NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Catterick Integrated Care Campus

Full Business Case

Version 3 - May 2023

DURHAM & TEES
COMMUNITY VENTURES

Contents

List of figures

List of tables

Document Control Sheet

Version	Issue Date	Status	Originator	Reviewed by	Issued to	Organisation
v.1	31.03.2023	DRAFT	Nicola Gundill	Karina Dare	Key internal stakeholders for review	
v.2	n/a	Working draft	n/a			
v.3.2	03.05.2023	Draft for board review	Nicola Gundill	Karina Dare	NHS Humber and North Yorkshire Integrated Care Board	
V3.3	03.05.2023	Draft for board review	Nicola Gundill	Mark Bradley	NHS Humber and North Yorkshire Integrated Care Board	

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 (HRW CCG) / North Yorkshire CCG (NYCCG) and now the ICB 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 rebasing of personnel and their dependents between 2021 and 2031, as well as the expected growth in the general population due to housing. 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 ICB have been instrumental in this design process and have provided the space to think creatively to address the forecast levels of MOD personnel and dependents and 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 ICB 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 ICB level with separate but inextricably linked approvals processes. The MOD commissioned a detailed Assessment Study which represented a key technical milestone in the scheme's development. The outputs from the Assessment Study informed the OBC and MOD equivalent. Following OBC submission further design and commercial development occurred and now both MOD and the ICB have prepared their Full Business Cases for approval.

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 ICB 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.

Figure 1: Key partners in delivering integrated healthcare.

1. Introduction and background

This document presents the Full Business Case (FBC) which sets out the formal investment case for the development of an integrated healthcare facility at Peronne Lines in Catterick Garrison to provide capacity for MOD military healthcare and a projected patient list of 14,343 for Harewood Practice by 2031, as well as advanced primary care, mental health services, physiotherapy and community dentistry.

The whole population of Richmondshire will benefit from services offered at the Catterick Integrated Care Centre (CICC). The Harewood Medical Practice patients list will directly transfer into the building offering the full scope of services to their patients. A range of PCN services will also be offered from the new site which will be available to all residents so the whole population of Richmondshire will benefit from services offered at the CICC.

1.1 Timeline of the Catterick ICC project

The CICC scheme has been in development for several years and represents the vision and ambition of a series of system leaders and associated organisations to realise a new and innovative model of care.

A feasibility study was commissioned in 2017 which culminated in the development of a project initiation document (PID) for the NHS and subsequent need for respective business cases for the scheme at both MOD and CCG (now ICB) level with separate but inextricably linked approvals processes.

The FBC builds on the Outline Business Case (OBC), and OBC addendum, which provided an updated position on discrete elements, submitted to NHS England (NHSE) in May 2020 and Jan 2023 respectively. The OBC received unconditional NHSE approval on 31st March 2023.

The MOD have followed their internal governance process to obtain approval for the investment. The FBC was submitted (Appendix 2) on 29th February 2023 and concluded their Gateway 3 review in March 2023, with a positive outcome. The FBC proceeded to investment board and gained the necessary approval in April 2023.

1.2 Material changes since the submission of OBC / OBC addendum

The Health and Care Act 2022 dissolved Clinical Commissioning Groups (CCGs) and transferred statutory functions (duties and powers) to Integrated Care Boards (ICBs) on 1 July 2022. ICBs now have a statutory responsibility for commissioning services for the population within available resources. The Health and Care Act also transferred all statutory function policies from CCGs to ICBs on 1 July 2022, which has highlighted a variation in policies across the geographic areas of Humber and North Yorkshire.

The ICB recognised that the CCGs undertook significant and robust authorisation processes to develop local policies for local populations. Adopting a single policy is not always desirable or achievable quickly, for example due to differences in provision and local knowledge. An interim approach was therefore adopted by the ICB, to adopt commissioning statements and policy statements aligned to CCG areas as they were on the 30 June 2022.

A clinically and professionally led group has been established by the ICB, to lead the review of policies. This group is working to a review programme and aims to prepare policies for approval taking a phased approach. Accordingly reference is made to the relevant CCG policies as appropriate throughout the business case, which have been adopted by the ICB.

Material changes pertaining to the 5 elements of the business case are summarised at the beginning of each section.

1.3 Approach to writing the Full Business Case

The FBC 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 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;

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

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

2. Full Business Case (FBC) - 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:

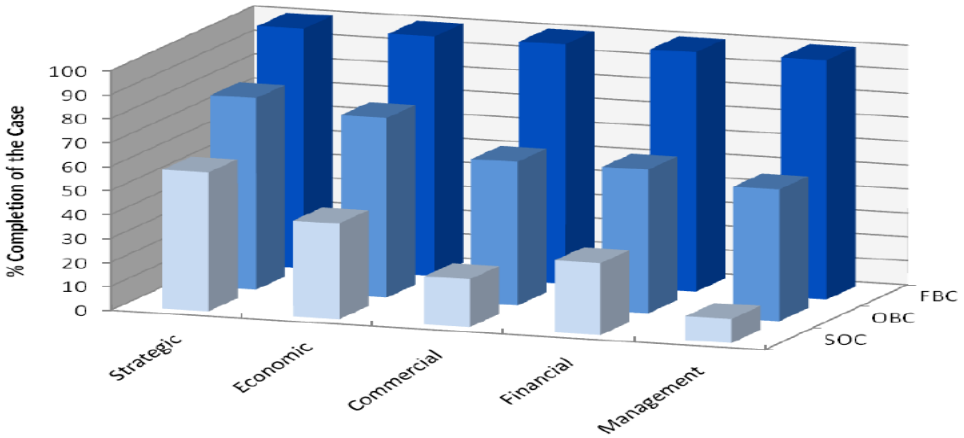


Figure 2; Business Case Development

Format of the Full Business Case

In line with the guidance described, the FBC 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 sets out 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.

The Business Case Author is Nicola Gundill ~ Senior Property and Health Estate Consultant, Durham and Tees Community Ventures with oversight provided by Karina Dare ~ Regional Partnership Director NHSPS acting as Estates Lead, Lisa Pope ~ Deputy Director of Primary Care, Community Services and Integration NHS Humber and North Yorkshire ICB acting as strategic lead, Hanna Hardy ~ Senior Transaction Manager NHSPS , acting as commercial lead and Dilani Gamble ~ Associated Director of Finance NHS Humber and North Yorkshire ICB, acting as finance Lead, all of whom are "Better Business Case Practitioners".

It is envisaged that construction will go-live in January 2024, following the approval of the NHS and MOD FBC's. The programme plan set out in the Management Case details the key milestones on that journey.

1.4 Background and current healthcare landscape

The population in Richmondshire is ageing. By 2030, there will be around 3,500 additional people aged 65+, a 31% increase from 2019, but a 11% decrease in the working-age population (excluding planned expansion of military personnel). This will lead to increased health and social care needs with fewer people available to work in health and care roles.

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.
- 'Richmondshire has the highest rate of homelessness compared with other districts in North Yorkshire.'

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, 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.

More specifically for Richmondshire:

- More than one quarter of children grow up in poverty in the Colburn, Hipswell and Scotton Wards in Catterick (27% of 2623)
- 25.6% of reception age children in Richmondshire are overweight (including obesity), higher than the national average of 22.3%. 36.2% of year 6 children in Richmondshire are overweight (including obesity) which is slightly lower than the national average of 37.8%.
- 64.4% of adults are overweight or obese (fingertips 2020/21 data) 1% higher than national average.
- The rate of people being killed on the road is more than double the English average (nearly 50 casualties annually)
- The excess winter deaths index for Richmondshire was 40.7% in 2019-2020, compared to the national index of 17.4%. This is the highest rate in the Yorkshire and Humber region and the 4th highest nationally for this period.
- 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)
- The suicide rate for Richmondshire is 14.8 per 100,000 for 2019-2020 higher than the national rate of 10.4, this is the 4th highest rate in Yorkshire and Humber.
- The proportion of newly diagnosed cases of HIV which were late diagnoses was 75% in Richmondshire (count of 3 in total), compared to the national proportion of 43.4% this is the 4th highest across Y&H for 2019-2021.
- There is a lower estimated diabetes diagnosis rate of 70.8% compared to the national proportion of 78% in 2018, it is the 4th lowest in Y&H.

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 ICBs 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 ICBs 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 the impacts of multiple wider determinants of health; social, economic and environmental factors such as housing, social isolation/moves, education and employment.

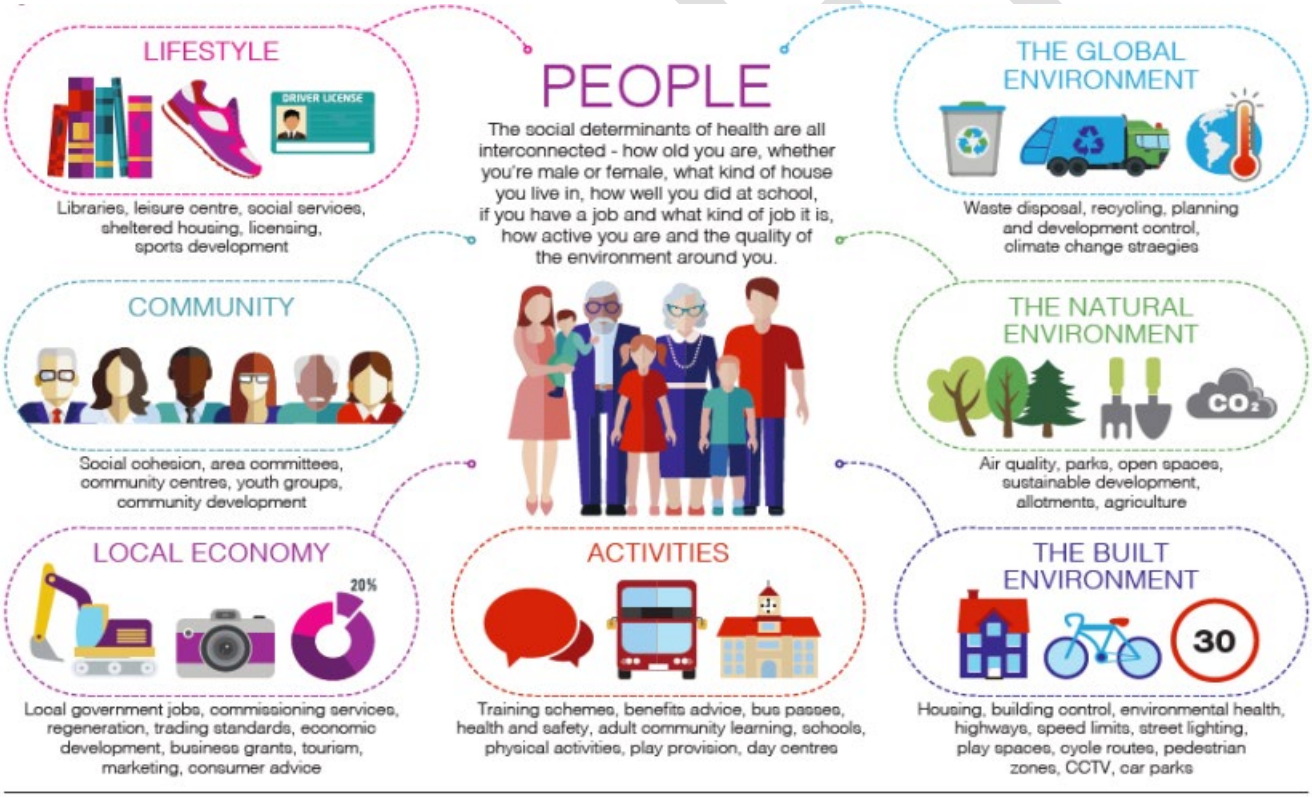


Figure 3; Wider determinants of health

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.

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.

1.4.1. Primary healthcare in Richmondshire and Catterick

The population of the Primary Care Network covering Richmondshire is 45,804[2]. Approximately, £9 million is spent per annum on primary health care in the area currently.

GP Practice	Registered Patients	Total Male	Total Female	Unknown
Aldborough St John Surgery	**3207**	1585	1622	
Catterick Village / Colburn Medical Group	**6377**	3087	3290	
Central Dales Practice	**4238**	2169	2069	
Harewood Medical Practice	**7840**	3460	4380	
Leyburn Medical Practice	**6053**	2981	3143	
Quakers Lane Surgery	**6272**	3016	3256	
Reeth Medical Centre	**1596**	809	787	
Scorton Medical Centre	**3557**	1751	1806	
The Friary Surgery	**5274**	2595	2678	1
TOTALS	**45,084**	21,825	23,259	

Table 1; Richmondshire GP registered patient numbers

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

Catterick Village / Colburn	18th on the IMD (2019) deprivation score HRW CCG (National GP Profiles, PHE)
	Higher than expected rates of smoking - QOF 21/22 Catterick 17.08%, CCG 12.50%, England 15.20%
	Higher numbers with adult obesity – QOF 21/22 Catterick 19.00%, CCG 11.27%, England 9.72%
	Significantly higher rates of depression - QOF 21/22 Catterick 14.89%, CCG 12.37%, England 12.65%
	Higher than national average of rates of admission due to injury for those under 14 years – QOF 21/22 Catterick 97.33, England 82.86
Harewood Medical Centre	Higher than expected rates of smoking – QOF 21/22 Harewood 17.58%, CCG 12.50%, England 15.20%
	Higher numbers with adult obesity - QOF 21/22 Harewood 14.97%, CCG 11.27%, England 9.72%
	Significantly higher than national and CCG average – rates of admission due to injury for those under 14 years – QOF 21/22 Harewood 113.33, CCG 107.35, England 82.86

[2] Source ; direct from GP practices Feb 2023

Table 2; Primary Care significant and multiple health issues

1.5 Current GP facilities within Catterick

1.5.1. 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.

1.5.2. 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 ICB.

1.6 Project Proposal

The ICB considers that the longer-term solution lies in an integrated approach to the delivery of healthcare by the MOD and NHS working together. The CICC will provide an integrated healthcare facility at Peronne Lines in Catterick Garrison to provide capacity for MOD military healthcare and a projected patient list of 14,343 for the Harewood practice by 2031.

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 Harewood Medical Practice patients list will directly transfer into the building offering the full scope of services to their patients. A range of PCN services will also be offered from the new site which will be available to all residents so the whole population of Richmondshire will benefit from services offered at the CICC.

The CICC will meet all 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.
- The facility will contribute to achievement of sustainability targets including bio-diversity and carbon reduction

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

- Physiotherapy
- Community dentistry
- GP out of hours
- Community space for health, social care and wellbeing advice with café area
- Clinical training facilities
- Community mental health
- Midwifery
- Diagnostics
- Sexual health
- Addiction support
- Range of outpatient services

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

The clinical operating model, section 1.11, describes the clinical outcomes sought. The Schedule of Accommodation (SoA) (Appendix 3) for the CICC further developed since the initial work at Assessment Study stage and reflects the as drawn facility which is compliant with both MOD and NHS requirement, to meet the activity and clinical requirements for Catterick and wider Richmondshire.

1.6.1. 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.

Figure 4; Locality Map

1.6.2. 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 2026	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 Friary	Owned by PHP 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 ICB 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.

Table 3; Summary of NHS services and facilities

1.7 Principles

Our vision as an ICB 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 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, clinically and environmentally sustainable health system.

The ICB, 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

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 offers 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 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 the integration opportunity for Catterick and the surrounding area

1.8 Rationale

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

- the MOD rebasing
- the need 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 MOD's medical healthcare facilities.
- the need to respond to substantial housing growth in the Catterick area.

NHS General Practice Requirement

A long-term sustainable solution is required to ensure general medical services can be maintained to the existing and expanding population. The population growth assumptions, tabled below, is based on information from November 2022.

Harewood List Oct 2020	**7851**	
Housing Development	3192	
Net Increase in Military Personnel		500
Net Increase in Military Dependents	600	
Catterick Population Increase	3792	
Harewood Population Increase due to:		
Increase in Catterick Population	3,792	
Transfer from Military GP	1,000	
Transfer from Catterick & Colborn Practice	1,700	
Total Impact	**6,492**	
Projected Harewood List 2031	**14,343**	

Table 4; Population growth assumptions

1.9 Objectives

This 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.

Partners also established a common set of project objectives which are set out in the table below. A series of credible benefits have been identified for each objective and these are set out in detail at Appendix 4 and included within the Comprehensive Investment Appraisal (CIA) (Appendix 5).

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

Table 5; Drivers for change

1.10 Financial Link to Benefits

The ICB 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 cash releasing, non-cash releasing, societal and unmonetisable benefits. The 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.

1.11 Clinical Operating Model

Programme teams and subject matter experts have been engaged in a series of planning, co-design and stakeholder workshops to engage service leaders, understand opportunity, recognise challenge and consider how services may be re-shaped to design, build and develop a comprehensive, integrated primary healthcare operating model and facility to serve the Catterick population at risk, from September 2026 and provide a replicable model for the future. Full detail of the clinical operating model can be found in Appendix 6, with a summary of key points provided below.

Vision

The NHS, MOD and its partners across the health and care system have developed a shared vision for the CICC;

"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, which is able to meet the current and future needs of the Ministry of Defence personnel and resident population."

Strategic and Policy context

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 CICC will address the aims of the Fuller Stocktake report, 5YFV and subsequent NHS Long Term Plan which 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 ICB spatial footprint, detailed in the CCG Estates Strategy (2017), 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.

Drivers for change

The clinical model has been designed in partnership with clinical and professional leaders across health and social care as an integrated primary care delivery unit, focusing on the following four pillars:

- **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.
- **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.
- **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.
- **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.

The principles adopted in the design of the clinical operating model are detailed in section 1.8.

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

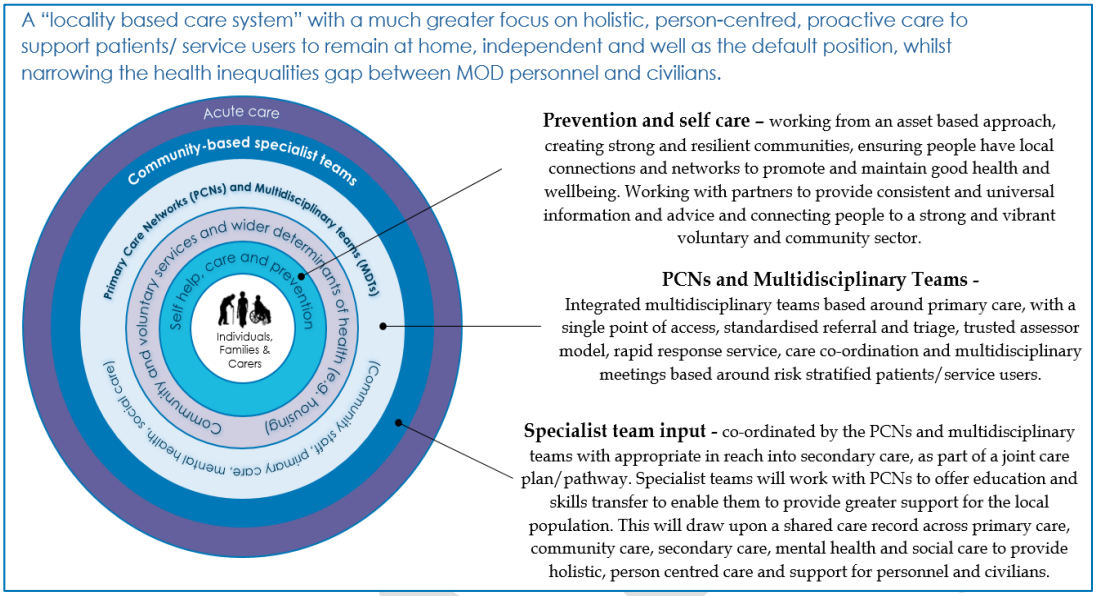


Figure 5: CICC Integrated Model of Care

Scope of services

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.

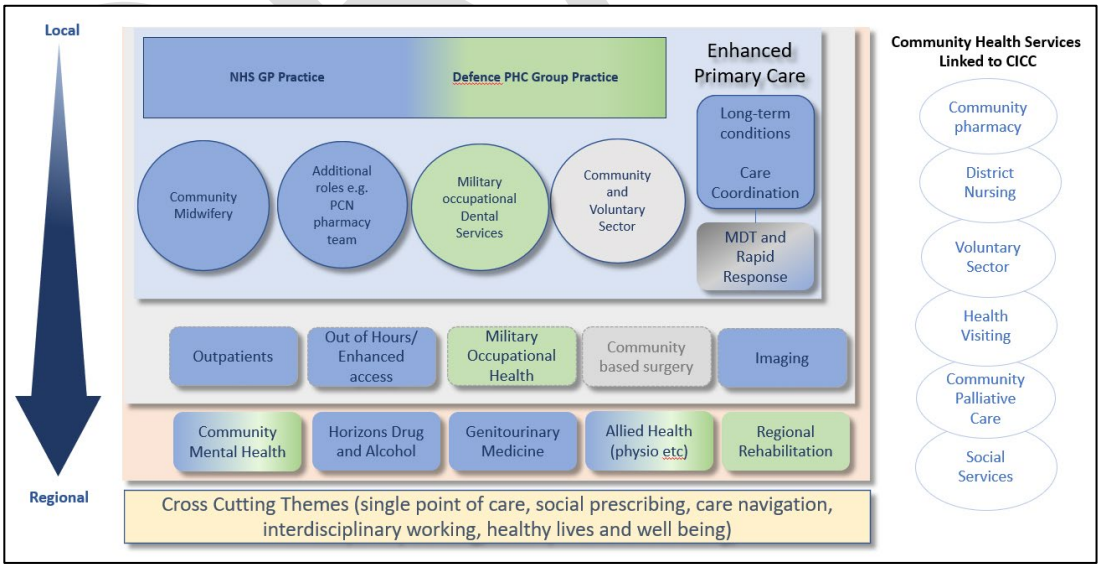


Figure 6: Service summary

Integration Roadmap

It is widely accepted that the CICC will not be fully integrated once the scheme becomes operational. It will take several 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:

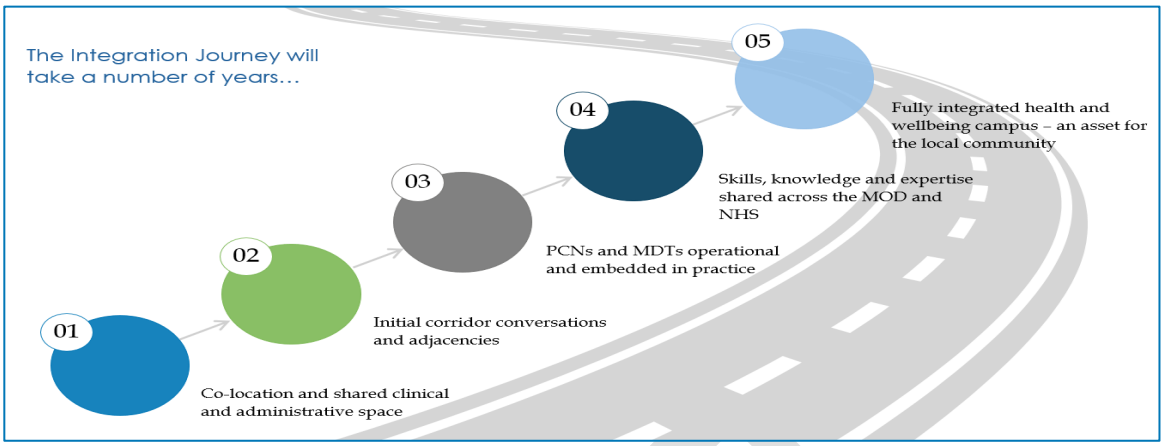


Figure 7; High level CICC Integration Roadmap

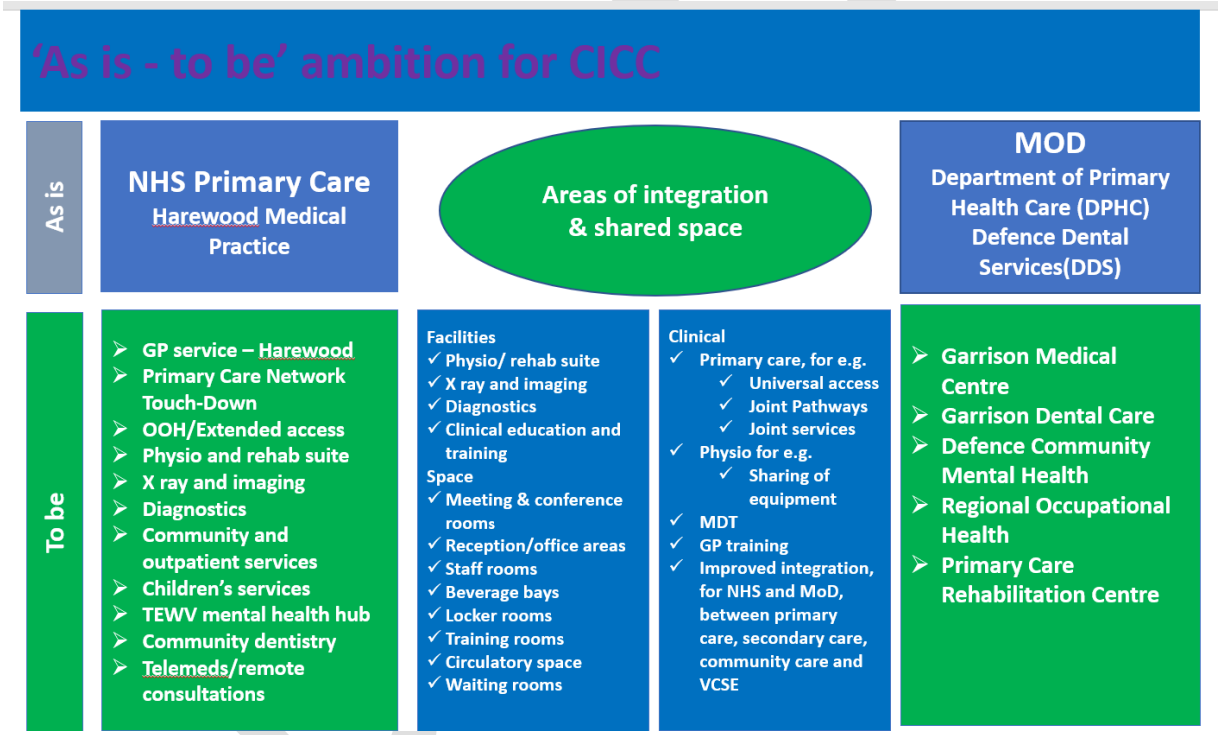


Figure 8: CICC Service Integration Opportunity

As part of the design and planning for the CICC, the MOD, NHS and partners have identified several opportunities for integration;

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

Integration road maps for each service are detailed within the COM, as per the example below.

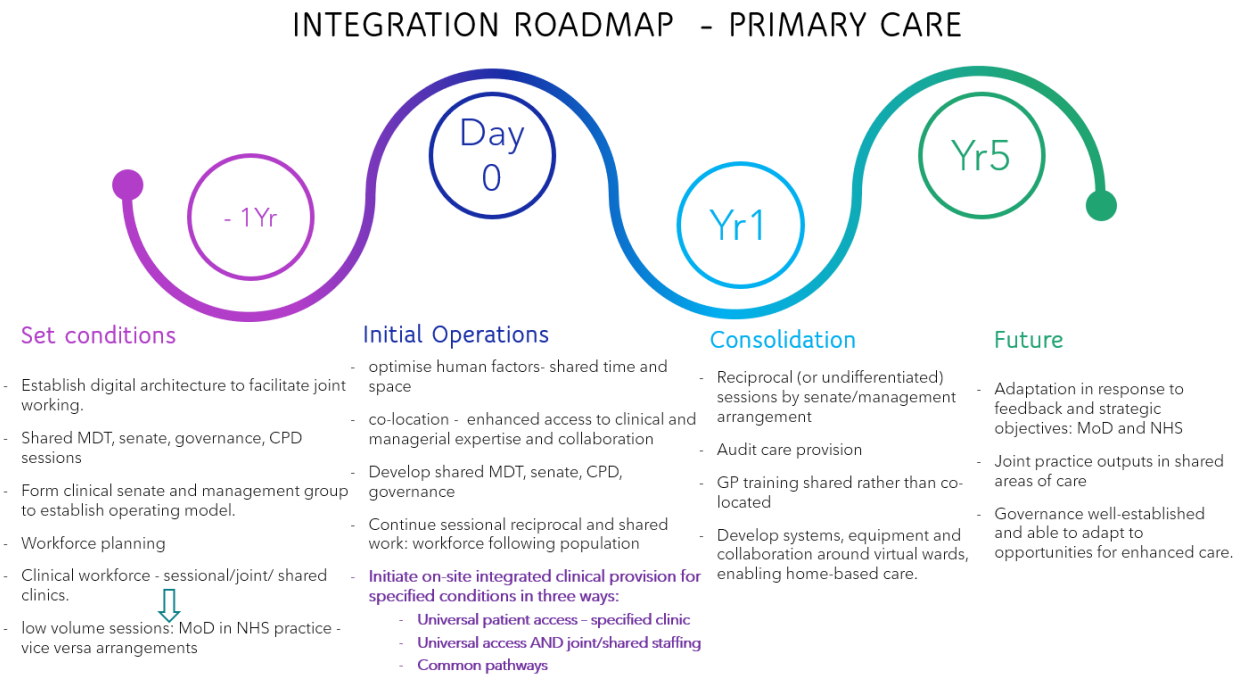


Figure 9: Integration Roadmap- Primary Care

1.12 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.

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 was presented to the Governing Body of NHS North Yorkshire CCG on 25 June 2020. It was subsequently presented to NHS England North East & Yorkshire for consideration.

On 21 September 2020 agreement was confirmed for NHS North Yorkshire to proceed with design of the project in parallel with MOD to align with the MOD approvals model through which they had agreement to progress to full business case.

Due to the significant time delay since initial OBC submission and due to significant growth in the capital cost of the scheme the OBC addendum was prepared and submitted to NHSE In January 2023, following approval from NHS Humber and North Yorkshire ICB at their board meeting on 12 January 2023.The OBC was formally approved 31 March 2023.

The Senior Responsible Officer (SRO) for the programme is Wendy Balmain, Place Director North Yorkshire. The SRO for the MOD element of the programme is Air Commodore Luke Houghton.

NHSPS and the key stakeholders below who have provided letters of support (Appendix 7):

- NHS Property Services Limited
- Harewood Medical Practice
- Tees Esk & Wear Valleys NHS Foundation Trust
- Harrogate & Districts NHS Foundation Trust
- South Tees NHS Foundation Trust

2. The Strategic Case

2.1 Purpose of the Strategic Case

The purpose of this section 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.

2.2 Material changes since the submission of OBC / OBC addendum

The strategic case has been updated to include how the CICC aligns strategically with the Next steps for integrating primary care; Fuller Stocktake report May 2022 and Naylor review of NHS Property and Estates. All other elements of the strategic case, including but not limited to the scope or objectives, remain as per the OBC / OBC addendum. The recommend proposal still satisfies the strategic objectives and business needs.

2.2.1. Organisational overview

North Yorkshire is the largest county in England covering over 3,000 square miles. The total North Yorkshire has a population of around 604,900 (ONS mid-2016 population estimate)[3] 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 most 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, with commissioning responsibilities until these were taken over by NHS Humber and North Yorkshire ICB on 1st July 2022.

The ICB 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.

The Integrated Care Partnership (ICP) across North Yorkshire and York are working together 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 ICB and is cited as a specific priority in the estates strategies, as detailed section 2.13. 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

[3] https://www.northyorks.gov.uk/north-yorkshire-population-information

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.

2.3 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 ICB has worked, with our partners across the system to develop a compelling case for change including but not limited to our key partner; the MOD.

Letters of support have been secured from each of our partners as referenced in section 1.12.

2.4 Alignment to Policy and Priorities

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

Next steps for integrating primary care; Fuller Stocktake report May 2022; The CICC aligns strategically with Dr Fullers vision for integrating primary care as it is designed with the patient and workforce needs in mind. It will provide a fit for purpose building, future ready space with flexible design to accommodate new ways of working driven by Population Health Management data. The CICC will create a positive working environment for staff and equip them with the infrastructure and tools to embrace digital advancements and target services where they are most needed.

The CICC will provide opportunities for neighbourhood and place teams to deliver integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

NHS Property and Estates: Why the Estate Matters for Patients: June 2017 (The Naylor Review: In 2017 an NHS Property and Estates Review (the Naylor Review) identified opportunities to rebuild NHS infrastructure to meet modern standards of service delivery for the future, and called for the NHS, through the STP process, to rapidly develop robust capital plans that were aligned with clinical strategies, maximise value for money (including land sales), and address backlog maintenance issues.

This project responds to the Naylor Review by providing a facility which will permit modern standards of service delivery, maximise value for money through shared infrastructure, and address the current backlog maintenance challenges.

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 recognised that most observers concur that solutions to the challenges facing general practice lie in a combination of investment and reform and require action from commissioning bodies 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 detailed in the CICC model of care, where NHS and 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.

Primary Care Additional Roles Scheme (ARRS); Our population is being increasingly impacted by more complex, long term conditions. There is a growing concern about areas of longstanding unmet health need with increased pressure to deliver for those in our communities and there is more that we can do to shift our focus from treating those who are unwell to preventing ill health and tackling health inequalities. The ARRS has enabled recruitment of a range of clinical and clinical support staff across different disciplines to support this work e.g. Physiotherapists. Clinical Pharmacists, Mental Health Practitioners, Social Prescribers.

Within North Yorkshire Place there are currently c150 WTE ARRS staff with a 2023/24 plan to recruit up to 300 staff across our 14 PCNs.

ARRS brings specialist skills directly into practices with clinical knowledge that adds capacity and increases choice for patients, who can be seen quicker and by the right clinician first time, allowing GPs to focus on patients with complex needs. ARRS roles, employed through PCNs can be directly employed or contracted through another provider working collaboratively together e.g. VCSE, mental health trusts and acute trusts.

GP Practices are increasingly working across a local geography or PCN to share back office staff e.g. finance, ITto make best use of efficiencies and joined up working. The use of Population Health Management methodology to identify patients with most need and target health improvement actions can be undertaken at individual practice level or at PCN level. NY practices have embraced this way of working and it forms part of the clinical strategies for PCNs to reduce health inequalities and improve the long-term health of those most in need.

Additional Roles	Richmondshire PCN October 2022 WTEs	North Yorks. October 2022 WTEs	North Yorks. 23/24 Plan WTEs
Pharmacy Technician	1.00	14.50	26.80
Clinical Pharmacist	2.93	34.55	44.53
First Contact Physiotherapist	1.00	20.36	26.10
Physician Associate		4.96	12.00
Care Coordinator		34.84	58.77
Social Prescribing Worker	3.72	19.34	27.53
Nursing Associate & Trainees	0.82	5.47	24.00
Advanced Practitioner		2.56	2.56
GP Assistant		1.00	32.00
Digital and Transformation Lead			6.00
Health and Wellbeing Coach		1.67	3.66
Podiatrist			1.00
Mental Health Practitioner	1.00	7.56	21.00
Occupational Therapist		1.60	3.10
Paramedic		4.68	12.50
Total WTEs	**10.47**	**153.09**	**301.55**

Table 6: Primary Care Additional Roles Scheme (ARRS)

Calculation of the space requirements for Harewood practice have taken account of current and planned ARRS staffing numbers in recognition of the significant workforce implications of ARRS. There are currently 10.47 WTE staff for Richmondshire with an ambition to recruit to 35 WTE by March 2024.

2.5 NHS North Yorkshire Strategic Priorities

The HNYICB have adopted the strategic priorities previously set by the North Yorkshire CCG:

Figure 10: North Yorkshire Strategic Priorities

Successful delivery 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.

Table 7: High level outcomes

The CICC will support our vision and the outcomes will significantly improve the health and lives of the people of Catterick and Richmondshire, now and for generations to come.

The project team have also ensured that social value has been incorporated into thinking in terms of how success will be measured, which has led to their inclusion in the benefits analysis and procurement activity, which are detailed in the economic and commercial case respectively.

2.6 Clinical quality

How services have been re-shaped to design, build and develop a comprehensive, integrated primary healthcare operating model are addressed in section 1.11; Clinical Operating Model.

The principles adopted to design a facility to support this new model of care are;

- Create a welcoming and pleasant environment that promotes health and well-being.
- Provide integrated medical services supporting both the local military and civilian population.
- Provide a highly flexible building that can respond to future changes in healthcare provision.
- Create attractive and usable internal and external spaces for use of the building.
- Produce a building design that aligns and promotes the clinical operating model and multidisciplinary team approach.
- Provide a safe and secure environment for staff patients and visitors.
- Provide a building, landscape and internal spaces that are accessible for all with clear wayfinding.
- Design a sustainable building which is MOD DREAM “Excellent” and net zero carbon.
- Retain and enhance the biodiversity value of the existing planting on the site.
- Encourage access to the site by more sustainable forms of transport e.g. walking cycling and public transport.
- Produce a design that is counter terrorism measures (CTM) compliant, standardised room sizes and position of built-in equipment for future flexibility.

Further information on this matter can be found in the design and access statement (Appendix 8)

2.7 Integrated Working

The Richmondshire Transformation Programme addresses health service and estate challenges through several interdependent transformational 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

WS 2 – 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.

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. 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:

Table 8: Richmondshire transformation programme GP / community estate

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

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

Colburn Surgery	Patients relocate to CICC/ Catterick Village Health centre
Bedale Health Clinic (completed)	Services relocate to Glebe House Surgery
Brentwood Care Home (closed) NHS service wing	Services relocate to Leyburn Medical Centre

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

Please see Appendix 9 for 'Reshaping Richmondshire'

The client brief, developed jointly the NHS and MOD, stipulated the importance of integrated working to be included in the design of the building, as can be seen in the design and access statement (Appendix 8).

2.8 Activity and capacity planning

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

- the MOD's rebasing exercise
- the need 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 MOD's medical healthcare facilities
- the need to respond to substantial housing growth in the Catterick area.

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 3. This has been completed with reference to NHS guidance.

We are currently assessing the use of OpenSpace which is an NHSPS online booking portal to manage the multi-user spaces within APC and in discussion about the scope to include shareable / bookable spaces within the MOD areas onto this platform.

2.8.1. NHS General Practice Requirement

The population growth assumption is tabled below[4].

Harewood List Oct 2020	**7851**	
Housing Development	3192	
Net Increase in Military Personnel		500
Net Increase in Military Dependents	600	
Catterick Population Increase	3792	
Harewood Population Increase due to:		
Increase in Catterick Population	3,792	
Transfer from Military GP	1,000	
Transfer from Catterick & Colborn Practice	1,700	
Total Impact	**6,492**	
Projected Harewood List 2031	**14,343**	

Table 9: Population growth assumption

The floor area has been modelled through the PAU Calculator Appendix 10. The calculation suggests the core practice requirement would be between 992 - 1075 sqm. The current practice space allocation is 712 sqm of dedicated space, but with inclusion of a pro rata share of waiting, circulation and plant space it is 1200sqm. The current as modelled space summary is provided at Appendix 11.

The PAU calculator was designed to calculate core GMS service delivery and made no allowance for the current range of Primary Care Additional Roles Scheme (ARRS) roles. It also does not allow for training and the SOA for Harewood includes for 3 GP Training rooms which equates to 77sqm.

[4] information from November 2022

Practice Core Requirement (14,343 list)	1075
GP & VTS Training Space	77
subtotal practice space	**1152**
current space allowed CICC	1200
variance	**48**

We have therefore undertaken an exercise to map the existing practice staff against the planned practice space within the facility. The output of this work is in Appendix 12; GP & ARRS utilisation schedule. This shows that the planned rooms will be utilised on an 83% basis based on a two-session weekday only model. If we assume that the practice staffing is increased from the current baseline to address the growth in patient numbers of 45%, we could reasonably anticipate another 7-8 clinical roles. In addition, the Richmondshire PCN will increase its ARRS staff numbers from the current 10 to 35. It is anticipated that CICC will be a key PCN facility in and this workforce will utilise significant clinical space in the facility. These planned staff increase will absorb any remaining capacity and require development of a 3 session / 7-day approach to space utilisation by 2031.

2.8.2. Advanced Primary Care Requirement

The utilisation of the Advanced Primary Care (APC) space has been developed through a combination of activity modelling and preparation of a detailed utilisation schedule. Demand has been modelled based on the transfer of current services and anticipated future expansion. All partners were engaged in developing the activity modelling, providing the requisite level of local knowledge to ensure our projections are accurate and meet the local population demand for these services. A copy of the current schedule is included in Appendix 12.

There is a significant level of shared use of space and also quite a number of services which will run evenings and weekends. There are several spaces which are not fully utilised, but these tend to be the specialist rooms such as x-ray and audiology. These services are transferring from other locations and the current levels of utilisation are shown, but it is anticipated that once CDC plans are approved and implemented these spaces will see increased volumes of activity.

The APC areas within the facility are showing utilisation of 76% on a 3 session 7-day model. There is more demand for space from services than it is possible to accommodate.

Based on the current assessment the facility will be very intensively used and future clinical integration plans will be key to maximising efficiency of space utilisation.

2.9 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. The objective is to move away from fragmented and reactive care to holistic and preventative care which is person centred. We anticipate that those benefits will be a ‘left shift’ in care as shown below. Further details are contained within the Clinical Operating Model (Appendix 6).

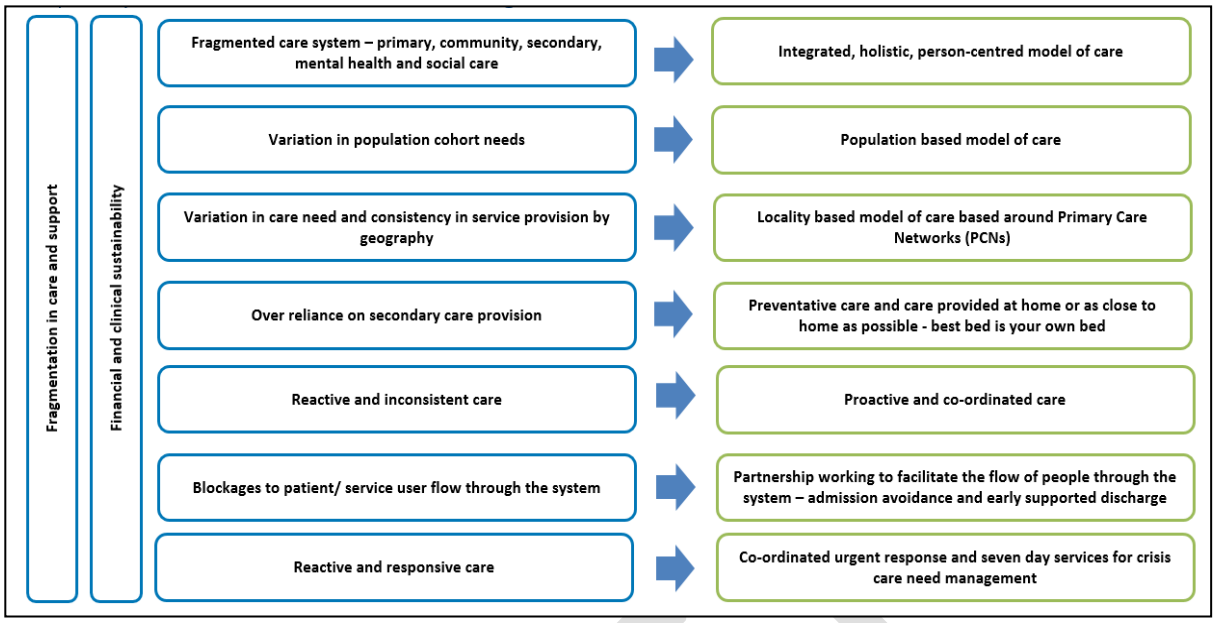


Figure 11: "Left shift" in care

The services which will be 'new' to patients at this facility will be access to X-ray, physiotherapy and rehabilitation suite. 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.

2.10 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 because 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.

The equality and diversity impact assessment in attached as Appendix 13.

2.11 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 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.

2.12 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 14.

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 15. NHS North Yorkshire is now in the Humber Coast & Vale ICS area, and for completeness the HCV ICS estates strategy is also included at Appendix 16.

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 was subsumed by the North Yorkshire CCG Estates Strategy upon merger as of 1 April 2020.

2.13 Engagement - Public and Stakeholder Consultation

The Communication and Engagement (C&E) Strategy (Appendix 17) details the approach taken to communicate with partners, stakeholders, patients, the Armed Forces community and local populations in and around Catterick as well as the Richmondshire area in relation to proposals to build a new local health facility.

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 C&E strategy contains details of the engagement activity undertaken from inception to Sept 2022, which focussed on the health service challenges of the Catterick area and those faced by serving personnel. It found inequalities of care and inequity of access compared to other areas. Since then, the local NHS, MOD, NHSPS and NHSE have worked together, alongside local groups such as Parents4Parents (no longer in situ), to better understand the challenges and potential opportunities.

Management has to date and will continue to, 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 18). 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.

Local issues and concerns

The local issues which have driven the need for change, and the ways that this proposal will address them are contained with the body of the business case. Whilst we are confident that the proposed intervention will deliver the improvements required, we are conscious that 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 have required challenging negotiations with all stakeholders. Careful management of expectations has been 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.

The Communication and Engagement Strategy (Appendix 17) details the approach taken to communicate with partners, stakeholders, patients, the Armed Forces community and local populations in and around Catterick as well as the Richmondshire area in relation to proposals to build a new local health facility. The strategy details engagement focussed on the health service challenges of the Catterick area and those faced by serving personnel, dependents and their families, from inception to Sept 22. It found inequalities of care and inequity of access compared to other areas. Since then, the local NHS, MOD, NHSPS and NHSE have worked together, alongside local groups such as Parents4Parents (no longer in situ), to better understand the challenges and potential opportunities. Specific information on previous engagement and how it has informed the programme is contained within Appendix 2 of the strategy.

On 13th October 2022, the proposals were presented to Richmondshire District Council's (RDC) Overview and Scrutiny (External) Committee. A series of questions about the provision of health services and primary care in Richmondshire were answered, and all members of the committee agreed that the meeting was productive and informative. There was however a question raised as to whether the MOD dental services provision could be accessed by NHS patients to reduce waiting times, as detailed in the letter dated 9th November 2022 (Appendix 19). The ICB responded on 22nd December 2022, in writing (Appendix 20). Full detail of the response is contained within the attached letter with the key highlights as follows.

"Dentistry services for the community are provided by the NHS (currently via NHSE), therefore service provision is assessed and provided based on the needs of the community considered alongside funding and workforce capacity. The MOD is funded to provide dentistry for the miliary population. Their capacity is determined by the requirements to meet the needs of the current and proposed military population as noted above. Therefore, at present the needs of both military and civilian populations are considered separately."

"NHS dental patients will continue to be served by local dental practices that are commissioned by the NHS. If the NHS dental provision model is reviewed and changed in the future, the MOD will examine those changes and likely review its own service provision."

"We understand that infection prevention and control measures to protect staff and patients were introduced during the pandemic, significantly limiting the number of procedures that NHS dentists could carry out. However, these have now been lifted so dental teams have been able to operate at full capacity since July, for the first time in two years. Now that the rules which limited dentists' ability to treat as many patients have been removed, dentists are required to fulfil their contractual obligations with the NHS in full, as before the pandemic. Anyone with concerns about their dental health should contact a local dentist practice as they usually would or seek advice from NHS 111."

"The concern around dentistry was not previously highlighted as a specific topic for engagement, however we acknowledge this has been of great concern during 2022 and has since been raised in a number of forums. For our ongoing CICC engagement, we will continue to listen to the invaluable views of patients/public and stakeholders including Healthwatch, and ensure they are considered as part of the Humber and North Yorkshire Integrated Care Board's future strategy for dentistry."

2.14 Risk

As part of the MOD Assessment Study (Appendix 21) a detailed strand of risk assessment activities were undertaken jointly by the project teams.

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 ICB 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.

The preferred option Risk Register has been prepared in accordance with the relevant MOD guidance documents, the consultants' own information and DIO (Defence Infrastructure Organisation) Business Assurance and Risk (BAR) team advice. The Risk Register, including three-point estimates, Monte Carlo risk analysis (Appendix 22) in terms of both cost and schedule with separate pre and post mitigation supporting information. The Risk Register has been developed and regularly reviewed throughout the lifecycle of the project.

The risk register is attached as Appendix 23, with post mitigation "red" risks summarised below;

Ref	Risk Description	Mitigation	Probability	Impact	Risk Rating
84	Inflation beyond allowance detailed within the GMP	Include budget allowances within works packages calculated to the mid-point of construction. Beyond this point as described in the comments, any additional inflation cost to be borne by the Employer	5	5	25
86	Interest rates	MOD/Trust to consider finance impact on budget	5	5	25

Regulatory risks such as compliance with the government construction strategy 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.

2.14.1. Government construction strategy

The rationale for the scheme is in line with all current mandatory government strategy.

2.14.2. Design

Compliance

The building has been designed in accordance with all relevant Health Technical Memorandum (HTM) and Health Building Note (HBN) standards including but not limited to infection control, patient access and safe design to achieve clinical compliance. Exemptions were discussed and approved by the project / programme board on 30th March 2023. The derogation schedule can be found at Appendix 24.

Net Zero Carbon / sustainability

The business case has been developed with Net Zero Carbon and sustainability in mind, which are in accordance with the North Yorkshire CCG Green Plan (Appendix 25) and ICB sustainability plans. Specific details pertaining to this topic can be found in the Commercial case; 4.6 & 4.7.

Schedule of Accommodation

The schedule of accommodation for this project is contained within the commercial case; 4.5.2.

Digital technology

It is anticipated that the NHS will use their existing systems initially. As part of the wider programme the ICB digital lead is working with partner organisations to develop the digital approach for the scheme aligned to each organisation's strategies. There is a workstream dedicated to delivery of this discrete element, as detailed in the management case section 6.2, which also explores the interoperability of NHS and MOD systems to maximise all opportunities to work collaboratively and maximise digital capability ahead of operational commencement.

2.15 Constraints and dependencies

Constraints pose limitations to the project, whilst dependencies relate to the sequence of events and developments which can affect the overall delivery of the scheme.

The following table demonstrates how constraints and dependencies have been treated.

Constraints	**Update for the FBC**
The availability of capital and revenue funding	This will always remain as a potential constraint. In the financial case of this FBC it is shown how both capital and revenue requirements are affordable.
Ability to secure planning permission	Planning permission has been secured subject to completion of sec 106 agreement by MOD, as per section 4.16
Dependencies	**Update for the FBC**
Development of the relevant workstreams in Clinical Operating Model, workforce, Building Operating Model etc.	Workstream activities are underway and on target to be completed within necessary timescales. Further information is provided in section 1.10. During the period of the infrastructure delivery there is a plan of activities to further develop the clinical operation model and supporting workstreams around finance, contracting, workforce and public health to ensure that these are further developed ahead of services moving into the completed facility.
Engagement and consultation with the local population to support the proposed development	Engagement / consultation has been undertaken as per section 2.14.
Ensure the design of the building provides sufficient flexibility to respond to future needs.	There has been continual engagement in the design of the facility involving a wide range of stakeholders to ensure the CICC is fit for purpose. Section 4.13 covers the Technical and Specialist Assessments pertaining to this project.
Delivering the project implementation plan, without disrupting services.	The ICB has compiled a project team with sufficient and adequately skilled resource to successfully manage the project through the relevant stages beyond FBC. As the preferred option is a new build on a new site all current operational arrangements are anticipated to continue through the construction period. A detailed occupier building commissioning plan will be developed and implemented alongside the construction commissioning plan and the soft landings activity with the FM providers.
NHS England verification of the business case.	An OBC addendum was submitted in January 2023 in light of the financial and policy changes since the initial submission in 2020. The OBC received NHSE approval on 31st March 2023

Table 10: Constraints and dependencies

2.16 Letters of support

This project is supported by NHSE England, NHSPS and the key stakeholders referred to at section 1.12 who have provided letters of support (Appendix 7)

2.17 Conclusion of the strategic case

We have demonstrated how the scope of CICC fits within the existing business strategies of the ICB and MOD. The rationale provides a compelling case for change, in terms of the existing and future needs of the whole population of Richmondshire.

Our 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 in a much more integrated approach to the delivery of healthcare by the MOD and NHS working together.

This intervention is unanimously supported by all key stakeholders including but not limited to the ICB.

3. The Economic Case

3.1 Purpose of the economic case

The economic case demonstrates the value of the investment to society, compared with not investing in the CICC. It is a requirement of NHS England on behalf of HM Treasury to provide assurance that any capital investment provides the best value possible to the tax payer.

To demonstrate this, the economic case contains an appraisal in line with the guidance setting out clearly the costs and risks and how these relate to the benefits and, therefore, whether the investment will achieve value for money.

Benefits can be defined in a range of ways and include benefits to other parts of the system and society. As such the economic case is concerned with more than just stakeholders' finances whereas the financial impact and affordability of the investment is the focus of the financial case.

In developing this section the preferred option, developed from the options appraised in the OBC is compared to business as usual which will be the option if the investment does not proceed.

3.2 Material changes since the submission of OBC / OBC addendum

No additional options have been identified since submission of the OBC addendum. The preferred option remains as per the OBC / OBC addendum; Integrated new build with NHS Capital via Section 2 Agreement with NHSPS holding the NHS Headlease and operationally managing NHS rights of access at the Peronne Lines site.

3.3 Summary of options appraisal

3.3.1. Long- short list

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. The options considered are described in the table below.

Option	Report narrative
Option 0 Business as Usual (BAU): existing services provided from existing facilities:	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 User Requirements Document (URD) and the constraints and requirements detailed in the MOD Technical Specification of Requirements (TSoR).
Option 1 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. It 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 Health Centre 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 178m2 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 retaining and improving Catterick Village Health Centre and offer increased appointments to spread patient demand.
Option 2 4c – separate new build NHS funded	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. 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.
Option 3 4d – separate new build 3rd party developer funded	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. 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.
Option 4 5b Integrated new build with NHS grant funding to MOD	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.
Option 5 5c Integrated new build with NHS Capital via NHSPS	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. As the capital is passed through NHSPS the charging policy approved by DHSC will be applied and a market rent applied.

Table 11: Options considered.

A detailed table linking the options from Assessment Study through to OBC and CIA is included in Appendix 26.

3.4 Costs

The proposal is compliant with NHS design and costing requirements and in line with approved derogations. Costs are calculated using BIS cost indices and based on key assumptions below;

- Operating costs increase by 2% annual inflation.
- All leases are FRI.
- New builds will be VAT elected.
- Third party developer would charge rent of £200/SM.
- Rents will be passed through at a peppercorn in OPt5b_CIA4.
- Lifecycle costs start from 2026 at Garrison in DN and DM.
- Lifecycle costs in the integrated build options are per the T&T 60 year specific costing profile. In other options they have been calculated at £50/SM (exc VAT) based on lifecycle profiling from other similar buildings and inflated at 2% p.a.
- No SDLT included as individual lease terms are unknown.
- Equipment of £500K (exc VAT) has been included in all new build options.

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. The Comprehensive Investment Appraisal (CIA) 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. The CIA has been updated with current capital costs and with benefits and risks information developed since the original OBC submission in 2020 and the OBC Addendum submission in February 2023.

The appraisal has been conducted over a 64 year period, reflecting the lead in for design, procurement and construction plus a the standard CIA 60-year term. It is important to note that the NHS right of use period is 40 years which has been agreed MOD as an acceptable lease term. Heads of terms have been agreed on this basis, and agreement for lease, lease and Sec 2 agreements are in their final form.

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 costs 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**

Figure 12: Elemental cost headings

The CIA 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	No opportunity costs have been identified
Capital Receipts	A small lease surrender value has been included associated with exit from NHSPS Long leasehold interest in Catterick Garrison HC
Capital Expenditure	Included on the basis of tendered capital costs from Tilbury Douglas GMP December 2022. The elemental cost plan is provided at Appendix 27.
Land - Construction (Buildings)	Detailed costs included from GMP and MOD advised project costs. These have appropriate inflationary uplifts included for construction costs to align with programmed start dates for commencing construction refer Appendix 27.
Equipment (inc.one-off costs)	An allowance has been Included in all new build options. There is an expectation that individual occupiers will bear some equipping costs or transfer equipment and that IT equipment will be supplied via existing replacement programmes ahead of occupation of the facility in 2026.
Lifecycle Costs	Included in all new build options and some allowance in existing sites to reflect ongoing requirement to maintain the site. While there is a lifecycle profile it is anticipated that charges will be levied by MOD as costs arise as there is no mechanism to hold a lifecycle fund.
Avoided Costs (for the Business as Usual Option	None included as significant investment in 2018/19 and 2020/21 to reduce 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 are anticipated to be in line with normal contracting process and cycles so have not been included in the calculation
• 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
• 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.

Table 12: Categories of data considered within CIA

Capital Costs

Option		Present Cost	% of highest cost	Rank
OPT1_CIA0	**Business as Usual**	**£1,112,068.02**	4%	1
OPT2_CIA1	**Do Minimum**	**£1,462,776.64**	5%	2
OPT4C_CIA2	**Separate new build NHS funded**	**£23,779,418.54**	89%	4
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£4,770,597.34**	18%	3
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£26,697,118.79**	100%	5
OPT5C_CIA5	**Integrated new build NHS funded**	**£26,697,118.79**	100%	5

Table 13: Capital costs

All costs modelled in the CIA model are exclusive of VAT. The NPC also includes an allowance for optimism bias. Capital cost cash flows have been provided in the CIA model (Appendix 5). The sensitivity analysis is included in the separate financial analysis file which is provided in Appendix 53.

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. MOD have included lifecycle costs in the Whole Life Costs modelling in their business case based on detailed report from Turner Townsend which is included in Appendix 28. These figures have been used in the CIA for the integrated build options and a per sq metre rate for the stand alone NHS new build options.

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 ICB and is deemed to be at a suitable level for each of the appraised options.

	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	1,112,068	1,462,777	23,779,419	4,770,597	26,697,119	26,697,119
Upper bound calculation	27.50%	27.50%	32.00%	34.00%	34.00%	34.00%
Unmitigated at FBC	48%	49%	55%	68%	8%	8%
Optimism Bias at FBC	13.31%	13.59%	17.60%	23.19%	2.72%	2.72%
Total OB (£)	148,016	198,718	4,185,178	1,106,206	726,162	726,162
% of Highest Cost	4%	5%	100%	26%	17%	17%
Rank	**1**	**2**	**6**	**5**	**4**	**4**

Table 14: Optimism bias calculations

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	£0.00	£362,983	£20,072,937	£0.00	£24,544,583	£24,544,583
Lifecycle Costs	£2,811,251	£2,811,251	£10,899,270	£10,899,270	£8,499,462	£8,499,462
Other Capital Costs	£0.00	£0.00	£500,000	£500,000	£500,00	£500,00
Residual Value	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Total Capital costs	**2,811,251**	**3,174,234**	**31,472,207**	**11,399,270**	**33,544,045**	**33,544,045**
Rank	**1**	**2**	**4**	**3**	**6**	**6**
Total capital inc OB	**3,185,428**	**3,605,454**	**37,011,315**	**14,042,532**	**34,456,443**	**34,456,443**
Rank	**1**	**2**	**6**	**3**	**5**	**5**

Table 15: Summary of capital costs

3.5 Benefits

3.5.1. 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 29. 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
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

Table 16: Drivers for change

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 17: 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

Table 18: Decision matrix weighting

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 19: 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.

3.5.2. NHS Benefits Assessment using CIA.

MOD and NHS jointly developed the spending objectives for the CICC project. The NHS benefits have been developed significantly since OBC submission in 2020. The table below shows benefits against the corresponding spending objective. A full summary of the identified benefits is included in Appendix 4.

Ref	Category	Spending Objective	Key measures
I01	**Compliance**	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
			Improved treatment of coronary and vascular conditions due to service colocation and development of MDT approaches
			Equality, inclusion and diversity training for staff and supply chain
I02	**Efficiency**	A fully integrated health and wellbeing service - provides full integration of the services being provided and provides links to other services	Pathology - Efficiencies in pathology courier service as one collection point
			Reduction in delayed transfers of care
			Create capacity for expansion of non-GP roles in general practice via ARRS scheme - right person first time
			Create capacity for specialist Pharmacy roles in practice - improved medication mgt
			MDT benefits - Care Home admission
			Armed Forces Single point of Access
			Retinal screening - increase activity
			Retinal screening - early detection
			Improved Diabetes Care - one stop shop
			Improved Diabetes Care - shared pathway pre-diabetes & diabetes
			Increased access to clinical services - GUM
			Mental Health Services Enhanced - link to VVADS
			Mental Health Services Enhanced - link to MHSOP
			Mental Health Services Enhanced - links to DCMH
			Drug & Alcohol Service Enhancements - BBV testing
			Drug & Alcohol Service Enhancements - Hep C Treatment
			Drug & Alcohol Service Enhancements - link to smokefree
			Drug & Alcohol Service Enhancements - link to GUM services
			Community Mental Health Services Enhanced - improved patient physical access
			Community Mental Health Services Enhanced - psychosis service access closer to home
			Community Mental Health Services Enhanced - improved co-operation CMHT & IAPT
			Community Mental Health Services Enhanced - improved co-operation MOD transition
			Community Mental Health Services Enhanced - improved family liaison colocation
			Integration of treatment pathways
			Improved clinical access
			Early intervention
			Implementation of joint clinical model
			Improved patient experience
I03	**Effectiveness**	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
IO4	**Sustainable**	Sustainable - provide an environmentally sustainable solution and meet the necessary DREAM and BREEAM requirements	More specialist services close to home - reduced strain patient transport
			More specialist services close to home - Reduced travel of patients
			Reduction in travel - Co2 reduction

			Energy efficient buildings
			Contribute to Net Zero Carbon policy objective
			Health & Wellbeing benefits of External space
			Travel convenience
IO5	**Compliance**	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
			Create capacity for expansion of non-GP roles in general practice via ARRS scheme - release GP time
			Create capacity for expansion of non-GP roles in general practice via ARRS scheme - Increased appointments
			Create capacity for specialist Pharmacy roles in practice - prescribing impact
			Create capacity for specialist Pharmacy roles in practice - post discharge medication
			Same day access GP
			Community Diagnostic Hub - increase CT
			Community Diagnostic Hub - increase MRI
			Community Diagnostic Hub - Increase x-ray
			Community Diagnostic Hub - Increase Non-Obs ultrasound
IO6	**Effectiveness**	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;
			Increased Construction spend in the local economy from construction work
			Increased Construction jobs and apprentices
			Contribution to VCSE
			Curriculum engagement/educational activity
			Increase in work day spend
IO7	**Efficiency**	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
			Better teaching and training and peer review, better environment to work in
			Staff saving from repeatable rooms
			Staff turnover – improved design reduces staff turnover
			Community Mental Health Services Enhanced - save staff time physical health space
			Community Mental Health Services Enhanced - improved patient environment / access
			Community Mental Health Services Enhanced - staff time benefit access to core IT systems
IO8	**Programme**	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

Table 20: Benefits summary

.

Benefits have been identified and quantified in line with Green Book Guidance as shown below;

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**	**£1,067,475.88**	**48%**	**3**
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£1,067,475.88**	**48%**	**3**
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£2,219,206.73**	**99%**	**2**
OPT5C_CIA5	**Integrated new build NHS funded**	**£2,231,754.82**	**100%**	**1**

Table 21: Discounted total for Cash Releasing Benefits.

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**	**£6,780,605.86**	**71%**	**3**
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£6,780,605.86**	**71%**	**3**
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£9,534,713.69**	**100%**	**1**
OPT5C_CIA5	**Integrated new build NHS funded**	**£9,534,713.69**	**100%**	**1**

Table 2: Discounted total for non-Cash Releasing Benefits.

Societal 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**	**£87,715,310.70**	**58%**	**3**
OPT4D_CIA3	**Separate new build 3rd party developer funded**	**£76,454,192.21**	**51%**	**4**
OPT5B_CIA4	**Integrated new build with NHS grant funding to MOD**	**£150,308,809.60**	**100%**	**1**
OPT5C_CIA5	**Integrated new build NHS funded**	**£150,308,809.60**	**100%**	**1**

Table 24: Discounted total for Societal Benefits.

3.5.3. Benefit Realisation

For each of the high-level benefits in the Business Case, SMART (Specific, Measurable, Achievable, Realistic, Timely) benefits have been identified which are cited in the Benefits Realisation Plan at Appendix 4. 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. The management case. Section 6.7 sets out how the benefits will be managed during key phases of the project post FBC.

3.6 Risk

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 to avoid duplication. The ICB have therefore applied the healthcare direct risks, identified across the whole lifecycle of the project to the CIA , for NHS elements of service delivery. The full risk register can be found at Appendix 23.

3.7 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. A significant level of development has taken place regarding the clinical operating model since OBC and this has allowed further development of the clinical benefits of integrated delivery models. The benefits picture is still not fully developed with further opportunity to enhance this during the construction period of the project.

Option 4 and Option 5 show the same benefit cost ratio however Option 4 presents a significantly better revenue outcome and is therefore preferred in terms of revenue position affordability by the ICB. This will be explored further in the financial case.

While the impact of the clinical risk around hand back of the existing GMS contract was a significant factor in this result at original OBC this is now less significant than the potential benefits around improved clinical care for CVD. The CIA can be found at Appendix 5.

	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 Incremental Capital	£401,411	£26,704,511	£4,616,719	£26,163,196	£26,163,196
Revenue Costs	£0.00	£5,407,484	£19,335,581	£3,402,535	£3,402,535
Total Incremental Costs	**£401,411**	**£32,111,996**	**£23,952,300**	**£29,565,731**	**£29,565,731**
Incremental Benefits					
Incremental cost reduction - risks	£2,100	£7,686,940	£7,686,940	£7,686,940	£7,686,940
Incremental benefits (combined)	£0	£95,563,392	£84,302,274	£162,062,730	£162,075,278
Total Benefits	**£2,100**	**£103,250,333**	**£91,989,214**	**£169,749,670**	**£169,762,219**
Risk-adjusted Net Present Social Value (NPSV)	**£399,311**	**-£71,138,336**	**-£68,036,913**	**-£140,183,939**	**-£140,196,487**
Benefit-cost ratio	**0.01**	**3.22**	**3.84**	**5.74**	**5.74**

Table 22; CIA model results

Economic Sensitivity Analysis is used to ensure that the preferred option is suitably robust in the event of changes to costs / benefits / risks. It is an important evaluation tool to demonstrate the robustness of the options appraisal, and as such it has been further refined at FBC to show the continued strength of the preferred option. A 10% increase in capital on the preferred option decreases the Benefit/Cost ratio to 5.27 whilst a 10% decrease in capital increases the ratio to 6.30, from a base ratio of 5.74. The sensitivity analysis confirms that at a 10% increase or decrease in capital costs Option 4 and Option 5 remain as the most economically beneficial options.

Sensitivity Table	**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**
Base Case		0.01	3.22	3.84	5.74	5.74
10% increase in capital cost	-	0.00	2.97	3.77	5.27	5.28
10% decrease in capital cost	-	0.01	3.51	3.92	6.30	6.30

Table 23; Sensitivity table

The switching table below shows the amount that costs would need to reduce by, or benefits would need to increase by, for the ratios of other options to match the preferred option. This has also been shown as a percentage in order to show the level of change required.

SwitchingTable	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
Incremental costs - total	£0	£401,411	£32,111,996	£23,952,301	£29,565,731	£29,565,731
Incremental benefits - total	£0	£2,100	£103,250,333	£91,989,214	£169,749,670	£169,762,219
Risk-adjusted Net Present Social Value	£0	-£399,311	£71,138,336	£68,036,914	£140,183,939	£141,196,487
Benefit cost ratio		0.01	3.22	3.84	5.74	5.74
Switching Requirement (Reduction to costs)	£0	£401,056	£14,124,368	£7,926,514		
As a %		100%	44%	33%		
Switching Requirement (Increase to benefits)	£0	£2,301,997	£81,072,527	£45,496,991		
As a %		109619%	79%	49%		

Table 24; Switching table

3.8 Conclusion of the economic case

The economic analysis gives a benefit cost ratio over the 60 year life of the preferred option of 5.74 and a risk adjusted net present social value of £140.2m. The modelling has demonstrated that even taking account of a 10% increase in costs, a benefit cost ratio of 5.27 would still be achieved. This confirms that this investment gives clear value for money. Given the range of benefits and the with the aim of this development becoming an exemplar of best practise to support future initiatives, this investment is clearly worthwhile and will make a substantial contribution both immediately in the long term to the healthcare for the people of Richmondshire.

4. Commercial Case

4.1 Purpose of the Commercial Case

The commercial case demonstrates that the preferred option will result in viable procurement and robust contracts being in place between the public sector and its construction partners. This includes understanding what is realistically achievable from the supply side and the various procurement routes available to deliver best value. The commercial case demonstrates our understanding of the requirements of this investment and its outputs and how risk is distributed between contracting parties.

4.2 Material changes since the submission of OBC / OBC addendum

There has been no change to the procurement strategy since P22 was identified. Expressions of interest have been received and a preferred bidder identified who have completed the design and issued a Guaranteed Maximum Price for the project, as detailed in section 4.6. Integrated Facility Management Arrangements have been finalised as detailed in section 4.9.

4.3 Commercial Feasibility

The current supply market conditions are proving volatile across MOD procurements due to the impact and recovery of the COVID-19 Pandemic, Britain withdrawing from the European Union and the Russian invasion of Ukraine in February 2022. These risks are being mitigated where possible by using the Department of Health's Procure 22 Framework where supplier capability has already been tested. CAAS-SI have been engaged and has confirmed there are no signs of financial distress with Tilbury Douglas. Given that NHS Procure 22 Framework is administered by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England, and that the MOD have undertaken a robust and transparent procurement process the ICB are satisfied this project is commercially feasible and deliverable.

4.4 Procurement

4.4.1. Procurement scope

The HLIP (Appendix 30) contains the detail pertaining to the procurement activity, led by the MOD. The scope covered demolition of existing facilities and provision of a new primary care facility to deliver the necessary MOD/NHS outputs in a combined facility and not to the detriment of either organisation's requirements.

A list of equipment required for the new facility has been developed and validated as part of the detailed design development, link to individual room designs. An allowance for the equipment has been included in the financial case.. Normal procurement process will be followed working with each relevant trust and delivery will be in line with the construction delivery programme.

4.4.2. Procurement strategy

The OBC explained how the decision was made to use the NHS Procure 22 Framework to contract the Prime Contractor for the two-stage approach. It is administered by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England. ProCure22 (P22) complies with all relevant procurement law and 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 commercial strategy is attached as Appendix 31.

4.4.3. Procurement process

The MOD have led on procurement as the lead organisation, following the PCSP process as required by the P22 framework. Peter Todd, NHS Property Services has provided assurance of a robust process. Six contractors completed Expression of Interests and attended interviews with MOD. Tilbury Douglas were found to be the preferred bidder on a two-stage approach. Tilbury Douglas have completed design and issued a Guaranteed Maximum Price for the Construction of the project under the provisions of Stage 3 of the Procure 22 framework.

4.5 Design

The design for the preferred option has been developed up to RIBA stage 4 in conjunction with key stakeholders, the design team, healthcare planner and the ICS to actively support healthcare outcomes resilient to threats and hazards.

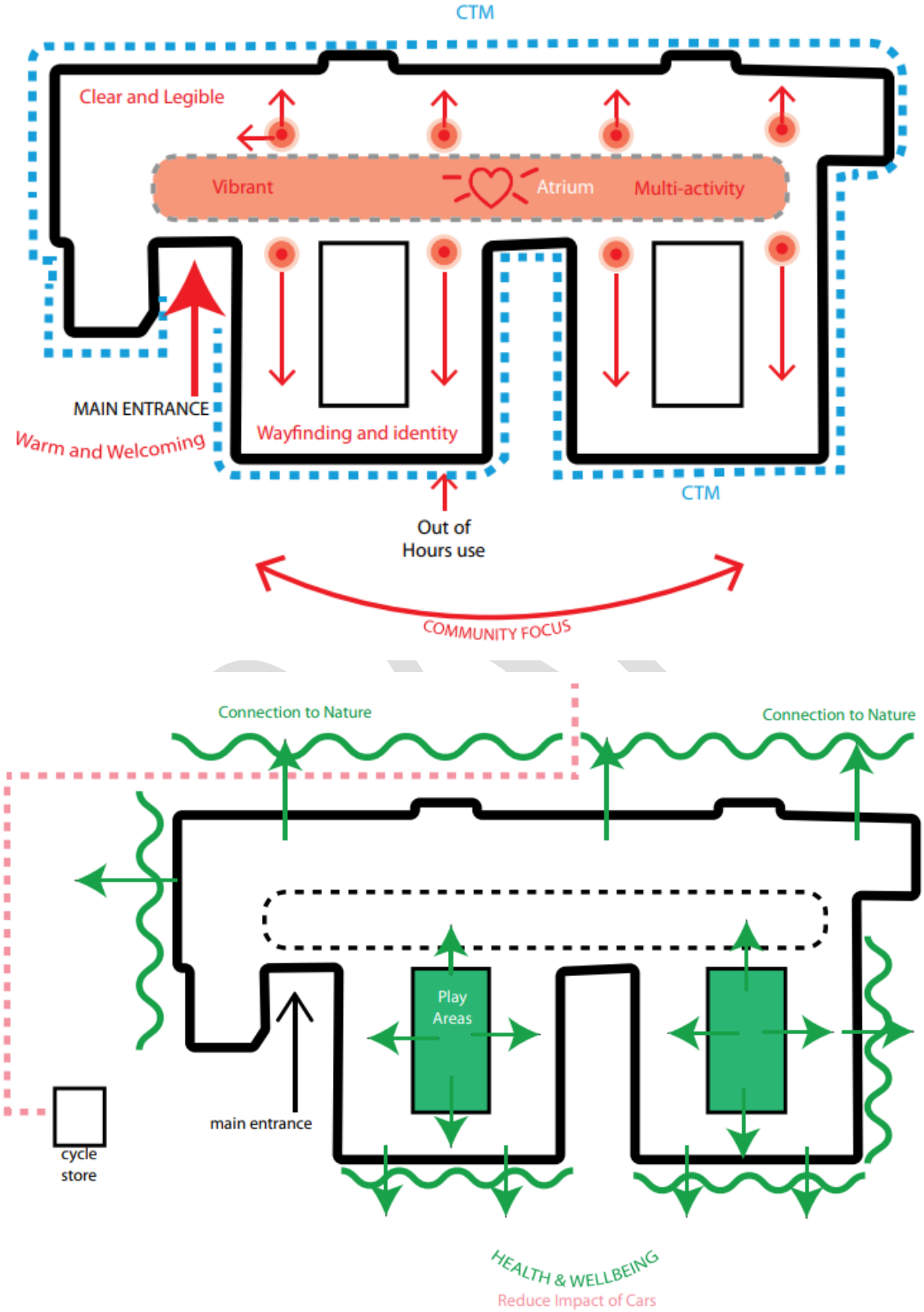
4.5.1. Design principles

- Create a welcoming and pleasant environment that promotes health and well-being
- Provided integrated medical services promoting both the local military and civilian population
- Provide a highly flexible building that can respond to future changes in healthcare provision
- Create attractive and usable internal and external spaces for users of the building
- Promotes a building design that aligns and promotes the clients clinical operating model and multi-disciplinary team approach
- Provide a safe and secure environment for staff, patients and visitors
- Provide a building, landscape and internal spaces that are accessible for all with clear way-finding
- Design and sustainable building which is MoD DREAM “Excellent” and Net Zero Carbon
- Retain and enhance the biodiversity value of the existing planting on the site
- Encourage access to the site by more sustainable forms of transport (e.g. walking, cycling and public transport)
- Produce a design that is counter terrorism (CTM) compliant
- Standardise room sizes and position built-in equipment for future flexibility

The building has been designed in accordance with all relevant Health Technical Memorandum (HTM) and Health Building Note (HBN) standards, with a derogation schedule in place as appropriate, as detailed in section 2.14.1.

Detailed designs to 1:50 detail, are available as Appendix 32.

Figure 13; Design principles



4.5.2. Schedule of Accommodation

The design is based on the Schedule of Accommodation (SoA) which has 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 requirement, to meet the activity and clinical requirements for Catterick and wider Richmondshire. The version 2.10 User Requirements Document (URD) including the NHS SoA was agreed as at CICC Programme Board in March 2022 (Appendix 33).

Whilst we have challenged the design team to be as economic as practicable, we remain committed to operating to Health Technical Memorandum (HTM) and Health Building Note (HBN) standards. Exemptions were discussed and approved by the project / programme board on 30th March 2023. The derogation schedule can be found at Appendix 24.

A summary is presented below with the key departments and their associated space requirements as modelled.

Department	Dedicated Departmental Area m^2
MOD Garrison Medical Centre (GMC)	1,936
MOD Primary Care Rehabilitation Facility (PCRTF)	1,574
MOD MDSS (Medical Device support services)	58
MOD Defence Community Mental Health North (DCMHT)	493
MOD Regional Occupational Health Team North (ROHTN)	204
MOD Catterick Dental Centre (CDC)	727
Harewood Medical Practice (HMP)	713
Advanced Primary Care (incl Diagnostics)	545
Community Services Mental Health team	432
Shared Waiting Areas	558
Shared Staff Beverage Bays	67
Subtotal	**7307**
Engineering & Plant	**633**
Circulation	**3732**
Total Gross Internal Area (GIA)	**11,672**
Gross Internal Floor Area (GIFA)	**12,245**

Table 25: CICC SoA Summary for Key Departments

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 21.

4.5.3. Design review / appraisal

A design review process is anticipated as part of the scheme however this was not available for submission with this business case.

4.5.4. Modern methods of construction

The design has had a particular focus on the development of repeatable rooms, all GP consulting spaces are of a standard layout to facilitate the use of standard components. The use of the P22 framework has also meant access to the repeatable design toolkit developed through the framework.

The bulk of the design activity was concluded prior to the requirement to include an Modern Methods of construction assessment in business cases. A request has been made to the project team to provide an assessment however this will not be available until commencement of the Stage 4 design.

4.6 Net Zero Carbon

The client brief to the design team included Net Zero Carbon as one of the principles, as shown in section 4.1 design principles. A wide range of strategies have been adopted to achieve this aim, as shown below, with a provision being made in the risk register to account for carbon offset arrangements.

4.6.1. Embodied carbon

An embodied carbon assessment (Appendix 34) was undertaken by WSP in May 2022, to identify opportunities to enhance the sustainability performance of the structural components in line with carbon reduction. In doing so, due consideration was given to the imminent release of the NHS Net Zero Carbon Building Standard (not released at the time of the design) to ensure that the embodied carbon of a structural frame is considered together with the operational emissions and transport emissions of a development to obtain a fuller picture of the overall environmental impact. The building has been designed in accordance with the design philosophy and principles below;

Design philosophy & principles

LETI[5] targets for reducing the embodied carbon in buildings sets out six pillars to focus on during the design process to try and reduce embodies carbon.

[5] Low Energy Transformation Initiative

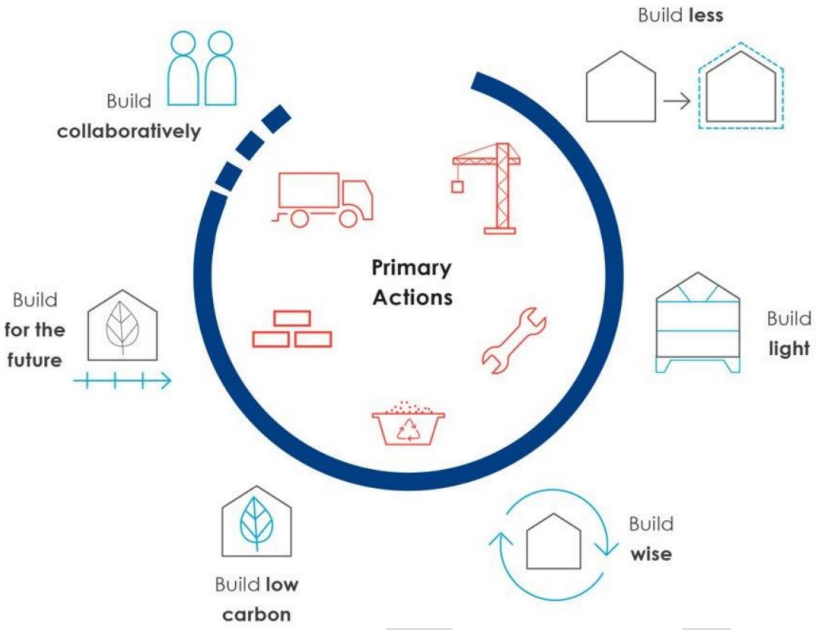


Figure 14; The LETI pillars

Accordingly, the design of the structural systems has been developed embracing the following principles

- Develop the concept to provide flexible space that can extend the life of the building and enhance the building users' experience.
- Design structures economically to minimise embodied carbon.
- Optimise loading criteria -no overdesign.
- Specify high levels of recycled material content (structural steelwork, reinforcement, recycled aggregates, cement replacement) and low impact materials.
- Consider future demolition and recycling opportunities.

4.6.2. Energy performance

A report summarising the energy strategy for the development was prepared by Hoare Lea, part of the design team, in July 2022. The recommendations and approach taken can be seen in the attached report (Appendix 35) and include but are not limited to the metering strategy.

A key element of the ambitions for Net Zero include metering of the building's energy consumption, to be able to manage the building and identify the sources of energy consumption that could be reduced. This will be crucial to understand the level of consumption, and therefore the amount of offset likely to be required. Metering shall be provided to all incoming supplies along with sub-metering to all major energy uses in accordance with Building Regulations and DREAM requirements. All metering shall be monitored by the Building Management System (BMS).

4.6.3. Electrical vehicle (EV) charging

A report detailing the electric vehicle strategy for the CICC was prepared by Hoare Lea, part of the design team, in August 2022. The strategy (Appendix 36) sets out the specification to be adopted for the scheme in order to achieve Net Zero Carbon ambitions and building regulations.

4.6.4. Mechanical, Electrical and Public Health Engineering (MEP)

A report detailing the MEP strategy for the CICC was prepared by Hoare Lea, part of the design team, in August 2022. The strategy (Appendix 37) sets out the proposals to achieve the Net Zero Carbon ambition. It considers renewable or zero carbon technologies, however it is to be noted that many renewable technologies or not commercially viable or suitable.

The strategy includes an Air Source Heat Pump (ASHP) system to generate and deliver the building's space heating, cooling and domestic hot water demands. ASHPs use grid supplied electricity to drive a compressor that extracts heating or cooling from the external ambient air using a refrigeration cycle. The systems are highly efficient, delivering a number of units of heat per unit of electricity supplied. By using external air as a heat medium, the system is classed as a renewable energy technology under EU and UK law, as the temperature of external air is controlled by solar energy.

As the building's energy demands will be met by electrically led systems, a reduced reliance on non-replenishable sources will be achieved by the development. This is due to the recent rapid decarbonisation of the national grid, which is set to continue to decarbonise even further as more renewable energy systems are brought online nationally.

4.7 Technical and Specialist Assessments

4.7.1. BREEAM

The MOD use the DREAM criteria for evaluating their schemes while the NHS applies BREEAM. DREAM[6] was designed and developed by the Defence Infrastructure Organisation to specifically address the unique nature of MOD buildings and provide the MOD with an equivalent to the industry standard BREEAM. The building has been designed to achieve DREAM "Excellent" a well as Net Zero Carbon with the design focussing on sustainability and improved running costs for the whole life of the building. The DREAM rating has targeted an excellent rating from the outset and the design will achieve this rating, as per Appendix 38.

The derogation tracker (Appendix 39) describes any relevant derogations and reasons / benefit.

4.7.2. Infection prevention and control /

The ICB lead, Michelle Carrington Executive Director of Quality and Nursing will be undertaking a review of the design of the scheme from an infection prevention and control perspective. Operational assessment will sit with the individual trust providers.

4.7.3. Fire

The development will be principally designed under the guidance of Approved Document B Volume 2 – Buildings other than Dwellinghouses (2019 with 2020 amendments), also referred to as AD-B. Recommended sections of HTM have also been applied where appropriate. The strategy has been developed with input from the design team, relevant technical advisors from the partner organisations and updated based on Approved Inspectors comments. All recommendations made within the report are subject to discussion with, and approval by, the Statutory Authorities.

4.7.4. Sustainability

Sustainability has been a consideration at the forefront in decision making throughout the process as illustrated by its inclusion as a key driver, as detailed in section 3.5.1. A

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842733/20191003-Section_6-DREAM-O.pdf

Sustainability Appraisal[7] (SA) (Appendix 39) was consequently completed as part of the MOD Assessment Study (AS) to support the decision making process in choosing the preferred option, details of which were provided in the OBC. Travel and Transport was one of the key considerations in this assessment, in terms of location and adjacencies to public transport to reduce emissions from transport, aligned to North Yorkshire CCG's Green Plan (Appendix 25). The chosen site, Peronne Lines is located to the south of Catterick town centre, adjacent to the A6136 ring road and is surrounded by minor roads. It has good pedestrian and cycle paths to the north and west of the site which connect to the town centre to the north and surrounding residential areas.

This SA then became part of the specifications moving forward, to ensure that Sustainable Development Plans were considered as part of the decision-making process in development of the design for the facility.

A civil and structural engineering report was produced by WSP, as part of the design team, in November 2022. The strategy (Appendix 40) sets out the proposals to achieve the sustainability targets. Section 5.5 sets out the potential impacts of climate change on the proposed development;

- Wind
    - Whilst the frequency of storms bringing wind, rain and flooding are likely to change, there are no indications yet that the current peak wind velocities allowed for in current building standards will need to be increased. It is important to note that should a change in building design standards be required in the future, clear guidance will be given on the impact on any existing buildings. Therefore, in accordance with the LETI guidance to reduce embodied carbon in buildings now, the current design standards will continue to be adhered to in regard to wind loading.
- Temperature
    - Global temperatures are expected to continue to increase. The cladding support details are to be designed to allow future adaptability of the cladding.
- Water Table
    - There is a current trend throughout the UK of rising water tables. An appropriate allowance has been made to account for the potential water table rise during the design of the foundations and ground floor slab.
    - This has been accounted for by designing the substructure for potential heave, and in the SUDS proposals for the surface water drainage
- Resources
    - World demand for ggbs (ground granulated blast furnace slag) will exceed its production when other countries catch up with the UK's use of it in concrete, but this is not estimated to happen until approx. 2030, so WSP will continue to specify high % ggbs replacement until then. The hope is that other cement replacement products, such as calcined clays will be produced in large quantities and accepted for use in the UK concrete specification standard (BS 8500) by 2030
    - New materials allow new ways of building and maintaining the built environment.
- Technology
    - New advances in technology will allow new ways of building and maintaining the built environment with a lower impact as we transition to a net zero economy. This is one of the reasons that saving carbon now is the imperative.

[7] Based on the MOD's Sustainability and Environmental Appraisal Tools Handbook; Section 2: Sustainability Appraisal

All identified ecological surveys and monitoring activities will continue as programmed.

4.7.5. Security

The building has been designed to the MOD's stringent security standards, which far exceed the SABRE guidance. The ICB are therefore satisfied that the facility will meet NHSE requirements.

4.8 Integrated Facility Management Arrangements

Three options were considered for the integrated facilities management arrangements as follows: -

1. MOD to let the health space to an NHS head interest, who manage the sub-lettings and sessional space (in accordance with a nominations agreement with the commissioners).
2. MOD to let the health space direct to exclusive occupiers and manages the sessional space itself in accordance with nominations arrangements in the section 2 contract.
3. MOD to let the health space direct to exclusive occupiers but outsources management of the sessional space, to the commissioners, NHS PS or another organisation (also in accordance with the nominations arrangements in the section 2 contract)

The MODs preference was to let the health space to an NHS interest head tenant.

The parties to be considered for the 'head interest' in the scheme are, NHS Property Services (NHS PS), GP (Harewood Medical Group) or Tees Esk & Wear Valley NHS FT (TEVW).

NHS Property Services submitted a proposal to the CCG on 10 February 2021 and were confirmed as the head tenants on 6 March 2021 with the support of the CCG and the executive directors.

Discussions took place between the parties around the structure of the occupation and how this will meet the scheme requirements delivering integrated services. An exercise was undertaken reviewing a potential lease option on the site or a MOTO (Memorandum of Terms of occupation) or a potential mixture of core fixed space and sessional space.

Having analysed the benefits and constraints of each option, a preferred approach and case was presented to the MOD for a lease to be put in place. The main drivers for this were to protect the NHS position as a tenant in the building enabling covenants to be observed and performed and passed down to sub-tenants as well as a clear understanding of the Landlord and Tenant relationship, and demised areas whilst still having enough flexibility in the lease to allow the sharing of services.

4.8.1. Facilities Management

The MOD are to deliver fully managed building with facility management services to the whole of the building including the NHS demise.

The MOD have awarded facilities management contracts with two major FM Service providers contracted with two FM delivery services (VIVO Defence Services which is a 50/50 joint venture between Serco and Engie) across their whole estate for a term of 7 years, these services in turn will be delivered at the new facility in Catterick, The MOD and NHS PS continue to work closely with the facilities management providers to ensure that the statutory requirements and needs of the NHS are to be met. The MOD have confirmed they have established a route to ensure that the contracts are analysed and confirm value for money and have been market tested.

Due to the size and complexity of the building Facilities Management costs are currently not available from the MOD on a line-by-line basis. Research has been undertaken for comparators and a cross check analysis of the likely costs of buildings of a similar size and specification. Investigations were carried out based on NHSPS internal information as well as third party healthcare properties and adjusted to reflect accuracy based on current information.

This exercise was supported by an external service charge consultant. The service charge figures presented to the occupiers will be capped at an agreed rate per sq m for the first two years of occupancy to allow an annual budget based on actual costs developed as soon as possible. The ICS are in support of this to move the project forward. The MOD have profiled a lifecycle programme for maintenance of the building and the NHS will make contributions at appropriate points.

The facilities management solution is to be incorporated into the legal agreements between the parties.

A building operating manual is currently in development with the project team and key stakeholders on the project which details the operational plans for the building.

4.8.2. Legal Documents

As part of the development of the CICC a number of legal documents are required to provide protection and comfort to the parties and ensure robust agreement is reached and legally documented.

The legal documents required for this scheme are: -

- Agreement for lease, linked to the provisions of the build contract to ensure contract performance.
- Section 2 Contact – Agreement between the internal system on the structure/flow of funds
- Headlease - The overarching agreement for the NHS space and the covenants of the Landlord/Tenant relationship
- Sub Leases - Mirrored leases from the headlease to enable NHS PS to lease the space down whilst maintaining the control of the overall NHS Space to protect sub tenants.

4.8.3. Agreement for lease

The Parties to the agreement to lease are the Secretary of State for Defence and NHS Property Services. The Agreement encapsulates that the MOD has agreed to undertake the development prior to the grant of lease subject to the agreement for funding. The MOD will grant NHS PS a lease of the NHS space on the completion date.

The agreement for lease is in an agreed form by the parties.

4.8.4. Section 2 contract

The Section 2 Contract is a collaboration agreement for the funding and long-term use of the asset between: -

- NHS England
- NHS Humber and North Yorkshire Integrated Care Board
- The Secretary of State for Defence
- NHS Property Services Limited

The MOD are the registered providers of the property and have agreed to carry out the development on the property. The parties intention is to collaborate in financing, procuring delivering using the terms of the section 2 agreement. NHS England and the ICB enter into the agreement pursuant to Section 2 of the NHS Act 2006.

The capital investment for the NHS Element of the scheme will flow via NHS England using a Section 2 grant agreement providing a mechanism for the transfer of funds to the MOD. The construction will be delivered by the MOD with NHS in return being granted a right to occupy for a term of 40 years, under a headlease. The Section 2 contract forms the basis for the occupancy the of the health space to an NHS Property Services head interest, who will manage the sub-lettings and sessional space (in accordance with a nominations agreement with the commissioners). All NHS parties have worked jointly legally appointed Bevan Brittan

and have worked jointly on this agreement. Jon Murphy and David Iley from NHS England have both had engagement in the development and agreement of the Section 2 contract. NHS PS have negotiated liaised and engaged with all parties ensuring positions are respectively understood and protected. This document is now in an agreed form with NHS England, MOD, ICB and NHS Property Services.

A breakdown of the key terms can be found in Appendix 41.

An agreement has been reached by the parties that there will be no rental element payable for the scheme for the term of the lease and this will be a peppercorn payment to the MOD. The NHS occupiers will pay towards the operational costs of the scheme only.

The Section 2 Contract and Headlease are both for a term of 40 years. The capital over the term of the lease applying a market rent of £225 per sq m equates to a pay back period of 35.63 years, demonstrating the scheme is value for money on the capital cost of £24 million.

The 40 year term provides the NHS the flexibility to consider the future healthcare options and will reduce overall life cycle costs attributable to the NHS for the building.

Based on the opportunity cost for a standalone facility there would be no integration opportunities and therefore the need for an increase in floor areas and increasing the cost of capital for a scheme.

4.8.5. Headlease

The new CICC building will be situated Peronne Lines, Scotton Road Catterick Land which is owned by the MOD.

The MOD will develop, own and manage the building and self-occupying 74.8% with the NHS occupying the remaining 25.2% of the space. There is an intended sharing provision of the facility due to the arrangement and layout and opportunities for integration of services.

NHS PS will hold the headlease for a 40-year term aligned to the Section 2 contract. The MOD will issue any charges directly to NHS PS, who in turn will manage the sub tenancy arrangements.

There is provision of NHS bookable rooms within the facility to allow further services to utilise the facility.

The initial heads of terms agreed at outline business case have been developed and regular legal meetings are taking place to negotiate the legal documents required.

The MOD will hold the build contract with the NHS protected via the provisions of the agreement for lease, holding the MOD accountable for the delivery of the scheme.

The key terms for the headlease can be found in Appendix 42.

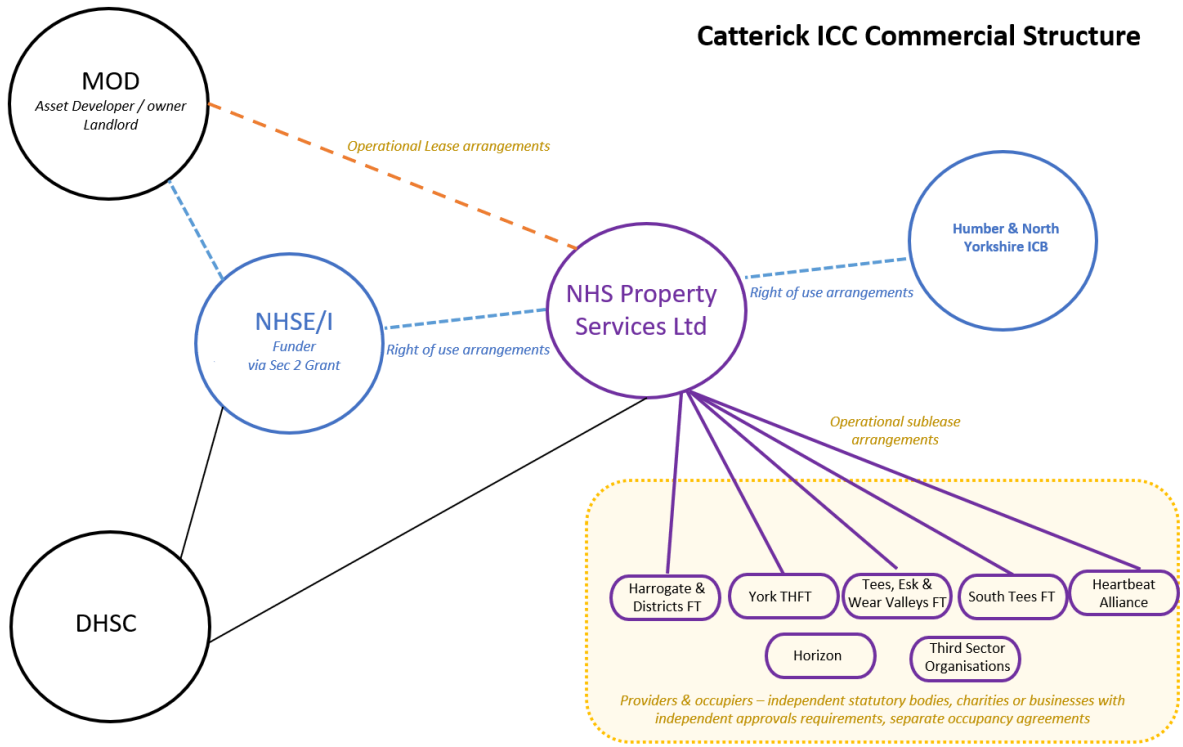


Figure 15; Catterick ICC Commercial Structure

4.8.6. Contractual milestones / delivery dates

FBC approval will trigger finalisation of contract terms with PSCP and allow completion of agreements and progress into contract. The detailed construction delivery programmes is included in the appendices.

4.9 Opt to Tax & VAT recovery.

The MOD have confirmed the intention to Opt to Tax the building to allow NHS to recover the costs on construction. NHS Property Services will Opt to Tax and make an onward supply for the recovery of VAT services to the occupiers.

NHS Property Services have received advice from Ernst Young around the structure of the transaction and are liaising with the MOD. A report on the proposed structure is included at Appendix 45.

4.10 Insurance

MOD have agreed to procure insurance for the building at NHSPS request. Advice has been received from Willis on the Insurance required and this cost will be passed down to occupiers. NHSPS have requested insurance cover in order to ensure that if the building is damaged or destroyed there is a mechanism for redevelopment outwith the capital resources of departmental budgets.

4.11 Planning Permission

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

- 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 needs 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.

Further Formal pre-application discussions took place and were positive around the principle of the design and supportive of the demolition of existing buildings on site. . The proposed site was earmarked for the scheme by the MOD at a national level.

Tilbury Douglas were appointed to deliver the design and build and to take forward a full planning permission which was submitted in June 2022.

NHS/MOD liaised with a range of project stakeholders from Catterick Garrison, Colburn and Richmondshire through public engagement events, sharing design ideas and concepts with positive responses.

On the 4th October 2022 Richmondshire District Council granted approval for the full planning permission, (Appendix 43) 22/00380/FULL

This approval is subject to several conditions including sec. 106 contributions, and these will be managed out as part of the scheme delivery plans. The number of planning conditions are considered minimal for the size and scale of the proposed development and have been accounted for in the costed risk register.

The granting of the planning permission has de-risked the scheme and enables development.

4.12 Land transactions / 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 expiring in 2066 from the MOD. Initial review suggests that there is limited realisable value in this asset. Catterick Garrison is occupied by Harewood Medical Practice, with some services delivered by Harrogate District Foundation Trust, and South Tees NHS FT. Discussions are taking place with the MOD around the timescales for the surrender of these premises by lease negotiation which will align to the overall programme for surrender & relocation.

The site is identified for redevelopment as part of town centre plans for Catterick Garrison which have recently been successful in securing national levelling up funding.

Tees Esk and Wear Valleys NHS Foundation Trust are currently located at Colburn Medical Practice with a from the GP occupiers, the site is owned by Assura plc. The lease is due to expire in November 2026, which will align to current programme timescales.

South Tees Foundation Trust are currently have some existing services Audiology and X ray that will be relocated to the new CICC build. There is a Project initiation Document in development for a replacement scheme at the Friary with the intention for a frailty hub. Ongoing discussions with the Landlord around the scheme and taking place with the assumption being that the services will remain in the existing location to align with timescales for the delivery of the CICC.

As the scheme progress monthly meetings are taking place with the occupiers, action logs and risk registers are currently being drafted to ensure that all tenancy requirements have been collated to assess any level of risk, monitoring timescales for any service of notices required to the existing premises.

4.13 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 31. 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 31.

Now that a firm position on capital funding source and flows is achieved, we are refreshing 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.

4.14 Personnel implications

The relevant personnel implications are addressed below;

4.14.1. National workforce drivers

The recruitment, retention and development of staff has been recognised as a key driver throughout all stages of project development, details of which are contained in the strategic case. It is consequently recognised as an investment objective and included in the benefits arising from the intervention, details of which are contained in the economic case.

4.14.1. TUPE

The implication on NHSPS employed cleaning and maintenance staff for the existing Catterick Garrison Health Centre is currently being assessed, given the management arrangements for the new facility. Due consideration is being given to TUPE and / or RoE implications and if applicable consultation will be undertaken in accordance with legislative / regulatory requirements. 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.

4.14.2. Sustainable development

The PSCP is undertaking work around apprenticeships, employment and diversity as part of their social value responsibility. These will be tracked as part of the benefits for the project, as detailed in the management case.

There is also a programme workstream dedicated on workforce, education and research which focusses on future healthcare careers.

4.15 Risk

The risks identified in the economic case have been an appropriately allocated to party best able to manage the risk between public and contract sectors. Operationally the MOD will hold full liability for maintenance and repairs and therefore building warranties are not required to the NHS.

The facility has been designed to meet HBN and HTM standards.

4.16 Conclusion of the commercial case

We have demonstrated that the preferred option will result in viable and deliverable project, with robust contracts being in place to safeguard the best interests of the NHS. We have demonstrated our understanding of the requirements of this investment and its outputs and how risk is distributed between contracting parties.

5. Financial Case Purpose of the Financial Case

The financial case assesses the financial impact of developing the CICC for the preferred option. It demonstrates that the investment is affordable to all stakeholders and shows the impact this investment will have on overall finance in subsequent years. It takes costs as detailed in the economic case (which have demonstrated value for money) and treats these costs in line with the accounting principles that apply to NHS organisations.

5.2 Material changes since the submission of OBC / OBC addendum

There have been no material changes since submission of the OBC.

5.3 Key Points

- The total capital cost of the preferred option is circa £115.34m (including VAT and inflation), £86.53m MoD and £28.81m NHS.
- The source of the NHS capital funding has been confirmed as and is noted in table 26 below.
- 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 at ICB level are estimated as circa £644k per annum including VAT, circa £198k more than current expenditure. The ICB expects to support this funding gap by cash releasing savings delivered through ICB 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.

5.4 Financial Evaluation

The financial evaluation looks at the capital cost, the economic case and the affordability of the preferred option in the Economic Case, section 3.3 of the FBC. The background to the financial modelling was detailed in the OBC and this section is focussed on the preferred option.

5.5 Capital Cost

Tilbury Douglas have prepared a GMP for the project based on the completed Stage 3 design. This pricing is based on market tendering exercise which was reviewed by the MOD cost advisors AECOM and independent cost consultants advising MOD.

A summary of the capital cost split between NHS and MOD is included in the table below.

	Total Cost £m	MOD £m	NHS £m
Stage 4 Inclusive of VAT	109.5	81.92	27.58
Stage 4 VAT	18.29	13.69	4.6
Stage 4 Excluding VAT	91.21	68.23	22.98
Stage 3	5.84	4.61	1.23
Totals	**115.34**	**86.53**	**28.81**

Total NHS Cost Incl VAT			**28.81**
Total NHS Cost Excl VAT			**24.21**

A copy of the elemental cost plan is included at Appendix 27.

The profile of the capital spend for the preferred Option 4 for an Integrated build through Section 2 transfer (CIA Option 4) is summarised in the table below. The final timing of payments will be agreed with MOD and reflects the position advised to MOD who are aware that the NHS have limited flexibility to move from this profile.

	NHS Capital Funding Requirement Excluding VAT					
	Prior Year £000	2021/22 £000	2022/23 £000	2023/24 to 2024/25 £000	2025/26 to 2026/27 £000	Total £000
NHSEI Revenue Funding	(106)	(659)				(765)
Primary Care BAU Funding			(717)	(1,420)	(1,809)	(3,946)
NHSEI Armed Forces				(500)	(9,500)	(10,000)
NHSPS (Re - Disposal proceeds)				(2,000)	(1,000)	(3,000)
ICS Capital Underwrite				(3,500)	(2,000)	(5,500)
Revenue to Capital Transfer				(500)	(500)	(1,000)
	(106)	**(659)**	**(717)**	**(7,920)**	**(14,809)**	**(24,211)**

Table 266: Capital Spend Profile

5.6 Capital Funding

The scheme has a confirmed NHS capital allocation. This is made up from funding from a number of capital sources including primary care capital allocations, and ICS capital contribution. Funds from NHSPS disposal recycling will be made available on the basis that this is a recognised ICB priority and with agreement from DHSC. It has always been recognised that this project was pioneering an approach in joint working with the military, and NHSE have supported the scheme by identifying a capital route for the project.

5.7 Financial model

A financial model has been developed, which has been reviewed and updated throughout the project which includes;

- Agreement and recording of underlying assumptions
- Funding
- • Input schedules for costs, cash releasing benefits, risks and contingencies. Covers an appropriate term

The design of the facility has taken place based on an assessment of demand and capacity utilising recognised space planning tools and recognising future workforce plans.

5.7.1. Key assumptions

NHS Property Services has sought advice on the treatment of Stamp Duty and Value Added Tax from Ernst Young and the treatment is compliant with legislation. (Neither is applicable)

5.8 Revenue Costs

The annual premises/operating costs of each option were calculated by NHSPS on behalf of the ICB. Detailed cash flow modelling was completed for each of the options and sub-options and was included within the OBC. This has been further updated for FBC.

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 £210 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 based on MOD modelling or on a per sqm basis.

The annual revenue costs calculated on the above basis at 2022/23 prices have been uplifted for inflation in the modelling. The table below shows the position in 2027/28 which would be the first full year of operation.

	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
Base Rent	153,560	153,560	711,303	648,507	-	867,810
Ground Rent	2,650	2,650	1	-	1	-
Rates	17,799	17,799	163,489	138,966	118,001	118,001
Other Site Operating Costs			26,449	26,449	21,352	21,352
Service Charge	8,233	8,233	-	-	-	-
Facilities Management	179,879	179,879	417,805	417,805	337,295	337,295
Management Fee	9,037	9,037	41,781	41,781	45,740	45,740
Lease Management						
Total Exc VAT	**371,158**	**371,158**	**1,360,828**	**1,298,030**	**536,373**	**1,404,183**
VAT	74,232	74,232	272,166	259,606	107,275	280,837
Total Inc VAT	445,389	445,389	1,632,993	1,557,636	643,648	1,685,019
Increase on BAU	-	-	**1,187,604**	**1,112,247**	**198,259**	**1,239,630**
CIA Total Revenue Costs	**7,050,270**	**7,050,270**	**12,457,755**	**26,385,851**	**10,452,805**	**10,452,805**

Table 27: Annual Rent and Operating Costs

Note: Table above shows the benefit of the Section 2 transfer option to the ICB, 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.

Several services will move from the Friary Community Hospital to the CICC. The areas vacated are planned to be re-used by services moving into 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.

5.9 Revenue Affordability

The key consideration for the ICB and system partners 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 £644k per annum including VAT. This compares against £445k per annum that is the modelled 'business as usual' current expenditure. There is therefore a funding gap of circa £198k per annum.

The ICB 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.

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 has been undertaken to determine the impact on each tenant/occupier. The ICB have reviewed individual provider impacts and held discussions with the provider as appropriate. Each provider has been asked to provide a letter of support based on the modelled operating costs.

The preferred option will therefore result in a total funding gap of circa £198k per annum that will require the ICB and system partners to plan for as an investment. The ICB expects to support this funding gap by cash releasing savings delivered through ICB transformational schemes and/or accessing primary care transformation funding through the ICS.

The following actions and projects will be undertaken to deliver an affordable solution to the £198k:

We have identified the following potential savings realised through the integrated model when it is fully in place and through new models of care. These are in the following areas:

- Improved recruitment/retention of staff through better working environment
- MDT integrated approach to support early discharge can reduce delayed transfers of care and reduce bed days.
- MDT integrated approach, will allow some care home admissions to be prevented.
- Reduce non-elective non-emergency admissions.
- Relocation of services from other premises within the ICB footprint

Allowing for block contract/AIC arrangements and the likelihood of cash releasing savings, this saving has been estimated at circa £145k at this stage.

In addition to these savings

- The Harewood practice is currently receiving financial support through section 96 arrangements from the ICB and NHSE. It is assumed that the integrated model solution will enable the practice to provide a financially stable primary care service and this level of additional financial support can be reviewed. 2022/23 financial support currently provided is £174k.
- PMS funding reinvested non-recurrently in primary care will also become available across the timescale for the ICB to consider reinvesting in primary care.
- There is also the opportunity to access future ICS transformation funding that the ICB will look to bid for/access primary care transformation funds to support revenue costs. This may be to support both the recurrent revenue cost and any non-recurrent revenue costs that may be incurred until scheme is fully operational.
- Other ICB savings opportunities to offset such as Medicines management DES and through new PCN operating models which are developing.

In conclusion the ICB will ensure that future plans will include the costs of the scheme and deliver the increased costs through a mixture of reinvestment of current income, delivery of savings and potential transformation funding.

5.10 Financial statements

5.10.1. Balance sheet treatment

The CICC facility will be held on the MOD balance sheet. There are no anticipated ICB balance sheet implications related to the flow of ICB capital to NHSE to support the Section 2 payment.

NHS Property Services will take the Head Lease interest on behalf of the NHS on the basis of a peppercorn rental. This headlease interest will be backed off against the subletting

arrangements with the NHS providers and Harewood Medical Practice so will not create an asset on the NHSPS balance sheet and therefore no CDEL consideration.

As the leasing arrangement from NHSPS to the providers will also be at a peppercorn it is not anticipated that there will be any IFRS16 or CDEL implication for the NHS providers and the general practice would not be on government balance sheet so the question does not arise.

5.10.2. Accounting treatment

NHS Property Services have provided advice to the project on the proposed approach as it relates to the NHSPS involvement in the leasing structure and commercial structure of the project. Formal advice has been sought on the proposed VAT arrangements from Ernst & Young. The commercial structure has been developed to allow the recovery of VAT on the NHS element of the project.

MOD are entering into the construction contracts and appropriate checks and balances are included in the legal agreements.

The managed service arrangements for hard and soft facilities management and other building services are covered in the commercial section of this FBC.

5.11 Financial Risks

The Harewood practice is facing considerable financial pressure due to local population need not currently being recognised within the national formula. The ICB and NHSE are providing additional support to the value of £174,000 through a Section 96 agreement, for the year 2022/23, 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 ICB 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 ICB allocations.

There is a risk with rising inflation that the overall build cost may increase, this is reflected in the project risk register and highlighted at section 2.14. Appropriate inflationary allocations have been made in the GMP to the mid-point of construction. The NHS has been clear with MOD partners that the scheme needs to be delivered within the funding available.

5.12 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 provided in the economic case at Appendix 5 which shows that the fully integrated scheme Options 5b & 5c has the highest ratio and provides the best public/social value.

5.13 Financial Evaluation

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

	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 Incremental Capital	£401,411	£26,704,511	£4,616,719	£26,163,196	£26,163,196
Revenue Costs	£0.00	£5,407,484	£19,335,581	£3,402,535	£3,402,535
Total Incremental Costs	**£401,411**	**£32,111,996**	**£23,952,300**	**£29,565,731**	**£29,565,731**
Incremental Benefits					
Incremental cost reduction - risks	£2,100	£7,686,940	£7,686,940	£7,686,940	£7,686,940
Incremental benefits (combined)	£0	£95,563,392	£84,302,274	£162,062,730	£162,075,278
Total Benefits	**£2,100**	**£103,250,333**	**£91,989,214**	**£169,749,670**	**£169,762,219**
Risk-adjusted Net Present Social Value (NPSV)	**£399,311**	**-£71,138,336**	**-£68,036,913**	**-£140,183,939**	**-£140,196,487**
Benefit-cost ratio	**0.01**	**3.22**	**3.84**	**5.74**	**5.74**
Annual Operating Cost incl. VAT	**£445,389**	**£1,632,993**	**£1557,636**	**£643,648**	**£1,685,019**

Table 278: Capital costing, Economic Appraisal and Affordability Assessment

An integrated new build funded by a Section 2 transfer gives the best all round financial outcome, this is due to the peppercorn rental. While it does not have the lowest capital cost of the new build options, a strong affordability assessment and the best return on investment as demonstrated by the NPSV and benefit cost ratio. The integrated new build with NHS grant funding to MOD is the most affordable in revenue terms to the local system.

5.14 Conclusion of the financial case

We have demonstrated that investment in the preferred option is affordable to the ICS and shown the impact this investment will have on overall finance in subsequent years. The ICS will remain financially viable and have access to cash to meet all operating and contingency requirements.

The preferred funding route for the CICC remains the use of a combination of capital funds via NHSE capital grant to MOD.

6. Management Case

6.1 Purpose of the 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.

6.2 Material changes since the submission of OBC / OBC addendum

The project has a joint project management office with MOD and the arrangements for the successful delivery of the project link to the wider arrangements for the delivery of the programme. Workstreams and task and finish groups are stood up to manage the individual streams of work as the programme is substantial and intensive focus is required on each element.

The details of the workstreams and task groups are set out in the NHS Project Execution Plan which has been refreshed for the FBC stage and is maintained as a live document. This reflects the wider programme management plans.

Workstreams and task groups report into the PMO meeting which is held fortnightly and subsequently to the SRO Programme Board. Individual projects have their own programmes, and an overarching timeline has been developed for the Programme.

Since OBC the workstreams have continued to develop products to support the operational delivery of the project and detailed infrastructure design and delivery arrangements have been developed. This work will continue through the construction delivery phase subject to FBC approval being achieved. The current workstreams are;

- Construction, Design and Delivery Workstream
- Clinical Operating Model Workstream
- NHS Business Case Task Group
- Legal/Asset Management Task Group
- Building Operating Model Task Group
- Digital Workstream
- Communications and Engagement Workstream

The detail is available in the Project Execution Plan at Appendix 46.

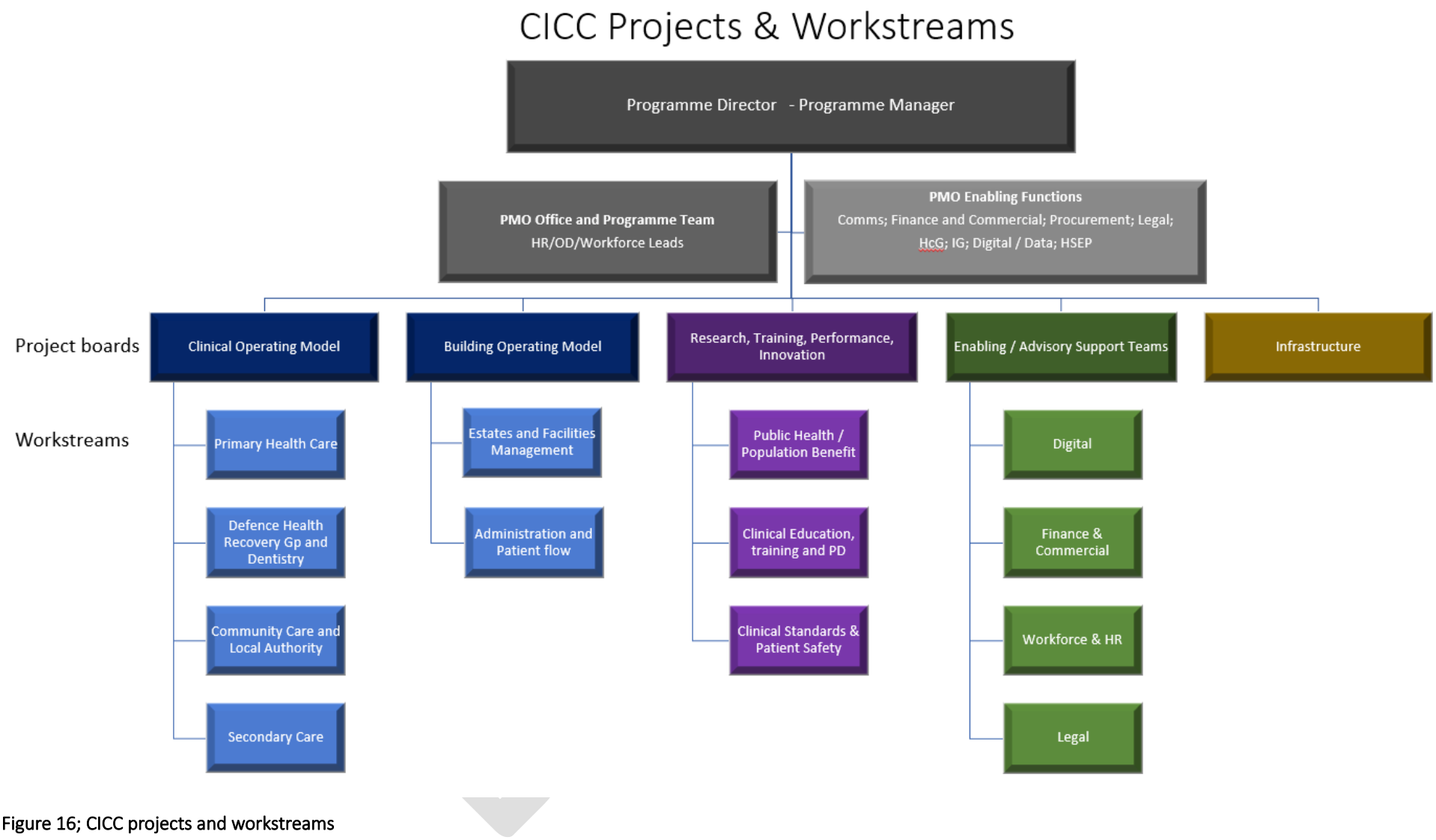


Figure 16; CICC projects and workstreams

6.3 Project Plan

Current proposals are summarised in the table below.

Milestones	Date	Responsibility
FBC completed and approved by Governing Body	April/May 2023	HNYICS
FBC submitted to Region NHSE	May 2023	HNYICS
FBC shared with MOD	May 2023	HNYICS
FBC approval	Sep 2023	NHSE
Construction period	Jan 24 - Aug 26	MOD
Services reconfiguration/transition plan implemented	Mar 23 – Aug 26	HNYICS
Building opened	By Sept 2026	All

Table 2928: Project Plan Current Proposals

Please see Appendices 48, 49 & 50 for the NHS Summary Programme, the Tilbury Douglas Construction Programme and the Programme wide programme extract.

6.4 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, and subsequently part of Humber North Yorkshire ICB in April 2022.

The ICB has compiled a project team with sufficient and adequately skilled resource to successfully manage the project through the relevant stages beyond FBC. To support the NHS Partners NHS Property Services is providing specialist advice and support on the design, delivery and acquisition of the NHS interest. NHSPS will take the headlease interest and manage the NHS occupancy arrangements once the building is completed and occupied.

The details of the legal and commercial arrangements are set out in the Commercial Case. Please see Appendix 46 for the current project team, roles and resources.

Please see Appendix 30 for the construction project management structure.

MOD have completed a Gateway 3 Review of the Infrastructure element of the project in February 2023. The ICB have completed and submitted a Risk Profile Assessment for the infrastructure project and submitted this to DHSC. The project assessment was that the scheme was low risk and no separate gateway assessments are currently programmed. The Risk Profile Assessment is included at Appendix 47.

6.5 Programme Management

The ICB 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 Garrison. Details of the project arrangements and interface with the wider programme are set out in the Project Execution Plan and in the CICC Programme Brief which can be found at Appendix 51.

In addition, a governance model has been developed for the operational phase of the scheme which covers clinical, estates operational and contractual considerations. It is show below;

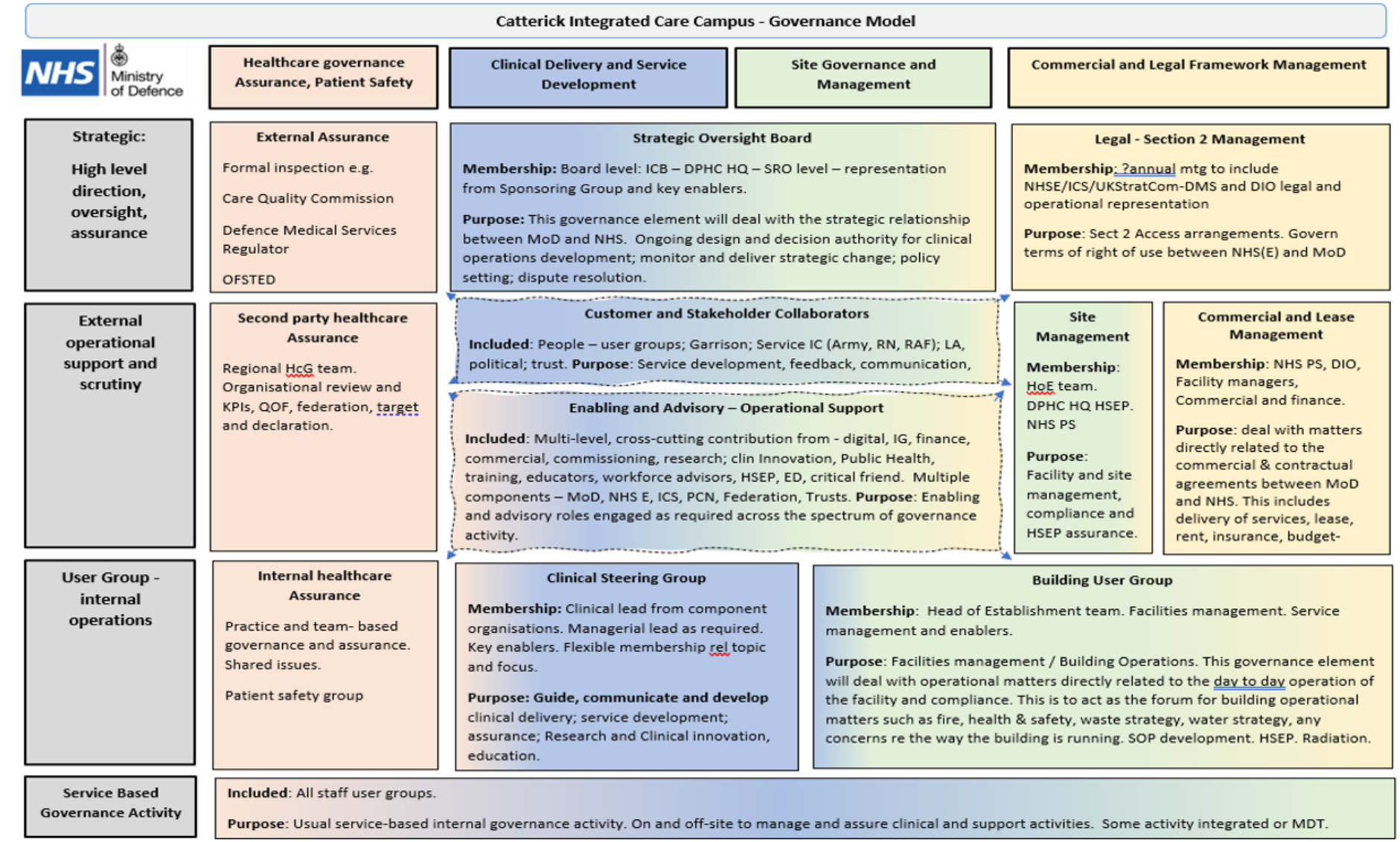


Figure 17: CICC Governance Model

6.5.1. 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. 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 ICB project management costs.

This 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 participate in relevant workstreams and task groups.

6.5.2. Integrated Commissioning

The move to a model of integrated primary and community care across the NHS and military organisations is a must to 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 ICB will continue to work with our integrated care system partners across HNY ICS 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 ICB 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 has been developed prior to the NHS FBC and MOD MGBC to ensure the delivery of outputs that will enable both the ICB and MOD to meet their respective statutory responsibilities and public accountabilities.

6.6 Project Reporting and Monitoring

The joint Programme Management Office coordinates the Programme on behalf of the partner organisations. Across the Programme it plans and controls work, tracks and communicates progress, facilitates benefits realisation and risk management and optimises the use of resources.

The PMO has four core roles.

- provide / act as the information hub of the Programme;
- establish and maintain programme management processes and set standards;
- give decision support to the Programme Directors and SRO Programme Board; and

- establish programme processes, conduct performance management of programme delivery, and promote best practice in programme, workstream, project and risk management.

The PMO carries out the functions of: coordination and integration; information management; strategic alignment, planning and interdependencies; progress monitoring, reporting and forecasting; communications and stakeholder engagement; benefits management; risk management and issue resolution; business cases and investment appraisal; programme budget; change control; version control; and secretarial support to the Project Workstreams, the SRO Programme Board and the Sponsoring Group. PMO meetings take place every two weeks. The PMO reports to Joint Programme Board at each if its meetings. To ensure the scheme continues to maintain traction and momentum issues requiring a formal decision or escalation are raised in the fortnightly PMO meetings. The Project Leads for the ICB and MOD will then provide direction or seek decisions from SROs.

Further details of governance structures and roles and responsibilities are set out in the Project Execution Plan and CICC Programme Brief.

6.7 Benefits Management

A benefits realisation plan has been developed and is included at Appendix 4. This has been updated since OBC. The programme team are identifying potential for more detailed work and engagement of public health specialists to understand the wider benefits that are achieved from the integrated approach. It is anticipated that baseline data will be gathered during 2023 to support this evaluation activity.

6.8 Change Management

Change management associated with the scheme will be managed through the North Yorkshire Place governance arrangements under the leadership of the SRO. Day to day change management issues will be discussed at the PMO meetings 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 and cultural 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.

Change management associated with the scheme will be managed through and under the chairmanship of the joint SROs.

Governance

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.

The Clinical Operating Model (Appendix 6) has developed the specify the pathways, levels of integration opportunities and mechanisms that will be realised and become integrated across the NHS and MOD medical delivery. This includes the development of the commissioning and contracting of the model to ensure its long term sustainability. All key partners are engaged in 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. The Clinical Operating Model workstream is responsible for managing the cultural change associated with the new ways of working.

6.9 Risk Management

In line with the MOD project requirements a comprehensive, fully costed joint risk log was created and is included at Appendix 23. The risks have been subject to a Monte Carlo Simulation and the risk allowances 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 key project risks are reported and managed via PMO meetings and presented to the SRO Programme Board.

6.10 Contract management

The MOD are the lead partner in the delivery of the infrastructure element of the CICC scheme. In line with MOD processes they use the DIO to provide project management of infrastructure projects. DIO have appointed AECOM as Technical Services Provider to monitor the delivery of the construction project. DIO have a specialist Commercial team who manage the contractual arrangements with the PSCP, and they will continue to undertake this role during Stage 4 Design and Construction.

NHSPS will appoint a monitoring surveyor to oversee the projects activities on behalf of the NHS partners during the Stage 4 design and construction phases. The arrangements for that appointment will be included in the Section 2 grant agreement documentation and further detail is provided in the Commercial section of this FBC.

6.11 Business Continuity

The proposal for the CICC will be delivered on a cleared brownfield site. Services will be retained at their existing locations until the new facility is commissioned so there are no business continuity issues to be resolved.

6.12 Use of External Advisers

In line with MOD process they use the 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 infrastructure project.

The NHS have been provided with property and infrastructure development support by NHS Property Services.

Where necessary NHSPS have sought input from subject matter experts on the design and procurement processes. A budget has been established for further specialist input in Stage 4.

Programme Management	PMO
Procurement technical services partner	MOD / DIO / NHSPS Construction
Consultation & Engagement Activities	CCG/ICB delivered
NHS Project Management	ICB/NHSPS
Valuation, Lease arrangements for general practice and VfM	Valuation Office Agency
BREEAM / DREAM	Tilbury Douglas and MOD SME review
Legal advice property and contract documentation for scheme	Joint appointment Bevan Brittan
Contract / Lease documentation advice	NHSPS commercial property / Acquisition advice

Subletting Agreements (if required)	NHSPS appointment of legal advisors and co-ordination
Tenant / occupier legal advice	Occupier joint appointment and cost
P22 documentation, procurement and selection	NHSPS Construction team specialist advice and co-ordination for NHS occupiers
Design development	NHSPS provided specialist advice and co-ordination for NHS occupiers
Financial Evaluation & Analytics	NHSPS E&A team to supported development of financial modelling and CIA
Business Case Production	NHSPS provided estates and commercial and economic case inputs and support FBC development. NHSPS appointed Community Ventures Ltd to prepare the FBC documents (funded by ICB).
Specialist Advisors	Authorising Engineers, Radiation Protection Advisors etc to be appointed on an as required basis.

Table 30: External advisors

6.13 Information and Communications Technology System Interoperability

The Digital Workstream have been tasked with delivering a technical solution to the clinical and building operating models. The aspiration is to have a significant level of interoperability, but this may not be deliverable on day one.

It is anticipated that the MOD Project 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 is proposed 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.

Full access to records will 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 Digital 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.

6.14 Workforce

The CICC programme is seeking to address 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 developed under the Programme Governance Structure and lead by the HR and Training specialists from both the MOD and NHS within the Working Group.

The design of the infrastructure solution is intended to maximise interaction between clinical teams and organisation through the use of shared staff rest areas, beverage bays and support facilities. There is a single reception for the building and sharing of meeting and training facilities. In the general practice element of the scheme a standard layout has been agreed for consulting space with the intention that these will be shared between MOD and NHS as part of planned joint working.

Within the APC area many of the rooms have been planned on the basis of shared use to maximise the levels of utilisation. This sharing of space will be supported through use of the Open Space platform providing a web based booking and billing process.

The building has also been designed to maximise the use of natural light and to create a vastly improved work environment for staff. It is well connected to areas of landscaping to support staff well-being and also linked to local active travel routes to promote cycling and exercise. There are local bus routes and staff will be encouraged to use green travel through implementation of the travel plan once the infrastructure solution is complete. It is anticipated that the combination of improved physical environment and the collaborative work environment will improve recruitment and retention, and this will be monitored as part of the benefits realisation plan.

The staff of partner organisations have been actively engaged in the design of the infrastructure solution and are also being drawn into the development of the clinical strategy and the programme of change. The building operating model has been drafted to ensure that the working arrangements within the facility respond to staff requirements and this will continue to develop through the construction period.

6.17 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 ICBs 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 ICB 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 . 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.

Several key risks have been identified as set out below:

- System sustainability;
- Challenging timescales;
- Ongoing engagement; and
- Development of the formal relationships and partnership agreements.

The NHS FBC has set out: governance, high-level risk assessment, enabling functions and a development plan that will form the basis of the work programme together with strategic integrated commissioning principles. This will be supplemented with detailed transition and mobilisation plans to ensure migration to the CICC in 2026.

6.18 Full Arrangements for Post Project Evaluation

The Full 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 FBC, and the processes involved in the scheme delivery. The ICB 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 ICB 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 ICB 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.

MOD have a well-developed Learning from Experience process (LFE) which takes place throughout the life of the infrastructure project. LFE input was gathered from all project partners at assessment study, OBC and FBC stages and will continue through stage 4 design, construction delivery, and commissioning phases.

A budget is in place for post implementation monitoring and Post Project Evaluation in the overall project cost (Appendix 52).

6.19 Conclusion of the management case

We have set out the framework for successful delivery of the project, including a robust programme and project management structures. The programme will be led by a skilled and experienced team with appropriate oversight and assurance arrangements in place at all levels to ensure delivery on time and to budget.

.

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 ICB'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 5B_CIA4 - Integrated new build with NHS grant funding to MOD**.

Milestones	Date	Responsibility
FBC completed and approved by Governing Body	April/May 2023	HNYICS
FBC submitted to Region NHSE	May 2023	HNYICS
FBC shared with MOD	May 2023	HNYICS
FBC approval	Sep 2023	NHSE
Construction period	Jan 24 - Aug 26	MOD
Services reconfiguration/transition plan implemented	Mar 23 – Aug 26	HNYICS
Building opened	By Sept 2026	All

8. Appendix List

App	Title
1.	NHSE checklist
2.	MOD FBC
3.	NHS Schedule of Accommodation
4.	Benefits register / realisation plan
5.	CIA
6.	Clinical Operating Model
7.	Letters of Support
8.	Design and access statement
9.	Reshaping Richmondshire
10.	PAU calculator for GP space
11.	Modelled space summary (as drawn)
12.	GP & Advanced Primary Care Utilisation schedule
13.	EIA
14.	CCG Estates Strategy
15.	NE& NC ICS Estates Strategy
16.	HCV ICS Estates Strategy
17.	Comms & Engagement Strategy
18.	SEAG Terms of Reference
19.	RCC letter re dental services 9/11/22
20.	ICB response re dental services 22/12/22
21.	MOD Assessment Study (app 15 in OBC)
22.	Monte Carlo stress testing
23.	Risk register
24.	Derogations tracker
25.	North Yorkshire CCG Green Plan
26.	Assessment Study through to OBC and CIA
27.	Construction costs / elemental cost plan
28.	Whole life cycle costs – Turner Townsend report
29.	Value Management Process
30.	HLIP
31.	Commercial Strategy
32.	Design drawings
33.	URD
34.	Embodied carbon assessment
35.	Energy strategy
36.	Electrical vehicle charging strategy
37.	MEP strategy
38.	DREAM report

39.	Sustainability Assessment
40.	Civil and structural engineering report
41.	Section 2 contract – key terms
42.	Headlease – key terms
43.	Planning approval
44.	Equipment schedule
45.	Opt to Tax & VAT Recovery Report
46.	Project Execution Plan
47.	OGC Gateway Risk Potential Assessment (RPA)
48.	NHS Summary Programme, the
49.	Tilbury Douglas Stage 4 Programme
50.	Programme Outline Plan
51.	CICC Programme brief
52.	Project Cost breakdown