22 is consistent) and sustainability requirements (a Governing Body approved Sustainable Development Management Plan which sets out clear Milestones to measure, monitor and reduce direct carbon emissions) have also been addressed and the relevant documents are included in the appendices to this business case.

3. The Economic Case

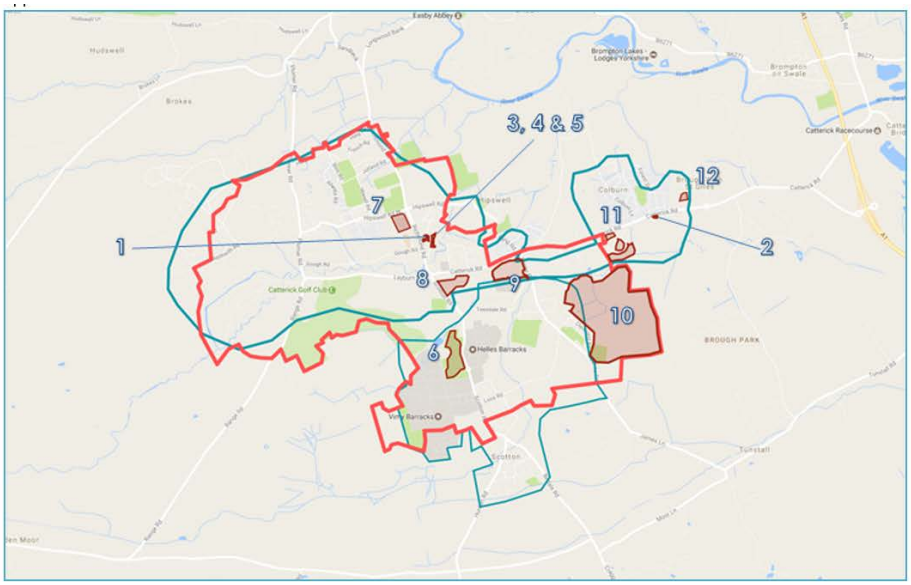
3.1. Options Assessment

As part of the development of the scheme and Assessment Study (AS), five infrastructure options were developed and considered for the realisation of the CICC; four options plus a 'Status Quo' option to respond to the vision and ambitions as set out by the NHS and MOD for the provision of the CICC at Catterick Garrison. These were subject to informed discussion and engagement with the key stakeholder groups as part of the development of the AS, to ensure they are reflective of the critical success factors of the scheme to arrive at a preferred option which offers optimum value for money.

They were also taken to the CCGs Senior Executive Team, Joint Finance, Performance and Contracting Committee and Governing Body as well as the CICC Joint Programme Board, all of which agreed with the Options assessment and Preferred Option.

3.2. Options Long List

In 2017 the NHS and MOD jointly undertook an initial feasibility study to explore options for joint delivery of a healthcare facility. This study explored available sites in the Catterick Garrison locality. Twelve sites were initially considered.



1 – Catterick Garrison Health Centre

2 – Colburn Medical Centre

3 – Shute Road – Old Swimming Pool Site

4 – Shute Road – Old Supermarket Site

5 – Shute Road – all sites combined

6 – Scotton Park

7 – Ypres Lines

8 – Peronne Lines

9 – Duchess of Kent Barracks

10 – Part of Harley Hill SDA

11 – Land at Colburn Business Park

12 – Land off Catterick Road, Colburn

Indicative space requirements for the MOD and the NHS were provided and each site was tested against the potential for independent and joint scheme delivery. The costs of the different schemes were modelled. Peronne Lines was identified as the preferred site for a combined scheme as it was the only site which was large enough and which had potential to be released by the MOD within the scheme delivery timeframes.

There were several sites which could accommodate an NHS standalone scheme, but initial modelling suggested that there were financial benefits to both partners of joint delivery. The initial 2017 Feasibility Study is included at Appendix 1.

3.3 Options Short-List

Following completion of the Feasibility Study an Assessment Study was progressed by the MOD and the NHS focussing on developing new build health facilities at the Peronne Lines site. The site is in MOD ownership. Further options were retained to ensure comprehensive review. The NHS are the smaller partner in the scheme so there is a balance required between the lead partner requirements and approach to establishing the case for change and the NHS requirements. The CCG have therefore used the support of NHSPS to undertake additional and separate financial modelling on a range of additional options to review financial implications of funding routes over and above the joint assessment work with MOD.

The list of options being considered jointly with MOD was;

- Option 1 –Status quo;
- Option 2 – Do Minimum - Modular Building at Piave Lines to replace existing GMC, and PCRF only. Relocation of DCMH (N) and ROHT (N) to Cambrai Barracks. Works to existing NHS buildings to increase capacity within these;
- Option 3 – Re-use Existing Baden-Powell Building at Peronne Lines and provide the remaining within separate facilities for the NHS and MOD at Peronne Lines;
- Option 4 – Provide NHS and MOD requirements within separate facilities at Peronne Lines;
- Option 5 – Provide NHS and MOD requirements within a fully integrated facility at Peronne Lines.

Further details are provided on each of the options developed and reviewed in detail below.

Assessment Study Option 1 –Status Quo

The “Status Quo” Option is provided as a basis of comparison. The current state of all facilities (both the MOD and NHS) is sub-optimal and will continue to deteriorate in the future making them unsafe and therefore unusable. This Option does not meet the requirements set out in the URD and the constraints and requirements detailed in the MOD Technical Specification of Requirements (TSoR).

Assessment Study Option 2 – Do Minimum

The “Do Minimum” Option consists of completing and re-providing the current MOD facilities with modular buildings to meet the demands to remain operational in the future. This option does not meet the Key User Requirements (KUR). The “Do Minimum” Option will keep the MOD and NHS developments separate and therefore it will not provide any integration between these entities.

The MOD element of the option consists of the provision of a modular building at Piave Lines to replace the existing GMC and PCRF only. The ROHT (N) and DCMH (N) Teams will relocate to Buildings 12, 19 and 20 at Cambrai Lines, with significant refurbishment of Building 20 required. Building 19 currently accommodates the GMC and no works are planned within this as part of this option.

The NHS element of the option consists of the following:

- Relocation of community services from Catterick Garrison site to the Friary or Catterick Village sites to release space for GMS services.
- Catterick & Colburn Medical Group will cease subletting to Tees Esk and Wear Valleys (TEWV) at Colburn Medical Centre creating 178m^2 of available space.
- TEWV will consolidate office requirements in Northallerton and access hot desks and sessional clinical space as required in Richmond locality.
- Finally, the option will rely on delivery of current proposals to retain and improve Catterick Village Health Centre and offer increased appointments to spread patient demand.

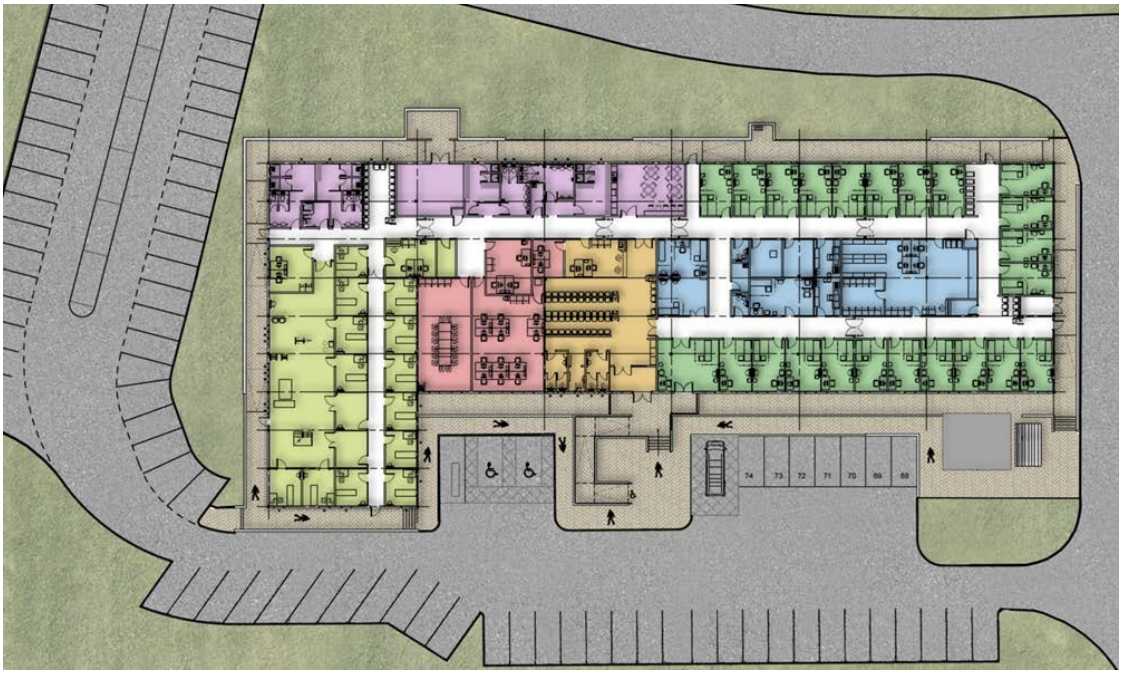


Figure 6– Indicative Layout of MoDular Building for MOD Option 2

The main advantages and disadvantages of the Option are noted below:

Advantages	Disadvantages
Relatively short delivery programme when compared with the other options	No capacity for growth and no capacity to accommodate additional Units and families
Limited re-provision of PCRF (GMC), however, this will meet only the current requirements	Infrastructure issues still remain in a number of locations (DDS and NHS facilities). Majority of NHS work are limited cosmetic enhancements
Marginal improvements to ROHT and DCMH with relocation to Cambrai Barracks, Catterick	Creates a barrier to integrated working between MOD and NHS and between individual functions
Limited disruption to service delivery	No improvement to current MOD dental provision
Minimal financial impact (NHS)	Low staff Morale
	Relatively high cost on modular solution (MOD)
	Short lifespan of refurbishment works (25 years)

Table 1 – Option 2 – Advantages and Disadvantages

Assessment Study Option 3 – Re-use Baden-Powell Building at Peronne Lines and provide remaining requirements in separate MOD / NHS facility

This Option considers the use of the existing buildings on the Peronne Lines site to provide part of the requirement and the remaining being relocated in separate new-build facilities for both MOD and NHS at Peronne Lines. The Baden-Powell building is available for re-use, as the MOD has now confirmed that Peronne House will be used for the Regional Headquarters of the DPHC (N).

After review it was agreed that DCMH (N) provided the best-fit for the floor area of this building (utilising circa 850 m^2 in the existing facility). The building (Baden-Powell) will be refurbished and upgraded to ensure that it meets the appropriate standards and regulations. In addition, two new facilities will be provided one for the NHS and one for the MOD. These will be standalone and independent buildings. While this is not a fully integrated solution, it still provides some level of integration as these buildings will offer a healthcare campus.

Figure 7 – Indicative Massing for Option 3

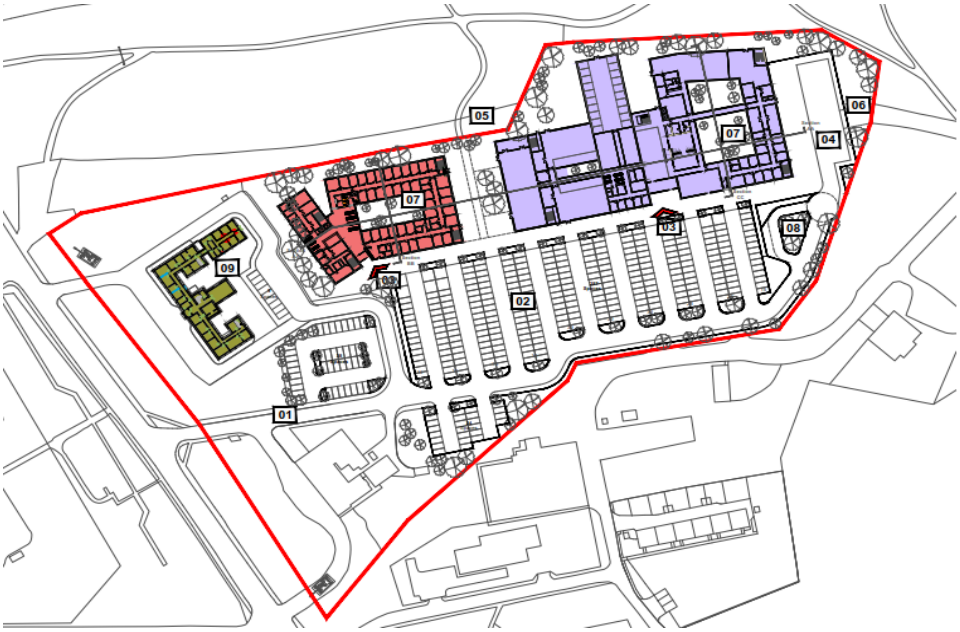


Figure **8** – Indicative Layout of Option 3

The main advantages and disadvantages of the Option are noted below:

Advantages	Disadvantages
Use of existing built estate Baden-Powell building (less than 10% - MOD)	Does not fully meet the requirements of the URD
Fully clinical compliant solution	Creates barriers to a fully integrated service as MOD / NHS facilities in separate buildings
Meeting the future service requirements	Lose Peronne Lines site for potential development
Improved facility	Singles out vulnerable patient group with DCMH being located separately
Improved patient experience	Limited integration between MOD / NHS
Improved staff morale	Increasing CAPEX
Co-location of services that are currently dispersed (MOD)	
Streamlined financial process	
Reduction in maintenance costs	
Lifespan of the new buildings	
Reduced energy costs through efficiency of new buildings and systems	

Table 2 – Option 3 – Advantages and Disadvantages

Assessment Study Option 4 – Provide NHS and MOD requirements in separate facilities – Peronne Lines

This Option considers the provision of new buildings for the entire requirement in separate facilities for the NHS and the MOD. This option is very similar to Option 3 with the exception that the DCMH (N) is now included in the main MOD building rather than in the existing Baden-Powell building.

As with Option 3, this is not a fully integrated solution, however, it still provides some integration as both facilities will be adjacent to one another and on the same site (Peronne Lines). The facilities will be new-build, standalone, and each facility will have their own access and reception area to allow autonomy of operation.

Figure 9– Indicative Massing for Option 4

Figure 10: Indicative Layout for Option 4

The main advantages and disadvantages of the Option are noted below:

Advantages	Disadvantages
Partially meets the requirement of the URDs	Increasing CAPEX
Fully clinical compliant solution	Creates barriers to a fully integrated service as MOD / NHS facilities in separate buildings
Meeting the future service requirements for MOD rebasing	Loses Peronne Lines site for potential development
Improved facility	Limited integration between MOD / NHS
Improved patient experience	Increased complexity of the procurement
Improved staff morale	Does not fully meet the CICC vision and ambitions
Co-location of services that are currently dispersed into a single facility (MOD)	
Streamlined financial process	
Reduction in maintenance costs	
Lifespan of the new buildings	
Reduced energy costs through efficiency of new buildings and systems	
Baden-Powell House remains available for other uses	

Table 3 – Option 4 – Advantages and Disadvantages

Alongside the operation disadvantages of this option which would mean a lack of integration, lack of ambition and a failure to create real added value through the scheme or to recognise and address the unique challenges faced by the garrison community, this option is also significantly more expensive than option 5 (estimated total cost of £62,916,656, compared to £56,471,185) without affording any of the advantages of the fully integrated facility.

Assessment Study Option 5 – Provide NHS/MOD requirements in a fully integrated facility

From the overall assessment of the options, Option 5 – Provides the NHS and MOD requirements within a fully integrated facility at Peronne Lines and is recommended as the preferred Option.

Option 5 will provide a new building that will consist of a single shared structure (design to be finalised and agreed) which constitutes a fully integrated facility shared between the MOD and NHS. The facility will have a shared reception, waiting area and the services will be co-located to realise the integration opportunity of the scheme.

Option 5 is fully compliant with the CICC vision, ambitions and MOD and NHS requirements and provides the additional benefit of a valuable asset not only for the MOD and NHS, but for the wider community as a whole.

In terms of the MOD value management process Option 5 provides the best solution outperforming all other options with a score of 4.71 which is notably higher than the next best option; Option 4 with a score of 3.32. Option 5 also has a comparatively lower CAPEX

and risk costs, excluding Option 2, which does not provide full compliance with the MOD and NHS requirements for the CICC. Option 5 has more advantages than the other options mainly due to the provision of a fully integrated solution between the MOD and NHS. In addition, Option 5 will include a community space that can be used for various activities, such as Help for Heroes, voluntary and community groups, Parents4Parents and the Royal British Legion to provide a valuable community asset for Catterick and the surrounding area. The indicative massing drawing for Option 5 is set out in Figure 11: Indicative Massing Drawings for Option 5.

Figure 11 – Indicative Massing for Option 5

It is estimated that there will be a saving of 10% on the floor area. Following detailed discussions with the healthcare planning and architectural team on the level of space sharing that could be achieved by occupiers a reduced area of 10% was considered achievable and included as a reduction on the single integrated facility footprint. This was considered a reasonable level of saving and it is anticipated that this may be improved during the detailed design phase. The further potential benefit of using P22 standard rooms is also seen as an opportunity which will be available to partners and is to be worked through once P22 partners have been appointed.

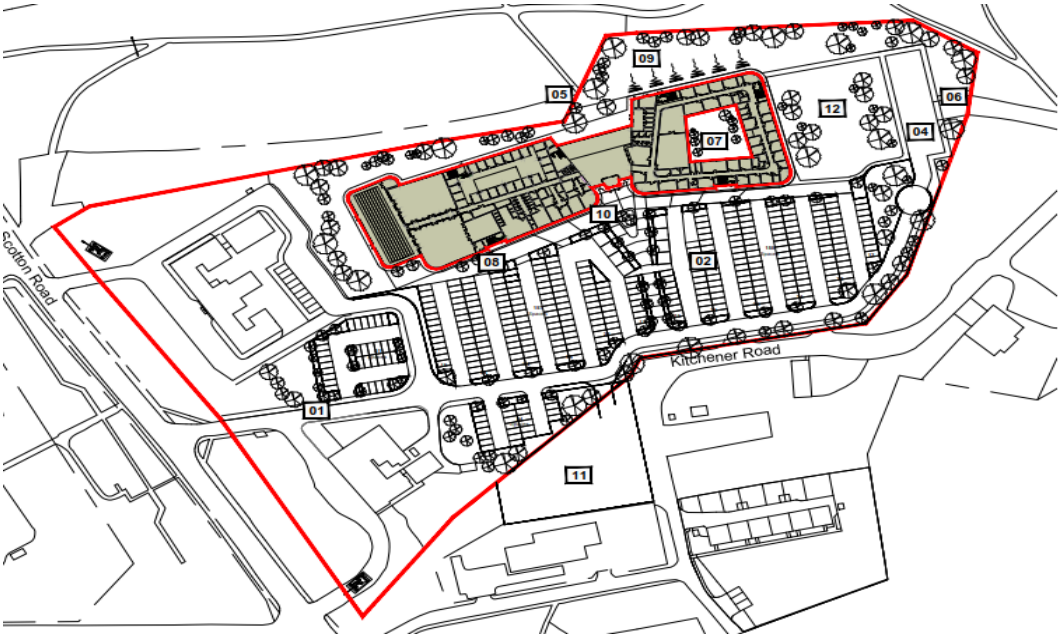


Figure 12 – Indicative Layout for Option 5

The main advantages and disadvantages of the Option are noted below:

Advantages	Disadvantages
Fully meets the requirement of the URDs	Lose Peronne Lines site for potential development
Fully clinical compliant solution	Streamlined financial process
Meeting the future service requirements	Increased complexity of procurement with potentially combined funding streams
Improved facilities for patients and staff	
Improved patient and carer experience	
Improved staff morale	
Co-location of services that are currently dispersed into a single facility	
Fully integrated clinical operating model	
Reduction in maintenance costs	
Lifespan of the new buildings	
Reduced energy costs through efficiency of new buildings and systems	
Optimise the efficiency of the building with shared spaces	
Single point of service delivery	
Holistic Approach	
Better knowledge transfer and training opportunities across staff	

Table 4 – Option 5 – Advantages and Disadvantages

Assessment Study Option	NHS OBC Option	CIA reference	OPTION CODE
Option 1 – Status Quo	Option 1 Status Quo / BAU	Option 0 –BAU	OPT1_CIA0
Option 2 – Do Minimum	Option 2 – Do Minimum	Option 1 – Do Minimum	OPT2_CIA1
Option 3 - Re-use Baden-Powell Building – balance in separate MOD / NHS facilities	Option 3 – Separate NHS facility (campus solution)	NOT MODELLED – SAME FOR NHS AS OPTION 4	OPT3
Option 4 - Provide NHS and MOD requirements in separate facilities – Peronne Lines	Option 4a - NHS separate build MOD fund and recover capital via rent, NHSPS hold property interest	NOT MODELLED IN CIA – MOD CONFIRMED FUNDS NOT AVAILABLE	OPT4A
	Option 4b – NHS Separate build NHS grant to MOD pass through of peppercorn rent	NOT MODELLED IN CIA – CCG DISCOUNTED	OPT4B
	Option 4c – separate new build NHS funded	Option 2 – 4c – separate new build NHS funded	OPT4C_CIA2
	Option 4d – Separate new build 3rd party developer	Option 3 – 4d – separate new build 3rd party developer funded	OPT4D_CIA3
Option 5 - Provide NHS/MOD requirements in a fully integrated facility	Option 5a – Integrated new build with MOD capital funding and NHS rental	NOT MODELLED IN CIA – MOD CONFIRMED FUNDS NOT AVAILABLE	OPT5A
	Option 5b - 5b Integrated new build with NHS grant funding to MOD	Option 4 – 5b Integrated new build with NHS grant funding to MOD	OPT5B_CIA4
	Option 5c - 5c Integrated new build with NHS Capital via NHSPS	Option 5 – 5c Integrated new build with NHS Capital via NHSPS	OPT5C_CIA5
	Option 5d - Integrated new build with 3rd party developer taking ground lease and part developing	NOT MODELLED IN CIA – DOES NOT ALIGN WITH MOD APPROACH	OPT5D

3.4 Assessment of Short-Listed Options

The following critical constraints were identified during the final assessment:

- Must be located within Catterick Garrison and as close to the Town Centre as possible – in order to be fully accessible to as much of the population as is possible;
- Must be fully DDA Compliant;
- The facilities must conform to the standards detailed in JSP315, the Health & Social Care Act 2008, all relevant Department of Health publications and standards (HTM, HBN & British Dental Association (BDA) A12 Advice Sheet (Infection Control in Dentistry and the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2006), regulations for compressed air and medical gases; and
- The output of the all Medical and Dental Centres and associated specialist services must remain throughout.

3.5 Costs

The best public /social value option is determined by way of a Benefits Cost Ratio (BCR) (or value for money threshold) that measures the financial relationship of benefits to costs, with the option with the highest ratio being deemed to be the preferred option.

The economic costs and benefits for each option are derived by assessing the appraised option(s) against BAU i.e. to identify an incremental change from BAU i.e. if there is an increase in costs1 against BAU this is classified as a cost whereas a reduction would be classified as a benefit. A breakdown of the elemental cost headings is set out below

Economic Costs	
Discounted Cash Flows of Costs (including Optimism Bias)	a
Risk Adjustment	b
Risk Adjusted Economic Costs	**c = (a + b)**
Benefits	
Direct and Indirect Cash Releasing Benefits ("CRB")	d
Direct and Indirect Non-Cash Releasing Benefits ("Non-CRB")	e
Societal Benefits (Quantifiable)	f
Unmonetisable Benefits	g
Net Benefit	**h = (d + e + f + g)**
Benefits Cost Ratio (BCR) / VFM Threshold	**h / c**

The Comprehensive Investment Appraisal has been used to model both the economic cashflow (costs) and the cash flows of the benefits referred to above in line with the model guidance and Green Book principles.

All relevant actual cash flows are considered; consequently indirect taxes such as VAT and non-cash financial items such as capital charges are excluded from the appraisal. The time-value of money is considered using an appropriate discount rate. For real cash flows this discount rate is 3.5% for years 1 to 30 and 3% thereafter.

The individual categories of data that have been considered within the CIA model are

Opportunity Costs and	No opportunity costs have been identified
Capital Receipts	A small lease surrender value has been included associated with exit from Catterick Garrison HC
Capital Expenditure	Included on the basis of capital cost assessment provided in the AS
Land - Construction (Buildings)	Detailed costs included from MOD funded assessment study. These have appropriate inflationary uplifts included for construction costs to align with programmed start dates for commencing construction refer Appendix 15
Equipment (including any one-off costs)	Included in all new build options
Lifecycle Costs	Included in all new build options and some allowance in existing sites to reflect ongoing requirement to maintain the site
Avoided Costs (for the Business as Usual Option	None included as significant investment has occurred over the last 3 years to reduce or remove backlog costs on the Catterick Garrison HC site.
Residual value of land/ buildings has also been appraised where applicable	Included in new build options where relevant
Revenue Costs, including:	
- Clinical	Clinical service costs will be included in the calculation at the FBC stage
Non-Clinical and Support Building Running expenses	Detailed operating costs were benchmarked using NHSPS and MOD data and an agreed per sqm rate has been used in both business cases. Rates and insurance figures have been separately confirmed and included.
Transitional Costs Externality (Displacement) Costs Net Contributions	None included

The appraisal has been conducted over a 44 year period, reflecting the lead in for design, procurement and construction plus a 40-year occupation period. This has been based on initial discussions with MOD regarding an acceptable lease term. Heads of terms have been agreed on this basis so it was considered appropriate to reflect this in the modelling. Once

confirmation of capital funding route is achieved it is proposed to refresh the modelling to determine the optimum lease period to secure NHS investment.

Opportunity Costs

No opportunity costs have been included in the appraisal.

Capital Receipts

There are no potential land sales which benefit the NHS as part of scheme options. The long leasehold interest at Catterick Garrison Health Centre has a nominal lease surrender value of £60,000 which is included in modelling.

Capital Costs

	Capital costs - £			
	Option	Present Cost	% of highest cost	Rank
OPT1_CIA0	**Business as Usual**	**£955,377.24**	7%	1
OPT2_CIA1	**Do Minimum**	**£1,306,085.86**	9%	2
OPT4C_CIA2	**Separate new build NHS funded**	**£13,949,005.51**	100%	6
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£2,633,362.09**	19%	3
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£11,481,795.97**	82%	4
OPT5C_CIA5	**Integrated new build NHS funded**	**£11,481,795.97**	82%	4

All costs modelled in the CIA model are exclusive of VAT. The NPC also includes an allowance for optimism bias. As the scheme progresses and cost certainty increases the level of optimism bias will fall and specific risks around cost will addressed. Capital cost cash flows have been provided and are in Appendix 16 along with a sensitivity analysis produced by MOD as part of the AS work.

The capital cost estimates include equipment allowances for the new build options.

Lifecycle costs are, in this case, illustrations of renewal and replacement costs of different components of the buildings over a 60-year period. In line with initial lease discussions the lifecycle costs have been modelled for a 40 year period following the initial capital expenditure investment. The MOD do not normally hold a lifecycle fund for individual buildings. It is proposed that the CICC have a ring-fenced budget including lifecycle in order to ensure that MOD as asset owner meets its obligations in maintain the facility to a standard consistent with healthcare use throughout the term of the lease. MOD have included lifecycle costs in the Whole Life Costs modelling in their business case at the same per sq. metre rate as the NHS.

Residual Value

In the case of buildings, the appraisal considers the useful economic life of the asset in use and it is the depreciated replacement cost that has been included in the CIA model. For the

purposes of this appraisal it is assumed that building will have some remaining useful life after the initial 40 year lease period. No allowance for residual value has been included as the financial assessment is only for the NHS elements of the scheme. The asset will be owned by MOD so any residual value after the initial 40 years would be included in their modelling.

Optimism Bias

The Green Book requires that explicit adjustments be made to appraisals to allow for 'optimism bias' in economic appraisals. With the optimism bias calculation methodology a percentage increase to capital costs is given as an 'upper bound' for project appraisal; for all options this has been calculated using the template' included in the CIA model. Contributory factors that are said to cause optimism bias are also included as part of the model with each contributory factor being assigned a weight to reflect its relative importance in causing the upper bound optimism bias. The weights are expressed as percentages, summing across all the contributory factors to 100%.

Optimism bias mitigation has been assessed by NHSPS on behalf of the CCG and is deemed to be at a suitable level for each of the appraised options. The level of optimism bias remains relatively high due to the multi-party multi-organisational nature of the scheme and also the early design stage.

	OPT1_CIA0	**OPT2_CIA1**	**OPT4C_CIA2**	**OPT4D_CIA3**	**OPT5B_CIA4**	**OPT5C_CIA5**
	Business as Usual	**Do Minimum**	**Separate new build NHS funded**	**Separate new build 3rd party developer funded**	**Integrated new build with NHS grant funding to MOD**	**Integrated new build NHS funded**
Whole Life Costs	955,377	1,306,085	13,949,005	2,633,362	11,481,795	11,481,795
Upper bound calculation	29.5%	28%	34%	34%	34%	34%
Unmitigated at OBC	60%	62%	61%	61%	60%	60%
Optimism Bias at OBC	11.8%	10.6%	13.3%	13.3%	13.6%	13.6%
Total OB (£)	112,734	138,967	1,849,638	349,183	1,561,524	1,561,524
% of Highest Cost	65%	8%	100%	19%	84%	84%
Rank	1	2	6	3	4	4

Summary of Capital Costs

The total net present costs of all the capital costs are shown in the table below.

	OPT1_CIA0	OPT2_CIA1	OPT4C_CIA2	OPT4D_CIA3	OPT5B_CIA4	OPT5C_CIA5
Summary (Discounted) - £	**Business as Usual**	**Do Minimum**	**Separate new build NHS funded**	**Separate new build 3rd party developer funded**	**Integrated new build with NHS grant funding to MOD**	**Integrated new build NHS funded**
Initial Capital costs	0	362,983	12,631,721	0	10,325,820	10,325,820
Lifecycle Costs	1,945,650	1,945,650	5,083,000	5,083,000	4,233,000	4,233,000
Other Capital Costs	0	0	250,000	250,000	250,000	250,000
Residual Value	0	0	0	0	0	0
Total Capital costs	**1,945,650**	**2,308,634**	**17,964,721**	**5,333,000**	**14,808,820**	**14,808,820**
Rank	**1**	**2**	**6**	**3**	**4**	**4**
Total capital inc OB	**2,175,236**	**2,554,272**	**20,346,843**	**6,040,155**	**16,822,819**	**16,822,819**
Rank	**1**	**2**	**6**	**3**	**4**	**4**

3.6 Benefits

3.6.1 Project Level Benefits Assessment

A Value Management Workshop was jointly held by the MOD and NHS and it was identified that the objectives of the workshop were to:

- Identify the main Value Drivers for this project;
- Agree the key Value Drivers/ Objectives most suitable for providing discrimination between Options;
- Calculate the weighting that should be applied to the key Value Drivers;
- Score each Option for its capability to deliver on the key Value Drivers;

Record the main Advantages and Disadvantages, Risks and Benefits for each Option

The Value Management process and outcomes are available in Appendix 17. Following consideration of the Advantages, Disadvantages, Risks and Benefits, a list of key value drivers was identified and reduced to 8 key issues that the Workshop believed provided sufficient discrimination for an empirical, evidence-based scoring of the relative effectiveness of each Option. The following were selected as being the most appropriate Drivers for Option evaluation:

ID	Drivers	Detailed Driver Commentary
A	An improvement to the health and wellbeing outcomes of the population (both Civilian / Military)	Does the option provide facilities that will allow identified health and wellbeing outcomes to be met

ID	Drivers	Detailed Driver Commentary
B	A fully integrated health and wellbeing service	Does the option provide full integration of the services being provided and provide links to other services
C	Adaptable and sustainable to the changing needs of the population	Health provision evolves to meet the changing needs of the population being served. Does the option provide a solution that can be adapted to meet these changing requirements
D	Sustainable (environmentally)	Does the option provide an environmentally sustainable solution and have the potential to meet the necessary DREAM and BREEAM requirements
E	Meeting the long-term policy requirements of NHS / MOD	Does the option provide facilities that allow the policy requirements of the NHS / MOD to be met?
F	A resource that adds value to the wider community (where people want to go)	Does the option provide a facility that can be used to meet the wider needs of the community over and above the healthcare needs
G	An environment that attracts and retains staff	Staff retention can be an issue particularly in the NHS. Does the option provide an environment where staff are happy and are keen to work
H	Programme	Does the option meet the programme or provide opportunities to improve on the required delivery programme

Having agreed the key Value Drivers, the Workshop assessed the relative importance of the selected Drivers using a paired comparison approach. This is an established Value Management process that assesses the relative importance of each key driver against every other key driver. The group setting of these discussions enabled all stakeholders to gain an appreciation of the various perspectives represented in the stakeholder group allowing an informed assessment to be made.

Decision Matrix	A	B	C	D	E	F	G	H
A		A	A	A	A	A	A	A
B			C	B	B	F	G	B
C				C	C	C	C	C
D					D	F	G	D
E						F	G	H
F							G	F
G								G

H										

Table 5 – Decisions Matrix for the key drivers

IDs	Description	Total	%	Weighting
A	An improvement to the health and wellbeing outcomes of the population (both Civilian / Military)	7	25%	0.25
B	A fully integrated health and wellbeing service	3	11%	0.11
C	Adaptable and sustainable to the changing needs of the population	6	21%	0.21
D	Sustainable (environmentally)	2	7%	0.07
E	Meeting the long-term policy requirements of NHS / MOD	0	0%	0
F	A resource that adds value to the wider community (where people want to go)	4	14%	0.14
G	An environment that attracts and retains staff	5	18%	0.18
H	Programme	1	4%	0.04

The Options were assessed using the weighted Drivers on the qualitative basis of how effectively each Option met each Driver. Each of the Options was scored against the Drivers stated in Section 8 above. The scoring system used was as follows:

- 0 Not Acceptable
- 1 Poor
- 2 Unsatisfactory
- 3 Satisfactory
- 4 Good
- 5 Excellent

The Options were then scored against each of the selected Key Drivers at the Workshop. This was done in an open setting to gain the benefit of the subject matter experts present. The scores against each Driver were multiplied by the Driver Weighting previously assessed to arrive at an overall Weighted Score for each Option. The Option scoring is summarised below:

Options	Total	Rank
Assessment Study Option 1 – Status Quo	0.54	5
Assessment Study Option 2 – Do Minimum	1.39	4
Assessment Study Option 3 – Re-use Existing Baden Powell Building at Peronne Lines and provide remaining requirements in a combined MOD / NHS facility;	3.07	3
Assessment Study Option 4 – Provide NHS and MOD requirements within separate facilities at Peronne Lines;	3.32	2
Assessment Study Option 5 – Provide NHS and MOD requirements within a fully integrated facility at Peronne Lines.	4.71	1

Table 6 – Rating Totals for Each Option

Option 5 was clearly ranked in first place with a score over 40% ahead of the next ranked option. The Workshop discussed the outcome of the Value Management exercise and were assured that the output of the VM Scoring was a fair reflection of the discussions on the relative advantages and disadvantages of each Option.

3.6.2 NHS Benefits Assessment using CIA

The NHS need to apply the tools provided within the CIA document to assess the relative merits of options and produce the relative ranking.

The table below lists each of the project objectives, which have been jointly developed with MOD as project partner, and then lists the relevant benefits against each objective.

Objective 1. An improvement to the health and wellbeing outcomes of the population (both Civilian / Military) - provide facilities that will allow identified health and wellbeing outcomes to be met
• Promotion of parity of esteem between mental and physical health and reduction of stigma • Fewer permanent admissions to care homes • earlier identification of need and support provided to reduce escalation
Objective 2. A fully integrated health and wellbeing service - provides full integration of the services being provided and provides links to other services
• Reduction in delayed transfers of care
• integration of treatment and care pathways • improved access to routine and urgent appointments • earlier identification of need and support provided to reduce escalation
Objective 3. Adaptable and sustainable to the changing needs of the population - Health

provision evolves to meet the changing needs of the population being served.
• Improved experience for the patient
• staff skill-exchange • increased opportunity for innovation • Implementation of new joint clinical model creates capacity for NHS to support more military families
Objective 4. Sustainable - provide an environmentally sustainable solution and meet the necessary DREAM and BREEAM requirements
• More energy efficient buildings to meet DREAM / BREEAM Excellent; inclusion of sustainable elements such as PV panels into the design, to support greening government commitments. • Provide a Net Zero Carbon or nearly Net Zero Carbon New build in line with government direction.
Objective 5. Meeting the long-term policy requirements of NHS / MOD - provide facilities that allow the policy requirements of the NHS / MOD to be met
• Reduction in emergency admissions and A&E attendances for Patients / Service users • Reduction in non-elective non-emergency cases • Fewer permanent admissions to care homes • Savings in the OOH contract due to Saturday and Sunday opening
Objective 6. A resource that adds value to the wider community (where people want to go) - provide a facility that can be used to meet the wider needs of the community over and above the healthcare needs
• less reliance on the statutory health and care sector. • greater patient/service user and carer activation and ownership of their health and wellbeing;
Objective 7. An environment that attracts and retains staff - provides an environment where staff are happy and are keen to work
• staff skill-exchange • better sharing of information between professionals • increased opportunity for innovation
Objective 8. Programme – be deliverable to align with military rebasing programme 2023/24 or provide opportunities to be operational sooner
• implementation of new joint clinical model creates capacity for NHS to support more military families

No cash releasing benefits have been identified. There are a small number of non-cash releasing benefits, some societal benefits and a larger number of Unmonetiseable benefits. The table below shows the allocation of the benefits.

Benefit	Investment Objective
Non-cash releasing	
Reduction in emergency admissions and A&E attendances for Patients / Service users	5
Reduction in non-elective non-emergency cases	5
Reduction in delayed transfers of care	2
Fewer permanent admissions to care homes	1, 5
Savings in the OOH contract due to Saturday and Sunday opening	5
Societal	
less reliance on the statutory health and care sector.	6
promotion of parity of esteem between mental and physical health and reduction of stigma	1
Unmonetisable	
integration of treatment and care pathways,	2
improved experience for the patient,	3
staff skill-exchange	3, 7
increased opportunity for innovation	3, 7
improved access to routine and urgent appointments;	2
better sharing of information between professionals;	7
greater patient/service user and carer activation and ownership of their health and wellbeing;	6
earlier identification of need and support provided to reduce escalation	1,2
Energy efficient buildings	4
Contribute to Net Zero Carbon policy objective	4
Implementation of new joint clinical model creates capacity for NHS to support more military families	3, 8

The table below shows the discounted total for non-Cash Releasing Benefits over each of the five options.

Non-Cash Releasing Benefits - £				
	Option	Discounted Total	% of highest benefit	Rank
OPT1_CIA0	**Business as Usual**	**£0.00**		**5**
OPT2_CIA1	**Do Minimum**	**£0.00**		**5**

OPT4C_CIA2	**Separate new build NHS funded**	**£3,350,384.24**	**50%**	**3**
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£3,350,384.24**	**50%**	**3**
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£6,700,768.48**	**100%**	**1**
OPT5C_CIA5	**Integrated new build NHS funded**	**£6,700,768.48**	**100%**	**1**

Table 7 – Non Cash Releasing Benefits

3.6.3 Benefit Realisation

For each of the high-level benefits outlined in the Business Case, SMART (Specific, Measurable, Achievable, Realistic, Timely) benefits have been identified which are cited in the Benefits Realisation Plan at Appendix 18. This sets out who is responsible for the delivery of specific benefits, when they will be delivered and how achievement of them will be measured.

A detailed Benefits Management Strategy will be developed during the NHS FBC stage and will be overseen by the CICC Programme Board. Once the CICC is fully operational, review arrangements will need to be established to ensure that the benefits have been realised. Review arrangements will coincide with the NHSE&I Post Project Evaluation (PPE).

See Figure 13: NHSE&I Post Project Evaluation, this will contain at the least:

Date of Report	that the report is completed. The entry box is validated to accept date entries only.is completed. The entry box is validated to accept date entries only.
Scope	The initial scope is that approved in the final business case before implementation – include a brief description that defines the project limitations (e.g. geographical, service etc.) Changes to scope should record any variations to the initial scope (e.g. change in services etc.)
Timetable	Focus on the "in use" date and looks at when the project was completed and available for use compared to the date in the final approved business case. NB. this is before any approved changes since the purpose is to explain why the project was delivered at a different time to that set out at the time of business case approval; part of the explanation may be because of changes in scope approved post business case approval.
Cost	Complete the financial analysis as required and then: 1. Set out brief explanations for any cost increase over the business case approval 2. Set out brief explanations for any variances between the outturn costs and approved funding.
Quality	Confirm that relevant quality standards have been achieved or give a summary where this is not the case. Examples of quality deviation may include non-compliant building adaptations or a lack of technical functionality when compared with the detailed specification for the project.
Benefits/ Outcome Delivery	Identify the benefits or outcomes that were to be delivered by the project as stated in the approved final business case and as may have been amended by any subsequent change to the project (e.g. a change in scope identified above). Confirm delivery of the benefit or outcome. The only options are Y or N. Where a benefit or outcome has not been achieved reasons for this should be given along with any details of any remedial action taken.
Lessons Learnt	Highlight the key (max.) 6 lessons learnt and give a brief description of the issue along with the action taken to resolve it.

Figure 13: NHSE&I Post Project Evaluation

3.7 Project Level Risk Management Approach

The CICC risk register will be reviewed on a quarterly basis throughout the life of the scheme by the CICC Programme Board. Relevant risks will be reported to the CICC Programme Board via the monthly highlight reports from the Local Steering Committee (LSC). Where risks potentially have an impact on the capital costs or delivery programme (time) for the scheme these will inform the contingency value.

The risk register will be maintained by the Programme Manager, but the risks are the responsibility of the risk owner. Key risks have been identified around:

- Challenging timescales;
- System sustainability and partnership relationships;
- Ongoing engagement with all partners; and
- Development of the formal agreed documentation.

As detailed earlier a full assessment has been carried out of potential risks and issues and is detailed at Appendix 19.

3.7.1 Risk management

The risk management principles for the scheme are:

- To identify all possible risks, putting in place mechanisms to minimise the likelihood;
- Ensure that risks to the achievement of the programme's objectives are understood and effectively managed;
- Have processes in place to ensure up to date, reliable information about risks is available, and establishing an ability to effectively monitor risks;
- Ensure appropriate allocation of risks to the party best able to manage the risk;
- Ensure that the high-level CCG and MOD risks are integrated within the overall risk register and the corporate governance arrangements;
- Ensure that the risks to the quality of services that the organisation(s) commissions from health and care providers are understood and effectively managed;
- To assure the public, patients, staff and partner organisations that the partners are committed to managing risk appropriately; and
- To protect the services, staff, reputation and finances through the process of early identification of risk, risk assessment, risk control and elimination.

A joint risk register, formatted according to the Treasury guidelines, is in use and being managed through the Local Steering Group, reported against the monthly Dashboard and overseen by the Joint Programme Board. Risk management is an on-going project management process and will become part of the Programme Management Office once established in the next phase of the programme.

As part of the MOD Assessment Study activities a detailed strand of risk assessment activities were undertaken jointly by the project teams. The AS, Appendix 15 contains a Risk Register for each option considered during the AS. Annex D shows the Preferred Option Risk Register which has been developed throughout the lifecycle of the project a Risk Workshop and subsequent reviews, the last of which was held on 20 Apr 2020.

The Risk Register has been prepared in accordance with the relevant MOD guidance documents, the consultants' own information and DIO Business Assurance and Risk (BAR) team advice. The Risk Register, including three-point estimates, Monte Carlo risk analysis in terms of both cost and schedule with separate pre and post mitigation supporting information.

The 50% confidence risk estimate for the preferred option is currently £4.668M in total for the combined scheme. This represents 13.27% of the construction costs (including Main Contractor Preliminaries, overheads and profit). Risk will continue to be managed throughout the next stage and mitigating actions will be applied. This comprehensive approach along with greater certainty to be gained as the design is developed should result in an improved understanding of risk and probable reduction of the risk estimate.

MOD have identified that as the project moves into the next stage, it is pertinent to deploy risk funds to manage risks that have been identified as occurring within that stage which has been calculated as £158,679 excluding VAT Authority risk up to FBC.

An Optimism Bias assessment has been undertaken on the wider project, and this compares favourably with the 50% confidence risk estimate. The calculated Optimism Bias is 9.85%. This assessment is separate from the optimism bias applied in the CIA model, at present the optimism bias within the CIA model has been applied rather than the wider project optimism bias. The optimism bias in the CIA is higher on all options, so this has been a cautious approach at this early stage of scheme design.

It is difficult to assess the direct interaction of overlaying the project level risk work with the NHS use of the CIA model. It has been decided to not apply the construction side risks to the CIA in order to avoid duplication. The CCG have only applied the healthcare direct risks for NHS elements of service delivery.

As noted on pages 43/44 the top 5 project risks, impact based on costs post mitigation are:

Ser	Risk Description	Mitigation	Probability	Impact	Risk Rating
66	Outcome of the public consultation changes to the NHS requirement	Early engagement with the public consultation can reduce and minimise the amount of changes to the requirement.	M	M	1
54	Lack of availability of skilled labour and materials	A market analysis could be undertaken to reduce the probability of this risk	M	M	2
53	Lack of competition for tenders	A market analysis could be undertaken to reduce the probability of this risk. Use of known Frameworks can	L	L	3

		ensure competitive tenders are received.			
56	Proposed Procurement methodology not agreed between MOD/NHS	No mitigation is possible.	H	M	4
17	Market conditions impact on competitiveness of tenders (Procurement / Construction)	A market research/analysis could be completed before going out to tender to confirm the current market conditions.	L	M	5

Comprehensive Investment Appraisal

The final stage of the appraisal is to combine the economic cost analysis with the benefits analysis to determine the "best public /social value" option with the result being determined by way of a Benefits Cost Ratio (or value for money threshold) that measures the financial relationship of benefits to costs. The option with the highest BCR is deemed to be the preferred option.

The approach in the CIA model is to calculate the incremental difference (up or down) of both costs and benefits for each option against the BAU option, thereby giving a true 'additional' economic cost benefit.

The results from the CIA model show that the integrated new build options present the best cost-benefit ratio. It is important to note that the impact of the clinical risk around hand back of the existing GMS contract is a significant factor in this result.

	OPT2_CIA1	OPT4C_CIA2	OPT4D_CIA3	OPT5B_CIA4	OPT5C_CIA5
Summary (Discounted) - £	**Do Minimum**	**Separate new build NHS funded**	**Separate new build 3rd party developer funded**	**Integrated new build with NHS grant funding to MOD**	**Integrated new build NHS funded**
Total capital inc OB	-£376,941.64	-£14,730,531.88	-£1,914,434.15	-£11,975,208.47	-£11,975,208.47
Revenue Costs	£0.00	-£3,032,128.20	-£12,229,919.86	-£1,940,574.64	-£1,940,574.64
Total Costs	**-£376,941.64**	**-£17,762,660.08**	**-£14,144,354.00**	**-£13,915,783.10**	**-£13,915,783.10**
Incremental Benefits					
Incremental cost reduction - risks	£2,100.00	£7,686,940.41	£7,686,940.41	£7,686,940.41	£7,686,940.41
Incremental benefit - non-cash releasing	£0.00	£3,350,384.24	£3,350,384.24	£6,700,768.48	£6,700,768.48
Total Benefits	**£2,100.00**	**£11,037,324.65**	**£11,037,324.65**	**£14,387,708.88**	**£14,387,708.88**
Risk-adjusted Net Present Social Value (NPSV)	**-£374,841.64**	**-£6,725,335.44**	**-£3,107,029.36**	**£471,925.78**	**£471,925.78**
Benefit-cost ratio	**0.01**	**0.62**	**0.78**	**1.03**	**1.03**

Furthermore, the analysis shows that the preferred option delivers all the identified unquantified societal and unmonetisable benefits, which are at least the same or over and above the benefits of the other short-listed options. Although the societal and unmonetisable benefits have not been quantified, they further justify the selection of an integrated new build ICC on the Peronne Lines site as the preferred option.

4 Commercial Case

4.1 Commercial Feasibility

If approval is received to proceed beyond OBC the preferred option for partners is Option 5 an integrated facility. This facility would be built on MOD land and procured by the MOD as lead partner. Consideration has been given to the available procurement options for delivery of this requirement taking account of the proposed scale, estimated value, technical complexity of the works and the indicative timescale for delivery.

A full commercial strategy document has been prepared by the MOD and is included in Appendix 20.

The procurement routes considered were;

- PF2/ PPP
- Stand Alone Prime Contract
- NEC3
- CCS Construction Framework
- ProCure 22 (P22)

The P22 Construction Procurement Framework is administered by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England. It is consistent with the requirements of Government Policy including the Productivity and Efficiency agenda; the Government Construction Strategy; the Public Contracts Regulations 2015; the National Audit Office guidance on use of centralised frameworks; and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector.

The framework allows the procuring Authority to select the most appropriate pricing mechanism, rather than simply firm price. Furthermore, as the framework members will have developed considerable expertise in delivery of medical facilities for the NHS, it is expected that the VFM will be better than other framework options when all factors are considered (Time, Cost and Quality).

The DIO Commercial team will explore the procurement options to seek the BVFM based on cost and risk transfer. Procure 22 was due to go out of service in September 2020 but has now been extended for a year as a result of COVID-19. Its replacement will be Procure 2020 which will run from October 2021 for 6 years. The MOD have confirmed that they can access the P22 framework. The current intention is that this will be free to use and discussions with NHS have confirmed that this is the case. With regards to the CCS Construction Works and Associated Services framework P2020 may consider this route but given that this may use regional suppliers this maybe unlikely as P2020 will still use the six suppliers based on Procure 2020 and going regional would take up existing resource. For this procurement therefore, it is considered that the Procure 22 option using 2 stage approach is the most likely option to deliver the best VFM.

The project programme reflects procurement timeframes using this route.

4.2 Scope

The procurement will secure delivery of a combined healthcare facility for MOD and NHS partners which meet the requirements of URD / SOA in line with agreed specification.

A separate procurement will be required for the delivery of facility management and for hard and soft facilities management services. The scope of this procurement will be agreed between OBC and FBC alongside other commercial matters.

A list of equipment required for the new facility has been developed and will be validated as detailed design is developed at the next project stage. This will then link back to individual room design work. If x-ray services transfer from The Friary it is anticipated that the existing, relatively new equipment would transfer as part of the service moves.

NHS commissioners plan to implement the NHS Standard Contract with their proposed service providers. Where voluntary and third sector groups are to offer services there remains scope to utilise grant agreements or potentially Alternative Provider Medical Services (APMS) agreements; where appropriate. Any service contract will be awarded for ten years with an option to extend for a further five years. Any service providers within the CICC will be required to be part of a formal integration agreement where all parties commit to working in a collaborative, sustained and integrated manner, the specifics of which will be derived by engaging with providers, patients and public before service commencement.

The contracts for service delivery will be phased over a three-year period to allow all services to co-locate and begin effective, tangibly demonstrable integration. Maintaining excellent governance and robust conflicts of interest management will help ensure success.

4.3 TUPE

There is a very limited scope for TUPE impact in the proposed development from an NHS perspective. NHSPS employ cleaning and maintenance staff for the existing Catterick Garrison Health Centre and will evaluate implications once final detail of the future management arrangements for the new facility have been agreed between partners. Due to the long construction lead time there is adequate scope to manage this impact alongside commissioning and go live activities for the integrated facility.

4.4 Integrated Facility Management Arrangements

Partners have reached in principle agreement to:

- A joint management arrangement to operate the facility
- MOD ring-fenced budget for their element of the site
- Outline heads of terms for occupancy

The MOD have a preference for a single NHS head occupancy partner as their current structures do not support managing sub-tenancy and service charging arrangements. In principle Heads of Terms have been agreed between the partners and set out the agreed approach to operating the facility and those matters for development between OBC and FBC. The Heads of Terms are included at Appendix 21.

4.5 Initial Design

The design for the preferred option has been developed up to RIBA stage 2 Concept Design. This includes site plans and indicative elevations. The design proposals are included as Appendix 22.

4.5.1 Schedule of Accommodation

The Schedule of Accommodation (SoA) for the CICC has been derived from a series of facilitated workshops undertaken as part of the development of the Assessment Study and is compliant with both MOD and NHS requirements. The SoA was agreed as at 12 July 2019 by all key stakeholders from across the MOD and NHS as representing the requirements at this stage of the development of the scheme. It has therefore been taken as the basis for the derivation of the options within the AS and resulting business cases.

The SoA and functional content diagrams are included in the AS cited at Appendix 23.

A summary is presented below with the key departments and their associated space requirements at this stage. Please see Appendix 24 for SoA Summary for Key Departments:

Department	Number of Key Function Spaces	Departmental Area m^2
Garrison Medical Centre (GMC)	44	3,944.52
Primary Care Rehabilitation Facility (PCRTF)	28	3,511.64
Defence Community Mental Health North (DCMHT)	30	854.14
Regional Occupational Health Team North (ROHTN)	10	577.23
Catterick Dental Centre (CDC)	23	1,554.56
Harewood Medical Practice (HMP) and Colburn Medical Centre (CMC)	26	2,453.29
Advanced Primary Care	18	819.79
Diagnostics	2	119.72
Community Physiotherapy	6	185.65
Community Services Mental Health team	11	877.04
Social Prescribing	NA	433.75
Total		**15,331.33**

Figure 14 CICC SoA Summary for Key Departments

The schedule of accommodation to support this design work is included as Appendix 10. This should be considered alongside the URD which sets out the MOD requirements – they make up 78% of the floor area of the scheme. The URD and SOA were developed as part of the assessment study stage with support from KD Health in their capacity as healthcare planners. Service adjacency work was developed as part of workshop activity and is included in the MOD Assessment Study Appendix 15.

In line with the MOD standard approach, the scheme will not move to detailed design until after OBC approvals. Agreement was reached between partners that the facility would be in

line with NHS standards as well as MOD specific requirements. NHSPS have provided their standard specification to support scheme costing work.

4.6 BREEAM vs DREEAM

The MOD use the DREEAM criteria for evaluating their schemes while the NHS applies BREEAM. An initial DREEAM evaluation has been undertaken to date, which is included in Appendix 25. Initial review indicates that there are differences between the approaches and the NHS anticipates it will need to appoint its own advisor to ensure early points are achieved in support of BREEAM excellent requirements.

4.7 Technical and Specialist Assessments

Specialist assessments for infection prevention and control, fire and sustainability cannot be undertaken until the detailed design phase of the scheme. The requirement to meet all existing NHS standards is recognised by both partners.

A Sustainability Appraisal (SA) has been completed as part of the MOD AS and become part of the specifications moving forward. The SA process helps to ensure that Sustainable Development Plans for considerations and policy requirements are integrated into all plans, programmes and projects that have the potential to affect the environment, society or the economy on, over or around areas owned, occupied or used by the MOD, its agencies and partners. This Sustainability Appraisal Report is based on the MOD's Sustainability and Environmental Appraisal Tools Handbook; Section 2: Sustainability Appraisal

An initial Sustainability Assessment was completed as part of the AS and this is included at Appendix 26. The report identifies opportunities to be developed during the next phase of the project and activities to mitigate risks. The assessment criteria is noted below.

A	B	C	D	E
Major positive effect	Minor positive effect	No effect	Minor negative effect	Major negative effect

The summary of long-term sustainability at this stage of the project is included in the table below.

Sustainability Theme	Sustainability Score			
	AS Option 2	AS Option 3	AS Option 4	AS Option 5
A – Travel and Transport	B	B	B	B
B – Water	C	C	C	C
C – Energy	C	C	B	B
D – Noise and Vibration	C	C	C	C
E – Air Quality	C	C	C	C
F – Waste	C	B	B	B
G – Sustainable Construction and the Built Environment	D	D	E	E
H – Sustainable Procurement	C	C	C	C
I – Geology and Soils	C	C	C	C
J – Biodiversity and Nature Conservation	D	D	D	D

K – Historic Environment	C	C	C	C
L – Landscape and Townscape	C	C	C	D
M – Health, Safety and Well-being	B	A	A	A
N – Communities, Amenities and Social Value	B	A	A	A
O – Climate Resilience	C	C	C	C
P – Economy and Employment	B	B	B	B

Table 8 – Long Term Sustainability

4.8 Planning Permission

Initial discussions have taken place with Richmondshire District Council on 22 April 2020 regarding the Catterick Integrated Care Campus proposals. Initial feedback was supportive and noted that

- The massing and scale is appropriate in this location.
- The Impact of the proposal on the HQ Building which is an important building within the setting needs to be assessed; this could be done as part of the Visual Impact Assessment.
- The quality of the external material finish needs to be carefully considered.
- The green credentials of the building are important, opportunities such as a 'green roof' should be considered and implemented into the design where possible.
- The use of flat roofs within the design need to be considered carefully to ensure that the overall design retains a high quality for this important building.
- The existing tree belt to the north of the site must be retained and protected during construction. This tree belt is important in itself as a feature within the garrison; it's also an important visual screen to the proposal from the North.
- It's important that the technical aspects of the development are considered early on to ensure that when the planning application is submitted the reports support the approach taken. In particular surface and foul water management.

Formal pre-application discussions will be the next phase and are anticipated to take 8 weeks from submission. The lead on will be MOD as the existing landowners and expected lead development partner, on behalf of and with agreement from, the principal partners once the design and plans are agreed in principle.. The proposed site has been earmarked for the scheme by the MOD at a national level.

4.9 Disposals

There are no NHS freehold disposals associated with the NHS element of the scheme. The existing Catterick Garrison Health Centre is held by NHS PS on a long leasehold basis from the MOD. Initial review suggests that there is limited realisable value in this asset.

The existing general practice premises at Colburn are leased by the practice from Assura Plc. The current strategy is to consider alternative occupiers for this space or to allow the lease to come to its natural end in 2026. This will be explored further to inform the development of the FBC.

4.10 Asset Ownership & Accounting Treatment

The proposed delivery route for the preferred scheme, an integrated healthcare facility, is for NHS funds to transfer to the MOD to procure the construction in line with their commercial strategy which is included as Appendix 20. The NHS would secure access for an agreed period which has currently been modelled at 40 years, via a Section 2 Agreement.

Initial advice has been received from NHSE national primary care estates team that use of Sec 2 payment is possible for primary and community care not solely for the general practice element of the scheme. It has also been confirmed that the route could be used for a transfer to MOD as envisioned in this proposal. Bevan Brittan have been jointly appointed by NHSE and NHSPS to provide legal advice on the proposals. They have reviewed the proposed Heads of Terms (Appendix 21) prior to them being agreed with MOD. A Sec. 2 checklist has been completed to reflect the current status of elements of the proposed Sec. 2 agreement and this is included in Appendix 27.

Once certainty on the capital funding source and flows is achieved it will be possible to refresh the modelling to reflect further detail on accounting treatment. The MOD have confirmed that they are able, and subject to appropriate guidance, will seek to make appropriate VAT recovery as part of the scheme.

In recognition of the additional obligations which are likely to fall to the MOD to ensure that the facility is well maintained during the term of the agreement with the NHS the financial modelling in both OBCs includes an allowance for lifecycle maintenance as an annual operating cost.

5. Financial Case

5.1 Key Points

- The total capital cost of the preferred option is circa £55.32m (including VAT and inflation), £42.63m MoD and £12.69m NHS
- The source of the NHS capital funding is to be formally confirmed by NHS England & Improvement – for the purposes of the OBC it is assumed that the scheme will be publicly funded
- The preferred option is to transfer the NHS capital allocation to the MoD under Section 2 (NHS Act 2006) agreement. The asset would be held by the MoD with the NHS entering into a contract giving the NHS use of the agreed floor areas at a peppercorn rent for an agreed period (40years).
- The recurring revenue costs of the preferred option attributable to the CCG are estimated as circa £556k per annum, circa £329k more than current expenditure. The CCG expects to support this funding gap by cash releasing savings delivered through CCG transformational schemes and/or accessing primary care transformation funding through the ICS.
- The additional recurring revenue impact on service providers is expected to be minimal as current service provision is expected to continue for all options and peppercorn rental will be passed onto service providers.

5.2 Financial Evaluation

The financial evaluation looks at the capital cost, the economic case and the affordability of the options in the short list identified in the Economic Case, section 3.3 of the OBC.

A detailed evaluation against SMART criteria and objective modelling against financial and non-financial criteria was undertaken. This showed that Option 3 reuse Baden-Powell and new build on separate sites (OPT3) to have the same funding implications for the NHS as Option 4 (new build, co-located), but is more costly overall in terms of both capital and revenue. As Option 4 also scores higher in the non-financial evaluation Option 4 will always outperform Option 3. In view of this, Option 3 is discounted from further financial evaluation.

The table below outlines the options considered for financial evaluation, the sub options considered and highlights the reasons why some of these sub options have been discounted.

Summary of Options for Financial Modelling

Option	Description	Description & CIA Options for Financial Modelling
1	**Do Nothing** • Base Case	**CIA Option 0** • Continue at CGHC and Colburn (assumes lease renews). • Lifecycle costs of £50/SM (exc VAT) included with 2% annual inflation.
2	**Do minimum** • Capex at Colburn • Capex of £250K (exc VAT) for specialist equipment	**CIA Option 1** • Continue at CGHC and Colburn as per Do Nothing. • Capex of £363K (exc VAT) at Colburn funded by CCG.
4	**Build a new standalone heath centre for £12.8M (exc VAT) on MOD land** • £50/SM lifecycle costs on the new build only • Surrender ground lease with MOD at Catterick Garrison for £60k • Exit Colburn at lease end date of 31 March 2026 • Capex of £250K (exc VAT) for specialist equipment • Opportunity cost of land is £250K	Four separate funding options were considered: **a) REMOVED** (MOD fund the new build and recharge on Trust accounting methodology – this was eliminated as an option as MOD do not have the monies) **b) REMOVED** (A Grant is made to the MOD and MOD only charge a ground rent – this has also been eliminated as the Grant application was unsuccessful) **CIA Option 2** **c)** NHS fund the new build. NHSPS own the asset and enter into subleases with the tenants who are charged in accordance with the PS's new charging policy. MOD charge a ground rent on the land. **CIA Option 3** **d)** A third party developer builds and charges £200/SM (DV rent) to the NHS. NHS PS take headlease and enter into sub leases. MOD charge a ground rent.
5	**Build an integrated new build NHS use (22%) and military use (78%). NHS share of build cost is £10.6M (exc VAT).** • £50/SM lifecycle costs on the new build only • Surrender ground lease with MOD at Catterick Garrison for £60k • Exit Colburn at lease end date of 31 March 2026 • Capex includes £250K (exc VAT) for specialist equipment • Opportunity cost of land is £250K	Four separate options where considered: **a) REMOVED** (MOD fund the new build and recharge on Trust accounting methodology. No NHSPS involvement) **CIA Option 4** **b)** A Grant from the NHS under Direction 2 is made to the MOD who only charge a peppercorn rent on the building plus a ground rent. No NHSPS involvement. **CIA Option 5** **c)** NHS fund the new build. NHSPS own the asset and enter into subleases with the tenants who are charged in accordance with the PS's new charging policy. MOD charge a ground rent on the land. **d) REMOVED** (A third party developer builds and charges £200/SM (DV rent) to the NHS. MOD charge a ground rent – this option was eliminated as it was not considered practical for a developer to work on an integrated building)

Table 9 – Summary of Options for Financial Modelling

5.3 Capital Cost

AECOM consultancy on behalf of the MoD (and NHS as partner) has estimated capital costs for the whole project with NHS Property Services (NHSPS) providing professional support to the CCG.

Total Capital costs (including inflation and VAT) for each option are summarised in the table below. The costs included in this summary are the midpoint, or most likely costs.

	Option 0 BAU (1) £000	Option 1 Do Minimum (2) £000	Option 2 New Build NHS (4c) £000	Option 3 New Build 3PD (4d) £000	Option 4 Integrated S2 (5b) £000	Option 5 Integrated NHS (5c) £000
Total	0	15,147	61,778	46,620	55,324	55,324
MOD	0	14,711	46,320	46,320	42,633	42,633
NHS	**0**	**436**	**15,458**	**300**	**12,691**	**12,691**
NHS Floor Areas (GIA m2)	1,585	1,585	2,990	2,990	2,490	2,490
Ranking	**1**	**2**	**6**	**3**	**4**	**4**

Table 10 – Capital Costs (including VAT)

The cost estimates have been prepared using the following parameters:

- Main contractor's preliminaries (12.0%)
- Minimum contractor's OH&P (6.5%)
- Inflation : BCIS projection to mid- point of construction
- Risk and construction contingencies
- VAT at 20%

Costs have been based upon utilising rates from recent benchmark data for similar projects with due allowance for assumed specification and scope of works.

A more detailed breakdown of the capital costs is given in table below.

	Option 0 BAU (1) £000	Option 1 Do Minimum (2) £000	Option 2 New Build NHS (4c) £000	Option 3 New Build 3PD (4d) £000	Option 4 Integrated S2 (5b) £000	Option 5 Integrated NHS (5c) £000
Works	0	214	7,923	0	6,476	6,476
Allowance for overheads and profit	0	14	515	0	421	421
Site management, temp works	0	27	1,013	0	828	828
Risk allowance	0	48	1,318	0	1,025	1,025
Prof fees, surverys, planning	0	23	538	0	438	438
Equipment	0	0	250	250	250	250
Project Management	0	0	333	0	333	333
Inflation 2019 to 2022	0	38	991	0	805	805
Total (excluding VAT)	**0**	**363**	**12,882**	**250**	**10,576**	**10,576**
VAT	0	73	2,576	50	2,115	2,115
Total	**0**	**436**	**15,458**	**300**	**12,691**	**12,691**

Table 11 – Breakdown of Capital Expenditure

The profile of capital expenditure sees most costs incurred in the financial years 2021/22 to 2023/24 with a small amount in 2020/21 to reflect design fees. The profile of the capital spend for the preferred Option 5b for an Integrated build through Section 2 transfer (CIA Option 4) is summarised in the table below:

	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Capital Spend in Year	100	1,342	6,952	4,297	12,691

Table 12 – Capital Spend Profile

5.4 Capital Funding

At present, the scheme does not have a confirmed NHS capital allocation. Originally it was intended that the capital spend would be funded by MoD capital, with the NHS taking a revenue charge. It is now apparent that the MoD does not have sufficient capital to support this approach, requiring other sources of capital funding to be explored. These involve either NHS capital or capital accessed through a Third Party developer.

NHS England and NHS Improvement are aware of the challenges of setting out a definitive capital source in the OBC given that the preferred route is a section 2 transfer to the MOD. It has always been recognised that this project was pioneering an approach in joint working with the military and NHSE/I have confirmed that steps will be taken to secure the capital route for the project following submission and review of the Outline Business Case.

The capital funding routes for each option are:

Option 2: Do minimum

There is a relatively small capital requirement for this option with funding by either NHS capital or capital accessed via the existing landlord.

Option 4: New build - standalone health centre on MoD land.

Three funding sources have been considered:

a) Build using MoD capital with the NHS being recharged the capital financing charges. **This has been eliminated as an option as the MoD does not have a capital allocation sufficient to cover the NHS element.**

b) Build using NHS capital. NHSPS would take a long leasehold interest and develop and own the asset with the MoD charging a ground rent. Tenants would enter into subleases with NHSPS and the CCG would provide the agreed commissioner support letter. The subleases to the clinical service providers would reflect NHSPS's charging policy.

c) Build using a third party developer. This option would not require NHS capital and the asset would be owned by the developer. A commercial rent would be charged which would be validated by the District Valuer. NHSPS would take the head lease and sublet to the clinical service providers. The CCG would provide a standard

commissioner support letter. The MoD would charge a ground rent to the third party developer.

Option 5: Integrated new build with MoD (20% NHS, 80% MoD)

Four funding sources have been considered:

a) Build using MoD capital with the NHS being recharged the capital financing charges. **This has been eliminated as an option as the MoD does not have a capital allocation sufficient to cover the NHS element.**

b) Build using NHS capital, with the NHS capital allocation transferred to the MoD under Section 2 (NHS Act 2006). Section 2 can be used to transfer funds to support the innovative development of primary care services. This funding route has previously been used between the NHS and Local Authorities. Under this funding option, the asset would be held by the MoD with the NHS entering into a contract giving the NHS use of the agreed floor areas for an agreed period (currently modelled as 40 years, but potentially up to 60 years). In return for this contract, the MoD would charge a peppercorn rent. MOD have indicated a strong preference to deal with a single NHS tenant. NHSPS could potentially take on the role of head tenant and enter into subletting arrangements with the individual health occupiers. NHSPS have confirmed agreement in principle from DHSC to pass on the peppercorn rental to the subtenants. Initial legal advice via the NHSE team who advise on sec. 2 agreements that it is possible to use this grant route to flow funds to MOD and that it is possible for this to cover the full scope of primary and community services proposed in this scheme. Legal advice will be needed to support development of the final detail on the structure of the commercial arrangements and to ensure that the lease arrangement does not impact on the CCG's balance sheet. The standard commissioner letter of support would be required to commit to this arrangement. A completed S2 checklist is included within the appendices.

c) Build using NHS capital with the NHS capital allocation being transferred to the MoD by mandated transfer. Under this option, the MoD would own the asset and charge the NHS the capital financing charges associated with the asset. NHSPS would hold a head lease with sub leases with individual NHS tenants. NHSE advice is that mandated transfers can only be been used to transfer funds between NHS sectors, rather than between government departments.

d) Build using a third party developer. This option would not require NHS capital and the asset would be held by the developer. A commercial rent would be charged which would be validated by the District Valuer. NHSPS would hold a head lease with tenants having sublease with NHSPS. This is likely to involve commissioner letter of support from the CCG. The MoD would charge a ground rent. **This option is eliminated on the grounds that MOD are unlikely to agree to entering into this kind of commercial structure with a third party developer working on behalf of the NHS on an integrated build.**

5.5 Revenue Costs

The annual premises/operating costs of each option have been calculated by NHSPS on behalf of the CCG. Detailed cash flow modelling has been completed for each of the options and sub-options and is included within the appendices.

Costs for 'Business as Usual' and the 'Do minimum' options are based on current costs. The costs for the new build options are based on:

Rent/capital financing costs based on application of the Treasury rate of 3.5% for the options where NHS capital is used. In the case of a Third Party Developer market assessed rate of £200 per square meter is used.

Premises operating costs were developed jointly with MOD. These are a comparison between facilities management costs from existing NHSPS facilities and specification based quotation from the existing MOD facilities management requirement

Additional costs for insurance, rates and utilities were also identified by the joint project team and agreed for use in both MOD and NHS business cases

Allowance has been made for lifecycle costs for the facility on a per sqm basis

The annual revenue costs calculated on the above basis at 2020/21 prices are summarised in the table below (2027/28 in detailed financial model).

	Option 0 BAU (1) £	Option 1 Do Minimum (2) £	Option 2 New Build NHS (4c) £	Option 3 New Build 3PD (4d) £	Option 4 Integrated S2 (5b) £	Option 5 Integrated NHS (5c) £
Base Rent	158,780	158,780	550,200	550,200	0	458,194
Ground Rent	0	0	10,252	10,252	10,252	10,252
Rates & Operating Costs	94,960	94,960	135,966	135,966	135,299	135,299
Other Site Operating Costs	16,658	16,658	0	0	0	0
Service Charge	8,038	8,038	0	0	0	0
Lifecycling	45,684	45,684	148,889	148,889	123,991	123,991
Facilities Management	97,098	97,098	399,021	399,021	332,295	332,295
Management Fees	10,589	10,589	39,902	39,902	33,230	33,230
Lease Management	0	0	58,583	58,583	58,583	58,583
VAT	84,244	84,244	241,370	241,370	111,670	203,309
Total Recurring Annual Cost	**516,051**	**516,051**	**1,584,183**	**1,584,183**	**805,320**	**1,355,152**
Recurrent Revenue Costs Increase	0	0	1,068,132	1,068,132	289,269	839,101
CIA (GEM) Total Revenue Costs	199,273	199,273	305,397	662,009	261,788	261,788

Table 13 - Annual Rent and Operating Costs

Note: Table above shows the benefit of the Section 2 transfer option to the CCG, being significantly cheaper than the other new build options.

The revenue costs estimated for 2027/28 are used to provide estimated recurrent costs as this is the first year when revenue costs are at a steady state as the financial model assumes closure and cost release recurrently from both the Harewood practice premises and the Colburn branch of the Catterick Village practice. The Harewood practice premises are owned by NHSPS with costs released in 2025/26 and the Colburn branch premises are owned by Assura Healthcare Properties Ltd with costs released when the lease expires in November 2026.

For financial modelling, it is assumed that this lease will run to its expiry date. The CCG intends to explore how this can be mitigated either by agreeing an early surrender or a temporary subletting of the vacated space.

A number of services will move from the Friary Community Hospital to the CICC. The areas vacated are planned to be re-used by services moving in to the Friary as part of the Richmondshire estates strategy. As such they represent an opportunity cost rather than a cash releasing benefit.

In addition to these three main sites, premises costs will be released at the Colburn Children's Centre and at the Innovate unit on the Catterick Business Park. As the contractual position for these two premises is not known at present and any cost released will be minimal, they are not included in the financial appraisal.

5.6 Affordability

The key consideration for the CCG is whether the estimated annual running/revenue costs are affordable. The projected annual recurring revenue costs for the preferred option of an integrated new build through a section 2 transfer is circa £805k per annum including VAT. This compares against £516k per annum that is the 'business as usual' current expenditure. There is therefore a funding gap of circa £289k per annum.

The CCG is aware of the need for investment in the primary care estate, irrespective of the development of the Catterick Integrated Care Campus (CICC), and therefore recognises that the affordability gap is not solely due to the development of the new scheme.

Primary care costs have been assessed to estimate the impact on practice income as a result of the population growth in Catterick due to the MOD rebasing exercise and the transfer of an element of the Colburn practice list. This assessment estimates an average £40k per annum increase in practice income. It is assumed that the increase in practice allocation arising from the increase in list size will enable the practice to provide a financially stable primary care service.

As NYCCG is above its fair share target allocation for primary care, the CCG is unlikely to receive an increased allocation for the increase in population. This will therefore be a cost pressure that will fall to the CCG.

Primary care receives a specific allocation which is based on a needs based formula (Cahill). There is strong evidence that the current formula does not fully reflect the needs of a military population. The CCG is in dialogue with NHSE/I regarding this, and while no change to the current formula is expected, it hopes to influence the allocation methodology beyond 2023/24. While this is the CCG's objective, no assumptions regarding a change in practice allocations is assumed.

All current service providers have given support to the CICC scheme on the basis that there will not be any additional premises costs above their existing tenancy costs. Detailed work is required to determine the impact on each tenant/occupier and this will be undertaken following completion of the design phase.

The preferred option will therefore result in a total funding gap of circa £329k per annum that will require the CCG to plan for as an investment. The CCG expects to support this funding gap by cash releasing savings delivered through CCG transformational schemes and/or accessing primary care transformation funding through the ICS.

5.7 Financial Risks

The Harewood practice is facing considerable financial pressure due to local population need not currently being recognised within the national formula. The CCG and NHSE are providing additional support to the value of £201,000 through a Section 96 agreement, for the year 2020/21, to be reviewed for future years. It is assumed that the increase in practice allocation arising from the increase in list size will enable the practice to provide a financially stable primary care service. The practice is working with the CCG on a new model of care that will support this assumption until a fully integrated model of care as part of the CICC is established. It is expected that the additional financial support will be needed until the allocation has reached a level that is sufficient for the practice to be financially sustainable and for the new model of primary health care to have an impact on cost. For this to be effective, the benefits of integration need to be fully realised, otherwise it is likely that primary care costs will continue to grow above CCG allocations.

There is a serious risk that, should the issues at Harewood not be addressed through an integrated build solution, the GPs would resign, handing back the contract. Should this happen the CCG would have to seek to support the GP services through other means such as; identifying another practice to take over the list, tendering for a new out of area contract provider or (worst case) dispersing the list. A rough estimate of this suggests a cost of £500,000 per year, with this continuing until a solution has been sought. This is a serious risk under the 'business as usual' and 'do minimum' options and is included in the CIA.

5.8 Economic Appraisal

The economic appraisal has been carried out using the Comprehensive Investment Appraisal (CIA) model and in accordance with the HM Treasury's Central Guidance on Appraisal and Evaluation ("The Green Book").

The CIA calculates the best public/social value of the options by way of a Benefits Cost Ratio (or value for money threshold) that measures the financial relationship of benefits to

costs, with the option with the highest ratio being the option that supports best value for money.

A summary of this from the CIA model is shown below which shows that the fully integrated scheme Options 5b & 5c has the highest ratio and provides the best public/social value.

Economic Summary (Discounted)	Option 0 BAU (1) £000	Option 1 Do Minimum (2) £000	Option 2 New Build NHS (4c) £000	Option 3 New Build 3PD (4d) £000	Option 4 Integrated S2 (5b) £000	Option 5 Integrated NHS (5c) £000
Total Incremental Costs	0	-377	-17,763	-14,144	-13,916	-13,916
Total Incremental Benefits	0	2	11,037	11,037	14,388	14,388
Risk-adjusted Net Present Social Value (NPSV)	0	-375	-6,725	-3,107	472	472
Benefit-Cost ratio		**0.01**	**0.62**	**0.78**	**1.03**	**1.03**

Table 14 - CIA Model

5.9 Financial Evaluation

The outcome of the capital costing, economic appraisal and affordability assessment are summarised in the table below.

	Option 0 BAU (1) £000	Option 1 Do Minimum (2) £000	Option 2 New Build NHS (4c) £000	Option 3 New Build 3PD (4d) £000	Option 4 Integrated S2 (5b) £000	Option 5 Integrated NHS (5c) £000
Total Capital Cost	0	436	15,458	300	12,691	12,691
Ranking	**1**	**3**	**6**	**2**	**4**	**4**
Total Revenue Costs/Affordability	516	516	1,584	1,584	805	1,355
Ranking	**1**	**1**	**4**	**4**	**3**	**6**
Benefit Cost Ratio (NPSV)	0.00	0.01	0.62	0.78	1.03	1.03

Table 15 – Capital costing, Economic Appraisal and Affordability Assessment

An integrated new build funded by a Section 2 transfer gives the best all round financial outcome, having the lowest capital cost of the new build options, a strong affordability assessment and the best return on investment.

6. Management Case

The purpose of this section of the Business Case is to address the achievability of the preferred option and to set out the management arrangements that will be required to ensure the successful delivery of the scheme, in accordance with best practice.

This section of the Business Case also requires the spending authority to specify the arrangements for monitoring during implementation and for post implementation evaluation, as well as for Gateway reviews (where applicable), and the contingency plans for risk management of the scheme.

6.1 Project Plan

Current proposals are summarised in the table below.

Milestones		Date	Responsibility
CICC: phase 1 – CONCEPT - authority to proceed			
1	OBC completed and approved by Governing Body	June 2020	NYCCG
2	OBC submitted to Region NHSE	June 2020	NYCCG
3	OBC submitted to MOD	June 2020	NYCCG
4	Authority to proceed granted based on OBC and future project costs underwritten	By Sept 2020	NHSE Region
CICC: phase 2 – DESIGN - partnership and risk sharing agreements/full business case			
5	Developed design option completed and approved	By Nov 20	NHS PS/MOD
6	MOD Main Gate and NHS FBC	By July 21	NHS/MOD
CCC: phase 3 – IMPLEMENTATION - new build/service transition			
7	RIBA stand still period	Aug 21 – Jan 22	MOD/NHS PS
8	Construction period	Dec 21 – Sept 23	MOD/NHS PS
9	Services reconfiguration/transition plan implemented	Dec 21 – Sept 23	NYCCG
10	Building opened / re-basing exercise completed	By Sept 2023	All

Table 16 – Current Proposals

Please see Appendix 31 for the Phase 1 'authority to proceed' plan and whole life composite programme plan.

6.2 Project Management

Since the initial HRW CCG internal approval of project concept and approval of the PID in 2018, the organisational structure of the CCG has changed. HRW CGG became part of the North Yorkshire Clinical Commissioning Group on 1 April 2020. Until this date, a transitional governance framework was in place, with a new structure being formalised in January 2020.

The project has been raised within the transitioning CCG governance framework at:

Directors Board on 25 November 2019 and 10 February 2020
Joint Finance, Performance and Contracting Committee on 5 March 2020
Tabled at Governing Body on 23 January 2020 and on 26.March 2020 where the PPOA was approved.
Joint Business and Executive Committee on 29 October 2019

It is therefore well placed and socialised within the new CCG governance framework.

Please see Appendix 32 for the current project team, roles and resources.

Please see Appendix 33 for the project management structure

6.3 Programme Management

The CCG and MOD resources are supporting the work to secure the CICC as it is a core responsibility of commissioners to ensure the health and wellbeing of its registered and resident population including the military dependants from the current Garrison (and future expansion to the ‘’Super Garrison’’). They are using existing governance mechanisms to report along with regular informal meetings of both health and military senior leaders.

6.3.1 Project Management Arrangements

The programme is being managed in accordance with the PRojects IN Controlled Environments (PRINCE2) methodology and the Managing Successful Programmes (MSP) programme management approach. The management of the programme will remain with the MOD as the majority occupier of the build. However, as we have done from the outset of this work, we will continue to work as equal NHS and MOD partners throughout the coming phases of the work.

Funding has been included in the proposals to meet the costs of the design phase activities (£400k).

NHS budget for the design phase of the work which will be used to buy input from specialist advisors as well as on-going programme delivery from the NHS team. There is also a firm commitment from all providers who will occupy the building to resource the design phase and legal commitment stage in preparation for FBC. Details of this will be developed once we have received approval of the OBC.

6.3.2 Integrated Commissioning

The move to a model of integrated primary and community care across the NHS and military organisations must enable the delivery of improved services to the local population, including Armed Forces personnel and dependents that addresses;

- Health outcomes;
- Quality of care; and,
- Delivers a financially sustainable health and care system.

This aligns with the principles of place-based commissioning, where the commissioning of services is co-ordinated in an area to achieve maximum benefit for the local population.
Often the most advantageous mechanism to achieving this financially is via a whole population budget or capitated budget structure. The commissioners would need to extensively redesign and agree new pathways across multiple providers whilst also focusing heavily on the elements of strategic commissioning, in order that they best represent the public and population interests and hold the integrated delivery system to account.

There is a need for system wide governance and accountability arrangements sitting alongside contracting and any relevant included National Health Service Act 2006: Section 75 arrangements. The CCG will continue to work with our integrated care system partners across Humber, Coast and Vale (HCV) to align the vision, objectives and goals across the wider system, to ensure accountability to the arrangements and to provide a contract and performance mechanism overlaying risk and benefit sharing arrangements between partners.

Throughout the development of this work, the CCG have consulted with colleagues at NHSPS and NHSE – through the capital and estates and finance directorates. This has allowed us to shape the work in line with assurance and approval guidance prior to submission for approval from our regional and national colleagues. It is expected that this approach will continue to evolve and that the CICC Programme Board will provide assurance on progress under the vision of the scheme.

A programme of work will be developed prior to the NHS FBC and MOD MGBC to ensure the delivery of outputs that will enable both the CCG and MOD to meet their respective statutory responsibilities and public accountabilities. The detail of specific governance, Terms of Reference (ToR) including membership of each group will evolve and require approval in tandem with the forthcoming development of the NHS FBC and MOD MGBC.

6.4 Project Reporting and Monitoring

The CCG Project Manager oversees a detailed programme plan and produces a monthly Dashboard for the SROs to give a position and assurance regarding the progress, delays, risks and issues. All Local Steering Group members are asked to contribute to this to ensure a balanced and informed reflection. The programme plan is monitored and overseen by the Local Steering Committee (LSC) which meets monthly and reports progress on a quarterly basis into the Programme Board and SROs. The monthly dashboard is approved by the LSC before its goes to SROs. The quarterly Dashboard is scrutinised by the Joint Programme Board at each if its meetings.

Please see Appendix 34 for the project meeting cycle and reporting mechanisms.
Please see Appendix 35 for the Joint Governance Framework
Please see Appendix 36 for the CCG governance structure

Key governance bodies consist of a collective of members from the NHS and MOD organisations as well as GPs and GP representatives, stakeholder organisations and providers. These form the basis of the programme architecture and are set out below:

6.4.1 CICC Programme Board

The CICC Programme Board (PB) works strategically, meets quarterly and has responsibility for the overall delivery of the programme and achievement of the vision, blueprint and strategic aims of the programme. The PB will agree, in principle to any funding decisions, resourcing and any deviation from the programme plan, see Appendix 35. The PB is co-chaired by the NHS and MOD Senior Responsible Owners (SROs) and will report progress into relevant local, regional and national bodies. Membership is cited within the CICC Programme Board's Terms of Reference (ToR) which is included at Appendix 37.

6.4.2 Local Steering Committee

The Local Steering Committee (LSC) has responsibility for operations and meets monthly (or more often where needed) to oversee the day to day delivery of the Programme and is accountable to the Programme Board for the delivery of the vision and Programme Plan. The LSC is co-chaired by the NHS and MOD. Membership is cited within the committee's ToR which is included at Appendix 38.

6.4.3 Working Groups

Working Groups meet according to the programme stage and project delivery requirements. The Working Groups are accountable to the LSC for all aspects of operation and will produce highlight reports to appraise the LSC of delivery, risks and issues. Membership is cited within the groups ToR which is included at Appendix 39.

6.4.4 Strategic Engagement Advisory Group

The Strategic Engagement Advisory Group (SEAG) will champion a culture of collaboration, innovation and entrepreneurialism in its attitude and ways of working, meeting on a quarterly basis or ad-hoc, if required. It will ensure that the needs of patients and service users remain at the heart of developments, communication and engagement. It will ensure that the commitment to the CICC Programme is sustained through effective communication and engagement. Membership is cited within the groups ToR which is included at Appendix 8.

The Communications and Engagement Working group will update the Strategic Engagement Advisory Group and act on behalf of this Group and it will be supported by the CICC Programme team.

6.4.5 Programme Management Office

The MOD Programme Management Office (PMO) will administer and host the activities of the Working Groups and is the information repository in which communication, risks and issues can be shared with the CICC Programme Board, Local Steering Committee and Strategic Engagement Advisory Group. The NHS team will support this by providing programme management assistance, specific technical advice on NHS requirements, construction, procurement, property and estates from NHSPS as NHS property partner.

The Programme Management Team (PMT) administers all groups to ensure that the programme is successful. The team will complete all programme administration, including all project logs and supply the management tools and frameworks for use by the Programme Board, Local Steering Committee and Working Groups. The PMT will be a joint function,

working in line with matrix management principles and consists of core staff from both the MOD and NHS. A formal joint PMO is to be developed ready for the next phase.

6.4.6 Joint Programme Directors

Joint Programme Directors (PDs) co-ordinate all activity and direct the programme to support milestone delivery. Where there are risks to the timeline, mitigations are actioned to reduce potential impacts whilst escalating appropriately to the joint SROs and PB. The Programme Directors (Lisa Pope, NHS and Andrew Smart MoD) are supported by a Programme Manager (Karen Hughes, MoD) and the Programme Management Team (Mandy Peacock, NHS and Sian McDonald, MoD.

6.4.7 Clinical User Group

The Clinical User Group (CUG) will be established during the detailed design phase of the work and will ensure the clinical functionality of the building design and fulfilment. The membership of the CUG will be defined and agreed prior to the NHS FBC stage and will consist of senior medics from the CCG, MOD, GPs and wider provider organisations who will interface with the CICC. Output from this group will be fed into the clinical operating model working group.

To ensure the scheme continues to maintain traction and momentum, all LSC partners must agree to a decision as required at the monthly meetings. Where not all partners are present (but the meeting is quorate by the groups ToR) and either;

- A decision is needed: or
- A decision needs agreeing by one or more organisations' internal approvals processes.

Then the nominated lead for each organisation will undertake to supply agreement to a decision within agreed timescales.

6.4.8 Meetings

CICC scheme meetings are convened on an agreed basis as defined in each set of ToR. A summary of which is provided in Figure 15: CICC Programme Governance Meeting Structure:

Purpose	Group	Meeting Frequency	Formal Minutes / Notes Taken
Decision making	The Programme Board (PB)	Quarterly	Yes
Reporting	The Local Steering Committee (LSC)	Monthly	Yes
Reporting	The Working Groups (WGs)	Ad-hoc	Yes
Reporting	The Programme Management Team	Monthly	Yes

	(PMT)		
Reporting	The joint Programme Directors (PD)	Monthly	Yes
Reporting	Clinical User Group (CUG)	Monthly	Yes

Figure 15: CICC Programme Governance Meeting Structure

The CICC reporting cycle has been defined and embedded in practice to facilitate the relevant flow and timings of meetings to ensure the overall governance, accountability and integrity of the programme. This is set out in Figure 16: CICC Programme Governance Reporting Cycle:

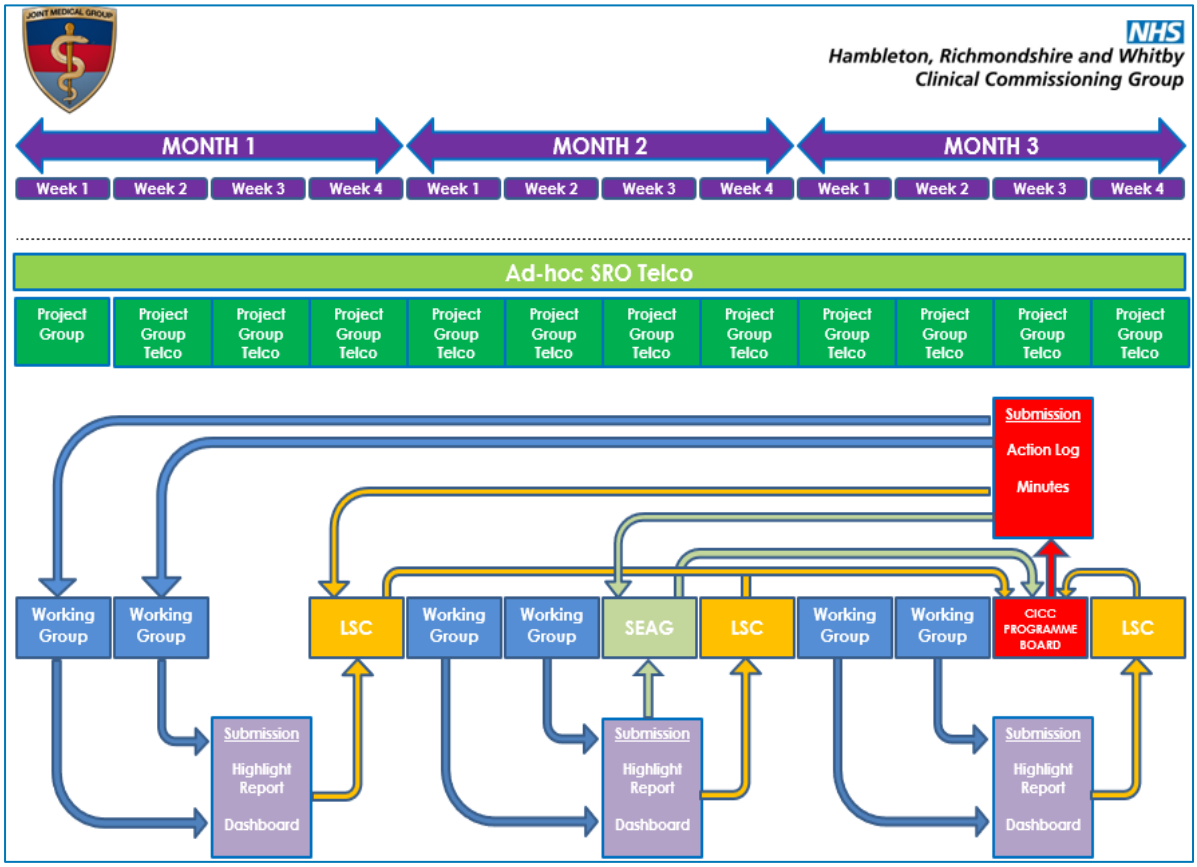


Figure 16: CICC Programme Governance Reporting Cycle

6.5 Benefits Management

A benefits realisation plan has been developed and is included at Appendix 18. This will be developed further between OBC and FBC.

6.6 Change Management

Change management associated with the scheme will be managed through the CCG Executive Committee, under the leadership of the Accountable Officer (AO) and SRO. Day to day change management issues will be discussed at the Local Steering Committee and any resultant contract and/or cost changes will need to be approved by the relevant

authorised decision-making group (where delegated) or within the approving organisation (where not delegated).

Due to the level of anticipated integration and co-location that the campus embodies there is significant perceived expected organisational impacts. This will take current organisations from sovereign entities to partners within a wider economy, accountable to each other and to levels that will be specified in the Integration Agreement that will be needed between all party providers. Levels of change will be measured in the successful achievement of the outcomes and metrics that are to be included in the Integration Agreement. Development of this additional agreement will need to be commenced before completion of the NHS FBC in order to adequately inform the potential and scale of integration possible.

Change management associated with the scheme will be managed through and under the chairmanship of the joint SRO. Day to day change management issues will be discussed at the Local Steering Committee and any resultant contract and/or cost changes will need to be approved by the CICC Programme Board.

Governance

The NHS Hambleton Richmondshire & Whitby CCG agreed the proposed development of the CICC following detailed accounts of the challenges faced and fatalities suffered by the MOD with their mental health offering to Armed Forces personnel. In addition, the significant Armed Forces personnel and dependent rebasing presented a once in a generation opportunity to realise a system level ambition to integrate wider MOD health and NHS health, along with allied health and care services into a unified offering to the public and workforce of Catterick and its surrounding areas.

The CICC approach to health and care was first considered and agreed in 2015 and the model was pursued in the coming 36 months culminating in a Feasibility Study (2017) and PID in 2018 and finally, the Post-PID Options Appraisal in March 2020. These clearly set the ambition, scale and initial outlook on timeline to realisation and service commencement.

Regular update reports from the governing structure committees and groups have been received by both the NHS and MOD as part of the ongoing Project Assurance Framework surrounding the programme as detailed in Figure 17: CICC Programme Governance Structure:

Domain	Level 1	Level 2	Level 3	Level 4
ICT System interoperability	Separate ICT systems – no interoperability or electronic record sharing	Electronic medical record shared across providers	As per 2, plus service user interface with outcome	Systems are integrated, and data aggregated across multiple providers

Workforce	The workforce model is centred around single episodes of treatment and the skills of the workforce are not well matched to future needs	Multi-disciplinary initiatives are in place, reflecting a full range of competencies and skills to meet patient needs	Workforce requirements and service redesign underpin ICS/ICP planning of new models of care	Innovative service redesign and workforce drive improved productivity and outcomes within and across organisational boundaries
Physical Estate and Assets	No estate profile across organisations	Estate profile shared across organisations	Integrated estate strategy across organisations (early stages)	Estate aligned to ICS/ICP strategy and compliant

Figure 17: CICC Programme Governance Structure

During the design phase of the work the care model will require further detailed development to specify the pathways, levels of integration and to identify the opportunities and mechanisms that will be realised and become integrated across the NHS and MOD medical delivery. This will include the development of the commissioning and contracting of the model to ensure its long term sustainability. We will ensure that all key partners are engaged during this key phase of the work, including Council Lead Officers across both NYCC and RDC, to ensure that the model will offer long term sustainability for the public across the health and care economy and service continuum.

6.7 Risk Management

Managing risks

In line with the MOD project requirements a fully costed joint risk log was created for each of the Assessment Study options at the workshop conducted by AECOM on 10 April 2019 which identified risks applicable to each potential option. All these risks are captured in the risk registers cited at Appendix 40. The risks have been subject to a Monte Carlo Simulation and the risk allowances as noted in the table below are the result of the model output. The risk allowances are based on the 'post mitigation' results at 10% (minimum), 50% (most likely) and 90% (maximum).

The risk registers shall be further reviewed as survey and design information is developed and shall remain a live document for the duration of the project. Based on a data set generated from 10,000 Monte Carlo Simulation iterations the following is noted:

Risk Summary (Post Mitigation)	Option 1	Option 2	Option 3	Option 4	Option 5
There is a 90% chance the outcome will be less than	N/A	£2,980,010	£9,214,780	£8,860,880	£7,736,840
There is a 50% chance the outcome will be less than	N/A	£1,834,820	£6,048,070	£5,609,930	£4,951,100

There is a 10% chance the outcome will be less than	N/A	£944,890	£3,343,200	£2,923,230	£2,591,690
There is a 10% chance the outcome will be more than	N/A	£2,980,010	£9,214,780	£8,860,880	£7,736,840
There is a 50% chance the outcome will be more than	N/A	£1,834,820	£6,048,070	£5,609,930	£4,951,100
There is a 90% chance the outcome will be more than	N/A	£944,890	£3,343,200	£2,923,230	£2,591,690

Table 17 – Costs for the risks based on the Monte Carlo simulations

Please see Appendix 41 for the risk log.

In addition a joint Project Risk Log is in use and reported against monthly at the Local Steering Group.

The key project risks are reported and managed via the Local Steering Group and presented to the Joint Programme Board through the quarterly Dashboard. The Joint Programme Management Office will manage the production of the dashboard and Risk Log once established post-OBC approval.

Please see Appendix 42 for February 2020 Dashboard

6.8 Use of External Advisers

The MOD are the lead partner in the CICC scheme. In line with MOD process they use the Defence Infrastructure Organisation (DIO) to provide project management and specialist property advice in the development of schemes with a built element. Joint Forces Command is responsible for the delivery of healthcare services to MOD personnel. They are the client for delivery of the CICC project. The MOD partially funded the feasibility study procured by NHSPS and have fully funded the Assessment Study which was delivered by AECOM as the TSP partner.

The NHS have been provided with property and infrastructure development support by NHS Property Services. This support included part funding of the initial feasibility study and ongoing support in the development of the PPOA and OBC and partnering in the project teams. Attain were appointed to produce the NHS OBC which has subsequently been further developed and delivered by the CCG Project team including NHSPS.

A range of specific advisors will be required by the NHS to support the design phase, procurement and development of FBC. Advice requirements and anticipated source are noted below.

Programme Management	MOD PMO
Procurement technical services partner	MOD / DIO
Consultation & Engagement Activities	CCG delivered
NHS Project Management	CCG
Valuation, Lease arrangements for general practice and VfM	Valuation Office Agency
BREEAM	Specialist Advisor external appointment
Legal advice – CCG commitments	CCG appointment
Legal advice property and contract documentation for scheme	NHSPS Appointment with recharge to CCG
Contract / Lease documentation advice	NHSPS to provider commercial property / Acquisition advice
Subletting Agreements (if required)	NHSPS appointment of legal advisors and co-ordination
Tenant / occupier legal advice	Occupier appointment and cost
P22 documentation, procurement and selection	NHSPS Construction team to provide specialist advice and co-ordination for NHS occupiers
Design development	NHSPS Construction team to provide specialist advice and co-ordination for NHS occupiers
Financial Evaluation & Analytics	NHSPS E&A team to support further development of financial modelling and CIA
Business Case Production	NHSPS to provide estates and commercial inputs and support FBC development

6.9 Enabling Functions: Maturity Matrix Assessment

A very broad initial assessment of the maturity matrix has been completed, based on several implementation tools used widely across the public sector. The current assessment is that the infrastructure and resource profile are at level 1. In order to achieve each level, the system must be compliant across all domains before progressing to the next level. It is envisaged that as the scheme progresses through the gateway reviews towards design and construction, and to operational delivery, the assessment will progress to level 3 in a relatively short period of time, see Figure 18: Maturity Matrix Assessment Grid.

Domain	Level 1	Level 2	Level 3	Level 4
ICT System interoperability	Separate ICT systems – no interoperability or electronic record sharing	Electronic medical record shared across providers	As per 2, plus service user interface with outcome	Systems are integrated, and data aggregated across multiple providers
Workforce	The workforce model is centred around single episodes of treatment and the skills of the workforce are not well matched to future needs	Multi-disciplinary initiatives are in place, reflecting a full range of competencies and skills to meet patient needs	Workforce requirements and service redesign underpin ICS/ICP planning of new models of care	Innovative service redesign and workforce drive improved productivity and outcomes within and across organisational boundaries
Physical Estate and Assets	No estate profile across organisations	Estate profile shared across organisations	Integrated estate strategy across organisations (early stages)	Estate aligned to ICS/ICP strategy and compliant

Figure 18: Maturity Matrix Assessment Grid

Further work on the implications for each of these elements will be carried out in the NHS FBC stage; however the following key points have been identified from the Implementation Matrix.

6.9.1 Information and Communications Technology System Interoperability

Forecasting the granular detail of the solutions required to enable the aims of the CICC is a challenge due to the exponential rate of system step-change within the Digital Healthcare arena. In light of this an initial direction can be defined from current developments and their trajectories with further detail being applied in an iterative manner.

The current design of the MOD CORTISONE programme is aligned with industry best-practice and towards full and native interoperability with existing NHS national systems and services in addition to healthcare interoperability initiatives such as GP Connect, GP IT Futures, and the Local Health and Care Record (LHCR)

CORTISONE will consume the same Primary Care Systems as English NHS GPs through a parallel Defence Medical IT Futures framework. This will lay the foundations for interoperability between both civilian and defence aspects of CICC by applications of common standards which can be further enhanced as NHS Interoperability initiatives (such as GP Connect, LHCR etc.) grow.

As well as the standardisation of consulting rooms and equipment within the CICC it should be anticipated that desktop hardware would also be standardised as far as possible with common peripherals (such as displays, printers, smart card readers, and medical devices) on the desk for portable, secure end-user devices to be brought in by the user at the start of their sessions and connected using a simple port replicator or similar.

Developments in network standards, segregation and security are improving at a similar pace allowing for this approach to continue however policy and technical decisions will need to be made around the detailed application of the ICT infrastructure (and media e.g. separate physical Ethernet structures or Wireless SSIDs) aspects.

Finally, there will also be a clear requirement to align governance and staff procedures further as technology is purely an enabler.

Some of the key challenges for Information and Communications Technology (ICT) are:

- Professionals have no 'single view of the person' and their care journeys;
- Lack of care co-ordination within and between care settings which can limit patient flow;
- Absence of technological solutions leads to inefficient processes;
- The absence of an integrated electronic care record makes patient experience and pathways fragmented. Those with complex long-term conditions face a disjointed service which can lead to unnecessary and costly admissions to hospital; and
- Information sharing agreements are not in place.

An Informatics Board requires establishing by the CCG which consists of all health, military and social care providers at Information Technology and Information Governance Director Level involved across the geography. Full access to records should be explored as part of the Local Digital Record or Informatics Board scope of work. Plans are recommended as a baseline until the new integrated care model can be operationalised which will break down organisational barriers, unify teams and enable digital processes to be refined.
From an interoperability perspective, local plans to develop a Health and Social Care Information Exchange to deliver a local care record across the geography would, from other systems' experience, cost broadly £6m and take up to 10 years to fully deliver.

The established IT and IM Working Group is working to clarify the current and future IT requirements of both parties, in line with the 2022 GP and NHS Long Term Plan, and will outline how these requirements will be aligned ahead of completion of the FBC.

6.9.2 Workforce

The design of the CICC addresses several workforce challenges, such as:

- Workforce not designed to manage the increasing number of complex patients;
- Clinicians' capacity to spend a meaningful amount of time with patients; and Health professionals are task orientated – need to take a holistic view of the patient.

Three overarching themes have been identified to simplify and conceptualise how to enact change to counter these issues:

- Theme 1: Achieving Teamwork and Integration;
- Theme 2: Managing Demands on Capacity and Capability; and
- Theme 3: The Delivery of Holistic, Person- Centred Care.

It is expected that following completion of the New Care models workforce assessment tool for the CICC, a collective system wide Workforce and Leadership Development Group would

be created to effect change and implement recommendations. This Group will support the creation of a baseline analysis of proposed changes to service delivery and will work with partners to ensure alignment of workforce plans. This will be progressed as part of the NHS FBC development. This will be developed under the Programme Governance Structure and lead by the HR and Training specialists from both the MOD and NHS within the Working Group.

6.9.3 Estates

There are many estates challenges, such as:

- There is a significant amount of unsuitable existing physical infrastructure for the health and care needs of the future population;
- It is important that the new proposed infrastructure is optimised to represent both significant value in addition to increased capacity that could also be used for alternative service provision; and
- An enhanced infrastructure should be leveraged or utilised in such a way as to deliver greater value for all its residents.

There is multi-agency estates involvement across the geography. This offers good baseline information and suggests opportunities for usage and savings to be considered by providers. It is recommended that a formal multi-estates strategy (one estate strategy) be developed and agreed between all parties.

As the scheme develops towards final agreement, it is recognised that a longer-term strategy is required to support the continued integration of services in line with the new care model. The system partnership needs to be fully represented as part of the local Estates Forum as well as initiating work to review existing accommodation and consider the use of estate across the wider North Yorkshire footprint in the future.

The CICC itself should enable better implementation of the Estates Strategy and may provide further savings as yet unspecified due to the campus approach and philosophy of co-location and ultimately integration.

For the purposes of the NHS OBC, the Estates Strategy should therefore be seen as both enabling, and being enabled by, the CICC to support subsequent sustainability for the health and care system. This will be developed under the Programme Governance Structure and lead by the Estates and Infrastructure specialists from both the MOD and NHS within the Working Group. The MOD has confirmed that the CICC building will be built to NHS Clinical Standards.

6.9.4 Patient Transport Services

Transport enables the proactive care, rehabilitation and rehabilitation of high volumes of low intensity patients and pre-patients. Transport is better able to support optimal use of services (i.e. the CICC) outside of the traditional hospital environment.

The impact on Patient Transport will also be assessed as part of the NHS FBC development for the scheme.

NYCC has worked with RDC and the Defence Infrastructure Organisation (DIO) on the revision of the Richmondshire Local Plan and the Catterick Garrison Master Plan over the last two years. As a part of this, NYCC has requested its transport consultants, WSP to complete an exercise towards the development of a new Strategic Highway Model (SHM) for the area. At the time of writing, the survey report is not available.

The Strategic Transport Assessment has demonstrated that the already committed development plus the development coming forward through the Local Plan up to 2035 will not have a significant impact on the highway network. Some impact will occur to 6 junctions along the A6136 and Gatherley Road, but the impact is such that it could be mitigated by relatively minor local intervention, that could come forward through the development management process.

Specifically for the CICC, no particular highway impact has been identified, and RDC have confirmed through their Transport Study of 2019 that no additional road network modifications will take place or that the additional housing will make a significant difference to the traffic flow. It has however been agreed that additional bus stops will need to be created to enable access to the new build.

6.10 Post Implementation Review

The Post Implementation Review (PIR) reviews ascertain whether the anticipated benefits have been delivered and are timed to take place immediately after the CICC opens and then 2 years later to consider the benefits planned against realisation. These will be programmed into the scheme's timeline.

Managing the Scheme

It is recognised that the benefits of the CICC will be realised through the integration and transformation opportunities that it presents as well as through the transfer of health and care services.

The governance arrangements to support the development of the CICC, including the introduction of an Integrated Commissioning Group (ICG) will be kept under review throughout the detailed design, construction and go live of the scheme. This will ensure they remain fit for purpose and proportionate to the size and scale of the CICC.

It is universally recognised that health and care services need to be much better co-ordinated around the individual, to ensure that the right care is offered, at the right time and place. Local authorities and CCGs should be able to demonstrate how those outcomes will be achieved for their local population through a single commissioning function and a single integrated budget. Recognising that tailored approaches are required, the CCG and Local Authority should agree locally how best to integrate commissioning, responsibilities and budgets.

The case for change in commissioning health and care services is overwhelming – the current fragmentation of commissioning arrangements is not sustainable.

As the Commission on the Future of Health and Social Care in England acknowledged:

'moving to a single budget with a single commissioner is not a sufficient condition to tackle the myriad problems that face health and social care. But we believe it is a necessary one.'

Forty years of successive attempts to achieve closer alignment between health and social care resources underline the scale of the challenge, but with widespread support for the goals of integrated care this presents an unprecedented opportunity to make significant progress.

Due to the philosophy of the CICC and the integrated nature of service provision being defined as a new model of care, any future procurement involving delivery from the campus could be recognised as a "novel procurement" by NHS England & Improvement. Where this is the case, there will be the clear need to proceed through the relevant checkpoints that make up the Integrated Support and Assurance Process Framework.

There will be the need to develop a number of enablers to support system wide transformation e.g., strategic workforce planning, strategic estates, Information and Communications Technology (ICT) and shared records across the health and care system as set out in the Strategic Case.

It is recognised that the CICC itself is a key enabler to elements of wider system transformation in the Richmondshire Model of Care and associated health and care economy.

A number of key risks have been identified as set out below:

i. System sustainability;
ii. Challenging timescales;
iii. Ongoing engagement; and
iv. Development of the formal relationships and partnership agreements.

The NHS OBC has set out: governance, high-level risk assessment, enabling functions and a development plan that will form the basis of the work programme to NHS FBC, together with strategic integrated commissioning principles. This will be supplemented with detailed transition and mobilisation plans to ensure migration to the CICC in 2023.

6.11 Outline Arrangements for Post Project Evaluation

The outline arrangements for Post Project Evaluation (PPE) have been established in accordance with best practice. As such, the scheme will be evaluated against the investment objectives set out in the NHS OBC, and the processes involved in the scheme delivery. The CCG and MOD will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the scheme.

These will be of benefit to:

- The CCG and MOD – in using this knowledge for future capital schemes across the Country;
- Other key local stakeholders – to inform their approaches to future projects;
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively; and
- Contractors – to understand the health and care environment better.

The evaluation will examine the following elements, where applicable at each stage:

- The effectiveness of the project management of the scheme – viewed internally and externally;
- The quality of the documentation prepared by the CCG and MOD for the contractors and suppliers;
- Communications and involvement during procurement;
- The effectiveness of advisers utilised on the scheme;
- The efficacy of NHS guidance in delivery of the scheme; and
- Perceptions of advice, guidance and support from NHS England & Improvement and NHS PS to progress the scheme.

Formal post project evaluation reports will be compiled by project staff and reported to the CICC Programme Board to ensure compliance to stated objectives.

7. Conclusion, recommendations and next steps

Our intention is to commission truly integrated, holistic, future-proofed health and care services across the whole of Catterick Garrison and in support of the wider rural hinterland. By creating an active partnership between primary, secondary, community and mental health provision through both the NHS and Defence Medical Services, we are now able to articulate a vision that will enable the whole population to experience equal access to high quality services in the most efficient way.

Regarding the specifically disadvantaged military population, our aim is to support the veterans, reservists, and the dependants of serving forces personnel of Catterick Garrison to be healthy and well and, when they're not, to ensure that they have access to high quality, holistic, and integrated, local health services.

The current health and care landscape for armed forces personnel, families and veterans is confusing and fragmented. The substantial presence of this military population in Richmondshire also reduces the average age of the population as a whole and masks local economic conditions because personnel are fully employed. These patients bring a range of specific health care issues, but the needs of this demographic can also obscure those of the local population.

Over the last five years, during which time this programme has been developed, we have worked hard to ensure that commissioners and partners work in a joined up way and build upon existing relationships to commission high quality, safe and effective care for both the Armed Forces Community and the civilian population - in accordance with the Armed Forces Covenant and the NHS Constitution.

To support the delivery of our vision of care, this programme will enable the design and creation of new, modern, integrated community health facilities on a major strategic site. This will include holistic health and social care provision and opportunities for wider partnerships with the voluntary sector, private sector and other services.

Our shared aim, which is to develop truly integrated NHS and MOD health and care services through redevelopment, regeneration and reimagining of provision for the first time in the world, means that we have a unique, once in a generation opportunity.

Moreover, it will continue the development and delivery of an integrated health and care system - which is at the heart of our vision for North Yorkshire Clinical Commissioning Group’s ambition to improve the health and well-being of its whole population by ensuring that there is quality-driven care available close to home – to the advantage of the whole community.

We have a chance to create a replicable model which will significantly enhance the health and care of patients in Catterick and Richmondshire for generations to come. The clinical model which we are proposing ensures the sustainability of services over the longer term, removing organisational barriers and maximising the benefits of integrated working.

The CCG’s preferred option for the future of health care provision on the garrison site, which has been developed following an analysis of the clinical evidence, the needs of the

population and taking account of public opinion, is to commission a fully integrated NHS and MOD facility as articulated under Option 5.

Next steps

Milestones		Date	Responsibility
CICC: phase 1 – CONCEPT - authority to proceed			
1	OBC completed and approved by Governing Body	June 2020	NYCCG
2	OBC submitted to Region NHSE	June 2020	NYCCG
3	OBC submitted to MOD	June 2020	NYCCG
4	Authority to proceed granted based on OBC and future project costs underwritten	By Sept 2020	NHSE Region
CICC: phase 2 – DESIGN - partnership and risk sharing agreements/full business case			
5	Developed design option completed and approved	By Nov 20	NHS PS/MOD
6	MOD Main Gate and NHS FBC	By July 21	NHS/MOD
CCC: phase 3 – IMPLEMENTATION - new build/service transition			
7	RIBA stand still period	Aug 21 – Jan 22	MOD/NHS PS
8	Construction period	Dec 21 – Sept 23	MOD/NHS PS
9	Services reconfiguration/transition plan implemented	Dec 21 – Sept 23	NYCCG
10	Building opened / re-basing exercise completed	By Sept 2023	All

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