NHS
Cambridgeshire
Community Services
NHS Trust

Strategic Outline Case for a Modular Hospital incorporating a Local Health and Care Hub for Ely

Table of Contents

Figures

Tables

Version control

Version	Date	Author	Details
V0.1	May 2020	Andy Whiting	Initial template and draft
V0.2	18/08/20	Andy Whiting	Strategic case
V0.3	16/10/20	Andy Whiting	Incorporating comments from R Dickson
V0.4	23/10/20	Andy Whiting	SOC for CCS Programme Board
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V0.8	22/11/20	Andy Whiting	Updates for director's QA

1 Executive summary

1.1 Introduction

1.1.1 Purpose of this business case

This strategic outline case (SOC) sets out the case for developing the Princess of Wales (POW) Hospital site in Ely and tests the feasibility of different options to expand the number of services provided from the site whilst also ensuring that all services operate from fit for purpose modern accommodation. The project described in the SOC responds to the following needs:

- The need to provide modern health and care environments that support the delivery of joined-up services as described in national and local strategy.
- The need for more physical capacity in Ely to meet anticipated rising demand from the growing and ageing local population.
- The opportunity to deliver more treatments and care in Ely thereby helping the C&P acute hospital sector to free-up space in hospitals such as Addenbrooke to in turn allow acute-based services to expand.
- The need to replace the existing ageing and no longer functionally suitable estate at the POW Hospital with fit for purpose buildings meeting all modern standards.

The business case takes as its starting point the SOC developed in 2017 and the related wave four funding bid, and proposes a preferred way forward comprising:

1. A new health and care hub.
2. A linked day surgery and therapy unit within retained estate currently forming part of the POW Hospital.
3. The expansion of the day service including the establishment of a 23-hour ward.
4. A multi-storey car park.
5. A land swap between Cambridgeshire Community Services (CCS) NHS Trust (the POW site owners) and Palace Green Homes to secure land for the health and care hub in exchange for part of the existing POW site which would then be redeveloped for housing.
6. The sale of part of the existing POW site for additional housing.
7. The further sale of part of the site for the development of a nursing home.

The CCS Executive Programme Board are asked to approve this SOC paying particular attention to the proposed shortlist of options to be taken to outline business case.

1.1.2 Structure of the business case

The SOC is consistent with the latest guidance from The Treasury[1] on the development of business cases and uses the five-case model. At SOC the business case:

- Makes the case for change.
- Tests options that respond to the case for change.
- Selects a preferred way forward using the Options Framework methodology.

[1] Guide to Developing the Project Business Case, HM Treasury, 2018.

1.1.3 Support and approvals

The business case requires formal approval by CCS and once received, will be shared with Cambridgeshire and Peterborough Sustainability and Transformation Partnership (C&P STP) partners to gain their support.

1.2 The strategic case

The strategic case demonstrates that the proposed investment to create a local health and care hub in Ely responds to both national policy and local need.

1.2.1 Need

The POW Hospital is located in the north of the city of Ely in the district of East Cambridgeshire. Whilst there is no defined catchment area as such for the hospital, people attending the POW will come broadly from the East Cambridgeshire district which has a population of just under 90,000. East Cambridgeshire has the lowest population density in Cambridgeshire and the rurality and associated poor public transport, does create challenges in delivery of and access to, public services.

The local population has a similar age profile as the county and England as a whole. Cambridgeshire and Peterborough is an area of high population growth as evidenced in historic trends and forecasts of new house building and, whilst East Cambridgeshire has experienced low growth relative to the rest of the county in recent years, it is predicted to have the second highest level of proportional growth (+25.4%) of any Cambridgeshire district between 2016-2036 with older age groups growing at the fastest pace. This growth in the older population is expected to lead to a significant increase in demand for health and care due to the correlation between ageing, the likelihood of having one or more long-term conditions and/ or meeting the classification of "frail". Need for health and care services is also determined by socio-economic factors. Deprivation is low in East Cambridgeshire, with none of the local electoral wards being within the most deprived fifth (20%) of areas nationally.

There are significant plans for new housing across the county and three of the county's 23 development sites are in East Cambridgeshire (and a fourth is nearby in Chatteris). The district council's 2020 Five Year Land Supply Report[2] sets out a requirement for 3,610 (+9.5%) new homes over the five years to 31st March 2024. Land supply has been identified sufficient to deliver 4,772 homes in the first five years (and a further 5,182 homes in the 15 years from 2024 to 2038). A large proportion of the available supply is linked to major developments most of which are in the north of Ely or Littleport. The Ely developments are relatively close to the hospital and are of sufficient size to warrant additional primary care capacity. The local council recognises the importance of expanding healthcare facilities in response to population growth and supports the redevelopment of the POW site. The council has also confirmed that community infrastructure levy (CIL) monies are likely to be available as a contribution to the costs of any new healthcare premises.

1.2.2 Current service provision

The following NHS organisations provide most of the NHS commissioned health secondary care services for local people:

- Cambridgeshire Community Services NHS Trust (the Trust also owns the POW Hospital and site).

[2] East Cambridgeshire District Council, April 2020.

- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) which provides mental health and community physical health services. This trust operates the ward at the POW as well as local neighbourhood teams which combine mental health and physical health clinicians.
- Cambridge University Hospitals NHS Foundation Trust centred on Addenbrooke's Hospital in Cambridge. This trust provides outpatient clinics and day surgery at POW.

General medical practice and pharmacies across the CCG are organised into primary care networks (PCNs). There are seven general practices in East Cambridgeshire (and one private GP) and 12 pharmacies. Cambridgeshire has 2,236 people per full-time GP, which is worse than most CCGs in England[3] and the CCG also faces a greater challenge than most CCGs regarding an ageing GP workforce with almost 26% of GPs being aged 55 or over[4]. Although both metrics relate to the CCG as a whole, this does indicate long-term sustainability challenges for primary care provision which will only become more challenging with the growth in the population across the district.

The POW Hospital is a key venue for the delivery of community health services and services currently provided from the site include a rehabilitation ward, day surgery, minor injuries, a GP practice and primary care out of hours, outpatients, physiotherapy, neuropsychology and community teams. Nevertheless, the overwhelming majority of people requiring secondary healthcare travel out of the immediate area to receive treatment, whether planned activities such as surgery, outpatients and planned diagnostics, or urgent and emergency activities such as A&E attendance and non-elective hospital admission. The largest flows are to Addenbrooke's in Cambridge.

Cambridgeshire County Council commissions and, in some cases provides, social care for local people. The council's Adult Social Care Market Position Statement for 2018/19 states that across the county the cost of living, as well as the high cost of land, means there are currently a comparably low number of care homes able to manage the residential, nursing and dementia needs of service users and that this is impacting on the level of choice available to individuals and the financial cost of placements to the county council. The East Cambridgeshire area is particularly short of nursing and nursing dementia placements (the more complex end of care home provision), homecare capacity and has a shortage of personal assistants. In response, the county council has agreed a requirement for a 65-bed nursing care home in Ely and is exploring the opportunity to develop such a facility on the POW campus.

1.2.3 The public sector estate in Ely

Public sector services operate from a relatively limited estate in the city with the hospital being, by some way, the largest facility apart from local schools. This limits alternate site options except if the local authority were to incorporate a new hospital into housing development plans – the council's expressed preference is to retain health services on their current POW Hospital site. The POW was built in 1939, the site extends to 3.4 hectares and provides approximately 6,500m^2 of space. Situated within an urban location the site is surrounded by housing development to the north and west (including 35 units of extra care living known as Baird Lodge) and public open space to the east and south. Arrangements for use of the hospital by organisations other than the owner CCS are

[3] NHS Digital. 2019
[4] NHS Digital, 2019

historic and varied (a mix of leases and licences) and these do not act to support moves to better integrate services. The range of services based at the POW has sometimes grown by accident rather than design with the opportunity to develop the hospital into an integrated service hub, not fully delivered.

The buildings were originally designed to provide ward-based acute care to inpatients and as such do not lend themselves easily to the outpatient or day service activity that is the basis of a large proportion of today's modern community-based care pathways. These pathways require spaces that can be flexed to meet the needs of individual patients (e.g. providing extended opening hours) or to accommodate different styles of delivery such as group-based therapy. The layout of the hospital is extremely inefficient and incompatible with modern service delivery models and accommodation standards. Accommodation is also highly segmented with excessive circulation space. The current configuration of long-narrow ex-ward buildings with multiple small spaces often leading on from each other, restricts professionals from offering these new ways of working to their patients (or rather restricts the extent that they are able to do so). There is one relatively modern building dating from 1989, which accommodates three day theatres (only two are currently used) and some therapy space. Site-wide backlog maintenance costs are estimated at £1.6m with a further £4.5m forecast for the next five years.

Adjacent to the hospital are land and buildings that are being redeveloped by Palace Green Homes (PGH). CCS and PGH have exchanged legal contracts to formalise a landswap. The land acquired by CCS will allow a new healthcare development to be built with no interruption to the provision of service. CCS will use a surplus part of the site in lieu of payment for the land it acquires. PGH will then develop the land it acquires from CCS for housing.

1.2.4 The national policy context

The NHS Long Term Plan (LTP) sets out the priorities for healthcare over the next ten years:

- Increasing the focus on population health and partnership with local authority-funded services through integrated care systems (ICS).
- Boosting 'out-of-hospital' care and ending the historic divide between primary and community health services.
- Redesign to reduce pressure on emergency hospital services.
- Giving individuals more control over their own health and more personalised care.
- Mainstreaming digitally enabled primary and outpatient care.
- Better care for major conditions.

In October 2020 NHS England published "*Diagnostics: Recovery and Renewal*", which recommends that emergency and elective diagnostics should be separated where possible and the establishment of Community Diagnostic Hubs (CDH) serving populations of approximately 333k people. The POW already provides many of the diagnostic modalities required in a CDH leaving it well placed to become the CDH for the north of the county.

In March 2017 Sir Robert Naylor published his review[5] into the NHS estate which sets out how the NHS can release up to £2bn of surplus estate to fund the investment required to support plans set

[5] NHS Property and Estates, Sir Robert Naylor, March 2017.

out by STPs; this project delivers against the Naylor ambitions. Looking beyond the NHS, the One Public Estate programme is a national programme which seeks to create economic growth, deliver more integrated, customer-focused services and generate efficiencies, through capital receipts and reduced running costs in line with the Carter Review recommendations. Locally, the OPE focus is on seeking opportunities to share estate across public sector partners.

At both a national and local level, it is recognised that improving the NHS estate is a key enabler to being able to deliver the new models of care outlined in the LTP. There is an explicit awareness that this investment is not just needed to improve or extend existing facilities to bring them up to modern standards and meet increasing demand, but also to be able to develop new spaces that have the flexibility to accommodate new multi-disciplinary teams, innovations in care for patients and the increasing use of technology in healthcare delivery. Reflecting national policy, the redevelopment of the POW site has been formally identified and confirmed as a C&P system priority project in the STP Estate Plan.

1.2.5 Local health and care strategy

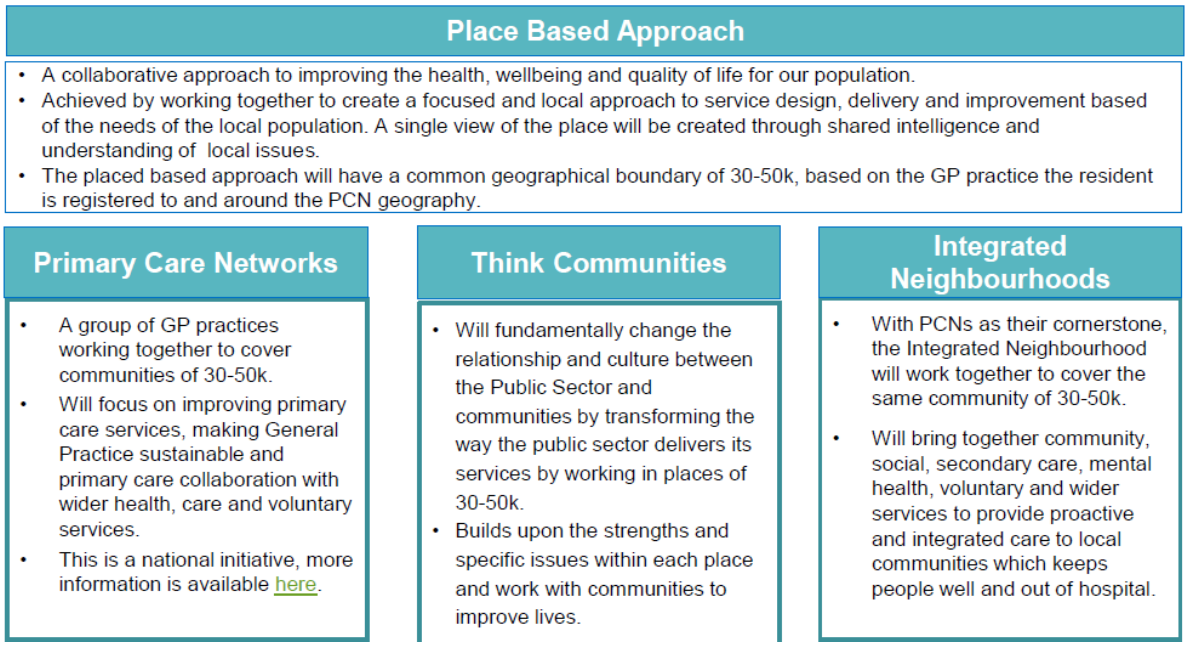
Cambridgeshire and Peterborough is one of the most, if not the most, challenged health systems in England. The STP-led response is a programme of work which has ten priorities for change.

Figure 1: STP priorities for change

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

The system has adopted a "Place Based Approach" to implementation of the elements of its plans that focus on primary and community care. A "Place" is typically a distinct geographical entity, such as Ely, with a population of 30-50,000. Each "Place" will have services delivered through PCNs and integrated neighbourhood teams with links to the "Think Communities" initiative led by the local authorities.

Figure 2: The C&P Place Based Approach



The PCN element of the Place Based Approach is tasked with providing "primary care at scale" which includes extended access and extended hours in primary care, as well as enhancing primary care to redesign outpatient and the urgent care pathways. Working alongside PCNs are two "provider alliances" which bring together the providers who would deliver integrated neighbourhood services alongside the PCNs – Ely is part of the South Alliance.

The local authorities' Think Communities initiative will work alongside PCNs and the provider alliances to identify integration opportunities. The county council's stated aim is to explore how the services they provide and / or commission can be further integrated with NHS services to improve the support available to help people remain living in their own homes.

Investing in a modern, fit for purpose estate is regarded as a key enabler to these plans and the STP estates plan highlights the community hospitals in Ely and Wisbech as being the sites with the most potential to be transformed into neighbourhood hubs and the sites most in need of investment to resolve existing condition and functional suitability problems.

1.2.6 Covid lessons

The East of England Clinical Senate has published an initial "lessons learned" report into Covid[6]. The report makes several recommendations divided between changes arising from the Covid experience that should be "adopted" permanently, "adapted" or "abandoned". These learnings must be built into the design of new health and care buildings.

1.2.7 Summary case for change and vision for a health and care hub

The system cannot "do nothing" in response to the challenges described in this strategic case. There are population growth, integration, estate and financial imperatives to do something radical to alter how services are delivered and this requires investment in the estate.

[6] The Regional COVID-19 pandemic response and system learning. What have we learned about how health care can be delivered during the last twelve weeks? The East of England Clinical Senate.

The C&P system is already one of the most challenged in England and the pressures, anticipated as a result of one of the fastest growing populations in the country, make it all the more difficult to implement the new models of care called for in national policy. The existing hospital facilities at the POW are out dated; they are not functionally suitable for modern health service delivery and, even though CCS has maintained the buildings to the best of its ability, backlog maintenance requirements are accumulating and the Trust is increasingly firefighting through reactive maintenance issues. The hospital is no longer fit for purpose and, given the projected population increase of 25% across the district, the ageing physical environment will increasingly fail to meet demand.

Community hospitals, such as the POW, have always played a role as a local care hub in the wider NHS system, but the role has been piecemeal and, despite policy for the last 20 years or so being focused on reducing the use of acute hospitals, the development of community hospitals into hubs has been hampered by organisational autonomy and a lack of joined-up systemwide planning. There is now an opportunity to change this because the move towards ICS creates a structure to promote integration and joined-up planning. This is very important for the C&P system because, if CUH's plans to redevelop its estate to provide more tertiary services such as cancer and paediatrics are to succeed, capacity at Addenbrooke's will need to be freed-up. This can happen if the system achieves a meaningful 'left shift' of activity out of acute settings into local communities including into hubs. Our plans for Ely therefore deliver on the need to make primary care more resilient, but also provide the estate needed to enable a managed transfer of meaningful levels of activity away from acute hospitals.

To date, although a large number of services are currently located on-site, their co-location in itself has not led to greater integration. The layout of the hospital is traditional with each service having its own demise and no incentivisation of integration through the use of shared space; site occupancy arrangements can also act as a barrier to occupation by services other than those operated by the site owner. Although there is a primary care presence on-site both in and out of hours, much more could be done by transferring much of the second Ely practices activity to the site and by using the site as the venue for PCN "at scale services". Greater collaboration between the two Ely practices is essential to being able to meet rising demand and the expectations of primary sector set out in the LTP, and will help make local primary care sustainable in the face of the area having an already low GP to patient list ratio and having a significant number of GPs approaching retirement age.

By co-locating at scale primary care services with team bases for local community health, social care and mental health teams, the triple integration of primary and specialist care, physical and mental health services, and health with social care, could be facilitated. New providers and partners, such as the ambulance trust, local authority services or the third sector could be encouraged to deliver part/all of their services from the same site, so that the hospital becomes a true, one-stop, care hub for local people. The site also offers the opportunity to support the redesign of urgent and emergency care pathways across the system by providing facilities to bring together same day primary care, primary care out of hours, the MIU/UTC, diagnostics and the joint health and social service emergency team. By enabling these services to share space the urgent care offer to local people will be enhanced which in turn should result in more people accessing urgent care in Ely instead of travelling to Cambridge.

The existing hospital also hosts a wide range of outpatient clinics, most of which, although physically present on-site, could be much better utilised – only one in 20 outpatient appointments for local people happen at the POW. The site's "market share" for diagnostics and day case surgery is also low creating a huge opportunity for the system to repatriate activity from acute hospital settings. This repatriation is a "must do" for the system because, without a meaningful shift of activity out of acutes, hospitals such as Addenbrooke's will be unable to deliver their strategic goal of focusing on the more specialist work envisaged in CUH plans for a new children's hospital and cancer centre. Although patient flows are far more modest, a redeveloped POW could also contribute to right sizing Hinchingbrooke and Queen Elizabeth Hospital, King's Lynn.

The current site extends to 3.4 hectares and because of the low-rise sprawl of hospital buildings, the site is not particularly well-utilised. Land disposal is, therefore, an opportunity thereby fitting with national policy, as per Naylor and making a substantial contribution towards achieving the delivery of new homes in Ely.

Land disposal opportunities are not limited to housing; CCS is aware that there is a shortage of nursing care home capacity in East Cambridgeshire and that previous site searches conducted by the county council have not resulted in suitable sites being identified. There is, therefore, also an opportunity for some of the surplus land to be sold for the development of a care home. This development would create an option of transferring the 16 community beds at the POW Hospital into improved accommodation within a new nursing home. In-reach from the local neighbourhood team based out of the POW health and care hub would then be possible. It is worth noting that for this option to be satisfactory, the 16 community beds would be developed as a standalone ward within the care home building rather than the beds being 'spot purchased' from the care home provider. The intention is for the NHS provider trust to occupy a separately demised area from which it would continue to provide intermediate step down and rehabilitation services.

The opportunities described above have been available in the past and national policy has encouraged 'care closer to home' for some time, but these opportunities have not been converted into meaningful change in the past because of the structure of health services being fragmented between organisations previously encouraged to compete as much as collaborate. The introduction of STPs and the move towards an ICS provide a key enabler to transforming the POW into a system hub able to offer part of the solution to the challenges facing services throughout the whole system.

1.2.8 Response to the case for change

The outcomes the STP wants to achieve from the project are:

- Improved clinical outcomes of the local population through the adoption of more joined-up models of urgent and planned care.
- More people treated closer to home resulting from new integrated care models supported by a sufficient community-based workforce to enable people, who can be cared for in their own home, to be so, and to repatriate services from acute hospitals to community hubs such as that proposed for Ely.
- Improved management of long-term conditions through the provision of care that is better joined up facilitated in part, by a fit for purpose estate.

- Value for money as represented by the optimal balance of investment in new estate and service models set against savings from no longer operating an old estate and quantifiable wider benefits to the system and society resulting from the proposed hub.

The aim of the investment is ***'develop a new local health and care hub which will provide accommodation for a wide range of health and related services for people living in and close to Ely'.***

The SMART investment objectives for this project are:

- **Objective one** - to facilitate the introduction of new models of care as set out in the STP's clinical model "Home is Best" including facilitation of 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
- **Objective two** - to provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design.
- **Objective three** - to deliver sufficient physical capacity to meet the forecast health needs of the growing and ageing population.
- **Objective four** - to enable the transfer of work done elsewhere back to Ely.
- **Objective five** - to release land for development in support of local housing plans.
- Objective six - to maximise estate value for money by optimising clinical use of new facilities e.g. achieving at least 75% clinical use for new facilities, 85% utilisation of clinical space Monday to Friday 9-5 and additional out of hours use over the current baseline.

1.2.9 Risks

The key risks to delivery are.

Table 1: Summary of key risks

Risk	Mitigation
Lack of available capital / capital affordability	• Design incorporates shared, flexible use space and minimises number of ring-fenced rooms • Maximise use of existing accommodation if fit for purpose • Modern methods of construction to keep costs under control • Intention to bid for NHSEI funding e.g. Wave 5 • High priory scheme within STP (local support)
Revenue affordability	• Existing estate costs released • Hub will facilitate new models of care and encourage joint working • Avoids backlog costs and lower cost

Risk	Mitigation
	than building at Addenbrooke's
Scheme not approved by NHSEI / delays in securing approvals from NHSEI	• Liaison with NHSEI from SOC
Redevelopment takes longer than expected	• Project management processes
Design requirements change because of changes to service requirements	• Involvement of service leads in design
Facilities designed before implications of changes arising because of Covid-19 are fully understood	• Design team keeping close to emerging Covid lessons
Scheme does not receive planning consent	• Pre-application submitted • District Council is supportive
Logistical challenges in executing redevelopment on site	• Land swap enables development to take largely a turnkey approach

1.3 The economic case

At SOC the economic case demonstrates that the Trust has a viable set of options that can deliver the project objectives – the 'short list' which will be taken forward to OBC.

1.3.1 The 2017 SOC

In the 2017 SOC the following options were longlisted.

Table 2: 2017 SOC options

Option number	Description
Do nothing	The hospital would continue to operate its current services and models of care from the existing buildings with minimal change.
Do minimum	Retain the existing hospital buildings and maintain/update space as required.
Option 3	Rebuild all existing services to modern HBN compliant standards (except day surgery which is already in a modern facility). Creates a local community hub including urgent treatment centre, fully integrate Cathedral Surgery. Reprovision of one intermediate care ward. Generic clinical, diagnostic and administrative space would be clustered appropriately.
Option 4	As per Option 3 but also including St Mary's surgery.

Option number	Description
Option 5	As per Option 4 except beds. Beds purchased from a care/ nursing home provider.
Option 6	As per Option 3 except beds. Beds purchased from a care/ nursing home provider.
Option 7	As per Option 4, but expansion of the Addenbrookes day surgery unit on site.

Since the SOC was approved by the CCS Board in 2017, NHSEI has published new business case guidance which increases the level of detail required at SOC and which mandates the use of the options framework to determine the shortlist of options to be appraised at OBC. Because the options framework was not used at SOC in 2017, we have refreshed the SOC – the results of this process are described below.

1.3.2 Longlist to shortlist – the options framework

The choices relating to this stage of the POW project and which are tested using the options framework are:

1. Choice of delivery model for inpatient services.
2. Choice of service scope i.e. which other services should be accommodated in the new hub facility.
3. Choice of the extent of day surgery done at the POW.
4. Choice of location for the new facility.

The options under each choice are tested against the project investment objectives and critical success factors (CSFs) and options that fail to meet objectives and CSFs were eliminated; those meeting both have been shortlisted to form part of the OBC options. The outcome of the options framework appraisal of the longlist for each choice is then combined to derive a shortlist of options for the OBC:

- BAU (as the comparator only – this option does not deliver the investment objectives)
- Option 1 – Expanded service scope (with St Mary's), with expanded day surgery and inpatient beds on mix of current site and MOD land adjacent (100% new build)
- Option 2 – Expanded service scope (with St Mary's), with expanded day surgery and inpatient beds on mix of current site and MOD land adjacent to POW Hospital (mix refurb and new build).
- Option 3 – Expanded service scope (with St Mary's), with expanded day surgery, but without beds mix of current site and MOD land adjacent (100% new build)
- Option 4 – Expanded service scope (with St Mary's), with expanded day surgery, but without beds on mix of current site and MOD land adjacent to POW Hospital (mix refurb and new build).

The table below illustrates the commonality and differences between the options.

Table 3: Summary of options

Option	Beds in hub	2 x GP	Urgent care centre	Expanded day care	Expanded outpatients	Expanded diagnostics	100% new build	Element of refurb
BAU	✓	×	×	×	×	×	×	✓
Option 1	✓	✓	✓	✓	✓	✓	✓	×
Option 2	✓	✓	✓	✓	✓	✓	×	✓
Option 3	×	✓	✓	✓	✓	✓	✓	×
Option 4	×	✓	✓	✓	✓	✓	×	✓

Options 2 and 4 are effectively both 'preferred way forwards' at this stage. The only difference between these two options is the location of the 16 rehabilitation beds i.e. **in the new health and care hub or in the new care home on the POW campus.**

The rationale behind the shortlist of options is that:

- The St Mary's practice (all or part) is always within the hub.
- Expanding day surgery fits with STP strategy so is within all options.
- The site is always a combination of the existing POW Hospital site and adjacent ex-MOD land.
- There is a choice as to whether beds are in or out of the hub building (if 'out' the beds will be in the care home on the POW campus site).
- There is a choice about the mix of new build and refurbished buildings.

1.4 The commercial case

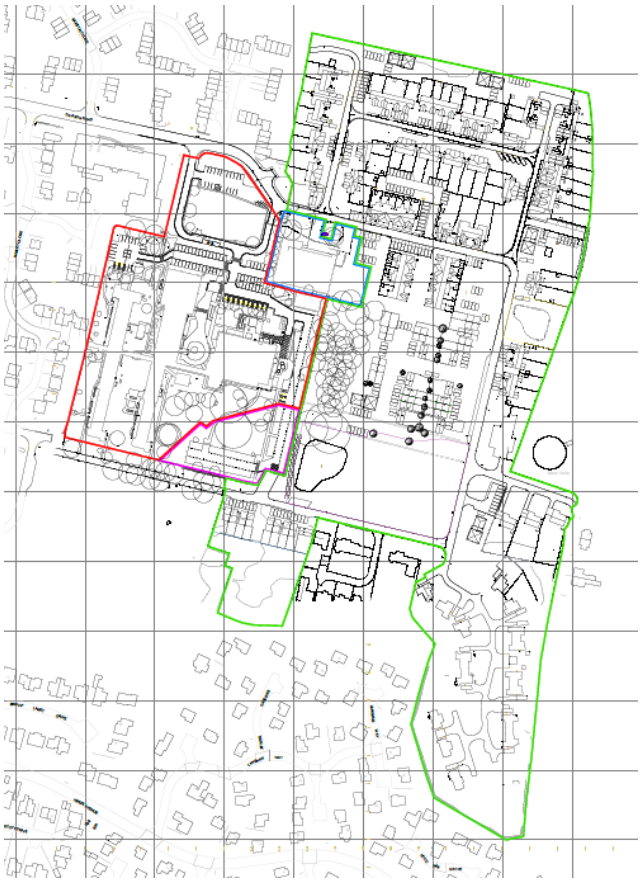
The commercial case sets out procurement and contractual issues associated with the preferred option. At SOC it is a relatively short discussion of potential issues.

1.4.1 Land issues

CCS and PGH entered into land swap and leaseback agreements on 16th October 2020 under which the two parties swap two parcels of land (parcels A and B) with CCS taking out a lease on Parcel B for four years. The map below illustrates the two parcels of land swapped:

- Parcel A outlined in blue is the plot on which the social club is situated – this land has been acquired by CCS.
- Parcel B outlined in pink was transferred to PGH and is being leased back by CCS for four years.

Figure 3: The land swap



The acquisition of Parcel A combined with adjacent existing areas of the POW site, creates a developable plot of land sufficient for CCS to build the new hub.

1.4.2 Scope of works to be procured

The scope of works is:

- The construction and fit out of the new local health and care hub.
- The construction of a multi-storey car park.
- Refurbishment works on the retained day surgery centre and co-located therapies suite.
- Associated site infrastructure works.

The scope of works does not apply the proposed nursing home or any potential phase two expansion of the health and care hub.

1.4.3 Procurement options

There are a wide range of procurement options open to the trust to deliver the project. The options can be summarised as:

- An open tender.
- The use of a framework.
- The use of competitive dialogue.

The procurement route will be confirmed at OBC.

In accordance with guidance, Modern Methods of Construction (MMC) are presumed for this project. It is expected that maximum practical use will be made of offsite manufacturing of components and modules, for transport and assembly on site.

1.4.4 Planning permission

The Trust submitted a planning pre-application in August 2020.

1.5 The financial case

The financial impact of each shortlisted option on the system will be determined and appraised as part of the work on the OBC.

1.5.1 Capital costs and revenue consequences

The initial investment (capital costs) has been estimated for the four shortlisted 'change' options (options 1 to 4) above. The table below shows the inclusions and exclusions from the costing.

Table 4: Initial capital cost estimate

Option	Total capital	Capital at today's prices	Equipment allowance	Contingency	Optimism bias
BAU	£9.33m				
Option 1	£70.7m	£60.5m	£3.3m	6%	5.3%
Option 2	£54.7m	£47.6m	£2.5m	6%	6.9%
Option 3	£65.9m	£56.4m	£3.2m	6%	5.3%
Option 4	£50.0m	£43.5m	£2.3m	6%	6.9%

The revenue consequences (capital charges) of the investment have been estimated as per the table below – numbers are presented without any MEA adjustment.

Table 5: Revenue consequences of capital investment

Option	Total capital	PDC int @ 3.5%	Depreciation pre MEA adjustment	Total capital charge pre MEA adjustment
BAU	£9.33m	£0.32m	£0.41m	£0.73m
Option 1	£70.7m	£2.5m	£2.4m	£4.8m
Option 2	£54.7m	£1.9m	£1.8m	£3.7m

Option	Total capital	PDC int @ 3.5%	Depreciation pre MEA adjustment	Total capital charge pre MEA adjustment
Option 3	£65.9m	£2.3m	£2.2m	£4.5m
Option 4	£50.0m	£1.8m	£1.7m	£3.4m

The cost pressure associated with capital charges on the new asset shown in the table above will be offset, at least in part, by capital charge savings on the existing buildings. Any net book value remaining on existing assets will need to be written off as an impairment against the CCS statement of comprehensive income.

At this stage it is not possible to confirm the affordability of this scheme in capital terms. This business case is being prepared to allow the STP to submit a bid for capital funding in the next funding round – whether that be through the STP Capital Programme, Health Infrastructure Programme or other source of central government funding. Central funding will be needed for the bulk of the investment needed, but additional funding sources are available:

- Developer levy – as noted earlier, the East Cambridgeshire District Council has offered £1.1m CIL funding for the scheme.
- Land sale receipts – CCS intends selling part of the existing land at the POW for housing and a second plot for the new care home (see above for discussion on demolition and preparing land for sale).
- Internally generate capital from CCS and potentially other system partners.
- Primary care funding sources – although the ETTF is ending, any new primary care capital funding routes could be a source of a contribution recognising the primary care elements of the scheme.

1.5.2 Other revenue costs

The new hub creates opportunities for efficiencies in administrative services ranging from reception costs to sharing of back office services – these will be considered at OBC.

The new hub also provides an environment to support changes to pathways. The financial implications of pathway changes are out of scope for this business case except for the impact of carrying out more day surgery at the POW. The financial impact will need to be worked-up by CUH as part of the OBC.

1.5.3 Future charging arrangements

The OBC will also need to consider how the ongoing operating costs of the new hub are to be paid for. The new hub will be owned by CCS, but it is a system asset making it important that financial arrangements for using space in the hub work for the system and for CCS as the 'landlord'. Hubs in other health communities have failed as a result of short-term financial decisions made by individual organisations which destabilise the financial viability of individual assets, often by leaving the landlord with void risk and these decisions have often caused an overall cost pressure to the

taxpayer. The financial viability of the hub relies on embedding the concept of the Cambridgeshire Pound and the associated focus on costs to the system or taxpayer rather than costs to individual NHS bodies. The inclusion of two primary care practices in the hub add complications to be resolved because of Primary Care Premises Cost Directions which set out how costs borne by practices (which are independent businesses) are reimbursed by the NHS. Potential charges to social services and other council funded services add further complication. At this stage, the system needs to commit to working through these issues as part of the ICS restructuring and a principle of not passing undue risk to CCS as the property owner

1.6 The management case

The POW project is led by the POW Project Board which includes representatives from all affected organisations. Reporting to the Project Board is the POW Project Team.

The project board is responsible for:

- Overseeing the implementation of the POW redevelopment project.
- Supporting the STP Estates Group by monitoring the delivery of the POW redevelopment project which is a key service development in the STP's strategic plan.

The key project milestones are shown in the table below.

Table 6: Project milestones

Activity	Milestone date
Strategic Outline Case completion	November 2020
Outline Business Case completion	January 2021
Planning submission	January 2021
Concept Design	Until February 2021
Planning approval	April 2021
Detailed Design	March to September 2021
Full Business Case completion	September 2021
Start on Site	December 2021
Construction completion	October 2023
Trust commissioning	October 2023 to December 2023
Building 'Go-Live'	December 2023

1.7 Conclusion

This SOC demonstrates that there are at least four realistic and achievable options by which the POW project objectives can be delivered and the strategic development of services in Ely taken

forward. This will represent a major contribution to the STP's strategic response to the case for change set out in this document.

The Project Board now requests approval to move forward to OBC at which stage the shortlisted options will be worked-up in more detail and carry a full cost-benefit-risk appraisal carried out to determine the preferred option to deliver the POW redevelopment project.

2 Introduction

2.1 Purpose of this business case

This strategic outline case (SOC) has been written for Cambridgeshire Community Services (CCS) NHS Trust and the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (C&P STP). The SOC sets out the case for developing the Princess of Wales (POW) Hospital site in Ely and tests the feasibility of different options to expand the number of services provided from the site whilst also ensuring that all services operate from fit for purpose modern accommodation.

The project described in this SOC responds to the following needs:

- The need to provide modern health and care environments that support the delivery of joined-up services as described in national and local strategy.
- The need for more physical capacity in Ely to meet anticipated rising demand from the growing and ageing local population.
- The opportunity to deliver more treatments and care in Ely thereby helping the C&P acute hospital sector to free-up space in hospitals such as Addenbrooke to in turn allow acute-based services to expand.
- The need to replace the existing ageing and no longer functionally suitable estate at the POW Hospital with fit for purpose buildings meeting all modern standards.

The business case takes as its starting point the SOC developed in 2017 and the related wave four funding bid, and proposes a preferred way forward comprising:

1. A new health and care hub.
2. A linked day surgery and therapy unit within retained estate currently forming part of the POW Hospital.
3. The expansion of the day service including the establishment of a 23-hour ward.
4. A multi-storey car park.
5. A land swap between CCS (the POW site owners) and Palace Green Homes to secure land for the health and care hub in exchange for part of the existing POW site which would then be redeveloped for housing.
6. The sale of part of the existing POW site for additional housing.
7. The further sale of part of the site to Cambridgeshire County Council for the development of a nursing home.

The CCS Executive Programme Board are asked to approve this SOC paying particular attention to the proposed shortlist of options to be taken to outline business case.

2.2 The Trust and the STP

CCS became a community NHS Trust in April 2010 and provides a portfolio of predominantly high-quality specialist services. The Trust's vision, values, objectives and behaviours are summarised in the diagram below.

Figure 4: CCS' vision, values, objectives and behaviours

The investment recommended in this business case will help deliver against all four Trust objectives and the development and operation of the new hub will be guided by the behaviours set out above.

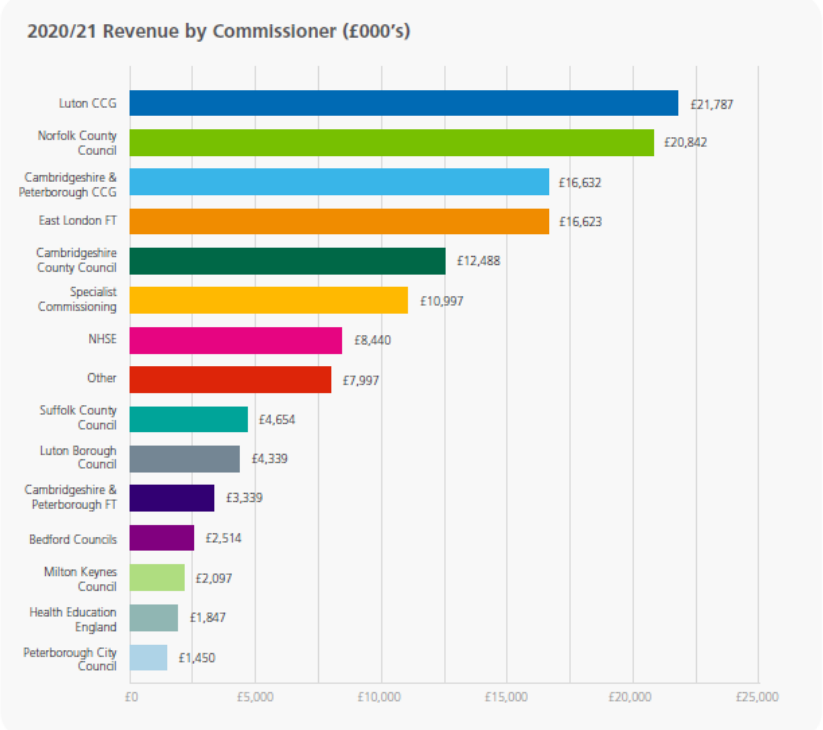
The Trust operates a diverse portfolio of services, all of which will have a relationship with the health and care hub either as a point of clinical delivery or an administrative base – CCS' portfolio is shown below.

Figure 5: CCS service portfolio

	Bedfordshire	Cambridgeshire	Luton	Norfolk	Peterborough	Suffolk
Adult services						
District nursing/ community matrons			●			
Specialist nurses/long term conditions			●			
Neuro-rehabilitation	●	●				
Specialist services						
Community dental services, Dental Access Centres, and minor oral surgery - MOS	● Oral health promotion only	●		● MOS only	●	● MOS only
Musculoskeletal services		●			●	
Sexual health services	●	●		●	●	●
Children's services						
Health visiting	●	●	●	●	● (see note)	
School nursing	●	●	●	●	● (see note)	
Therapies	●	●				
Community nursing	●	●	●			
Audiology		●	●			
Community paediatricians	●	●	●			
Family Nursing Partnership	●	●		●		
National Child Measurement Programme				●		
School immunisation programme		●		●	●	●
Emotional Health and Wellbeing service		●			● (see note)	

The Trust's budget was £128m in 2019/20 and grew to £136m for 2020/21. Many Trust services are provided at a regional level and are predominantly focused on preventative care, funded by public health commissioners. The Trust receives income from a relatively large number of commissioners as shown below.

Figure 6: CCS revenue by commissioner



CCS is currently planning and delivering to a balanced position with the potential to deliver a small surplus. This is in line with previous years financial delivery where the Trust since it was established in 2010 has delivered a surplus position. The Trust has a good track record on ensuring it gets the best return possible from its infrastructure and over the last six years has invested further in this infrastructure to improve return and support its growth model.

CCS is within the C&P STP which, in addition to CCS consists of the following organisations:

- Cambridge University Hospitals (CUH) NHS Foundation Trust.
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).
- Cambridgeshire County Council.
- East of England Ambulance Service NHS Trust.
- NHS Cambridgeshire and Peterborough CCG.
- North West Anglia NHS Foundation Trust.
- Papworth Hospital NHS Foundation Trust.
- Peterborough City Council.

2.3 Structure of the business case

This business case is consistent with the latest guidance from The Treasury[7] on the development of business cases using the five-case model and is structured as follows:

- The **strategic case** sets out the strategic context and the case for change together with the supporting investment objectives for the scheme.
- The **economic case** demonstrates that the Trust has selected the option which best meets the existing and future demands of the service and optimises value for money.
- The **commercial case** outlines procurement and contractual issues associated with the development.
- The **financial case** confirms the funding arrangements and affordability.
- The **management case** demonstrates that the scheme is achievable and can be delivered successfully to time, cost and quality.

The emphasis of the business case alters in moving from SOC to OBC to full business case (FBC) as illustrated in the diagram below.

Figure 7: The business case process

Box: The business case development framework

Determining the strategic context and undertaking the Strategic Assessment
Step 1: determining the strategic context
Gateway 0: strategic assessment

Stage 1 – Scoping the scheme and preparing the Strategic Outline Case (SOC)
Step 2: making the case for change
Step 3: exploring the preferred way forward
Gateway 1: business justification

Stage 2 – Planning the scheme and preparing the Outline Business Case (OBC)
Step 4: determining potential Value for Money (VfM)
Step 5: preparing for the potential Deal
Step 6: ascertaining affordability and funding requirement
Step 7: planning for successful delivery
Gateway 2: delivery strategy

Stage 3 – Procuring the solution and preparing the Full Business Case (FBC)
Step 8: procuring the VfM solution
Step 9: contracting for the Deal
Step 10: ensuring successful delivery
Gateway 3: investment decision

Implementation and monitoring
Gateway 4: readiness for service

Evaluation and feedback
Gateway 5: operations review and benefits realisation

This SOC refreshes Stage 1 (in light of the passage of time since the 2017 SOC).

2.4 Support

This business case is supported by the C&P STP.

[7] Guide to Developing the Project Business Case, HM Treasury, 2018.

At a local level, there has been a broad consensus of support for the proposals to redevelop POW site for several years in both formal and informal discussions with commissioners, providers and other key stakeholders. The 2017 SOC and Wave Four funding bids followed two stakeholder events at which commissioners, councillors, and representatives from the local councils, local GPs and other providers were very positive about the plans. An extensive engagement exercise was undertaken with all the current teams and services that are based at or use the POW Hospital in the summer of 2017. All the services expressed a desire to remain based in Ely on the current site, citing its geographical location as an important benefit in supporting a largely rural, dispersed, and predominantly older population (as well as families with young children) who would otherwise struggle to reach health facilities further afield in Cambridge or Peterborough.

The two GP practices also stated that they recognise the clinical benefits of being co-located with other teams such as providing integrated clinics and/or facilitating multi-discipline case discussions and clinical activity. For example, the current co-location of the occupational therapists and physiotherapists from the neighbourhood team on the same site as an intermediate care ward and the local Joint emergency team means that they can provide direct support to the delivery of rehabilitation to patients on the Ward.

Cambridgeshire and Peterborough Clinical Commissioning Group (C&P CCG) undertook extensive engagement in early 2016 on a range of options for the future of the three minor injury units (MIUs) in East Cambridgeshire and Fenland, and feedback from local people made clear how much they value not having to travel to Cambridge or elsewhere to access health and care services and how they feel it is crucial that current local urgent care services are maintained. More importantly, many admitted that they would have made an (otherwise avoidable) appointment with their GP practice or attended their A&E if their local MIU had not been open, thus putting more pressure on these already stretched primary and acute care services.

2.5 Approvals

This business case is being submitted by the POW Project Board to the CCS NHS Trust's Board of Directors for approval.

3 The Strategic Case

3.1 Introduction to the strategic case

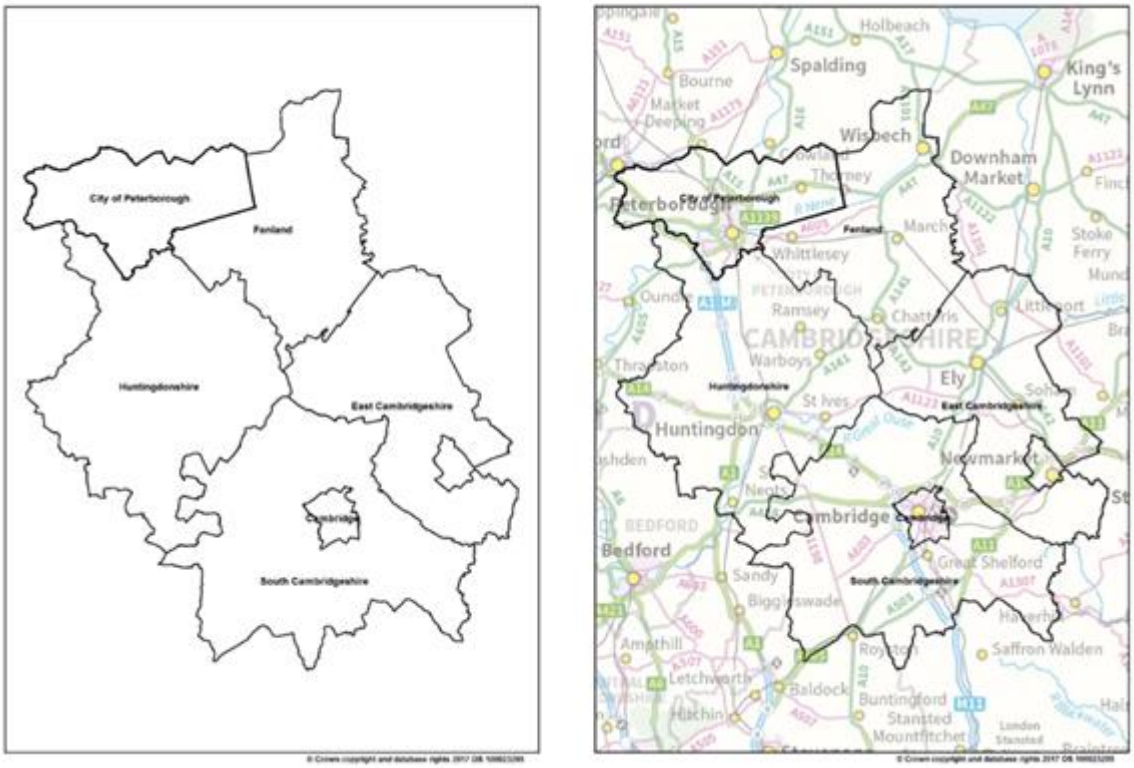
The strategic case demonstrates that the proposed investment to create a local health and care hub in Ely responds to both national policy and local need. In this section we:

- Describe the local context i.e. the characteristics of East Cambridgeshire including the demographics and housing plans, introduce the health services in the area including the POW Hospital.
- Describe and draw implications for this business case from, national and local strategy for health and care services.
- Set out the vision for the POW site which the system has greed in response to the case for change.
- Set out the objectives, constraints, critical success factors, benefits and risks linked to this project.

3.2 Strategic context – determinants of demand for health and care

The Princess of Wales Hospital is located in the north of the city of Ely in the East Cambridgeshire district of Cambridgeshire.

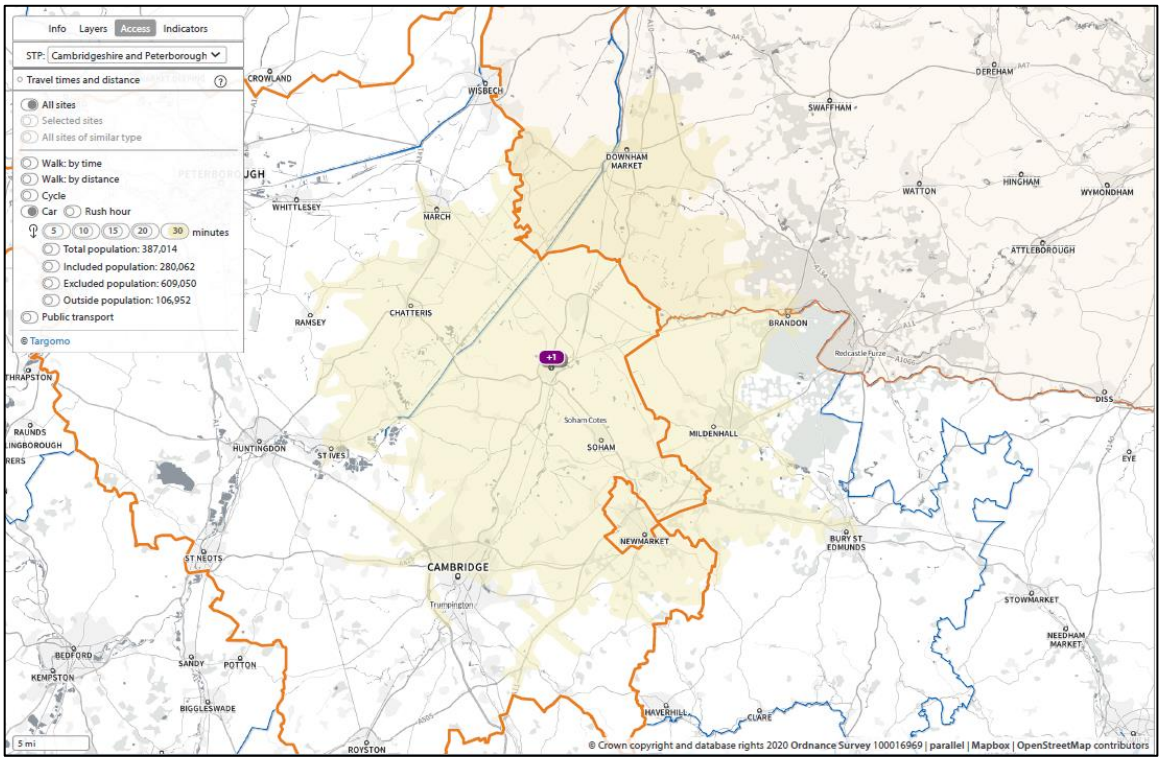
Figure 8: Local authority areas and major towns in Cambridgeshire



Whilst there is no defined catchment area as such for the hospital and effective catchments will vary by service, broadly people attending the POW will come from the East Cambridgeshire district which has a population of just under 90,000. The district's main service and commercial centres are Ely (population 20,720), followed by Soham (population 11,970), and Littleport (population 9,230); the

rest of the population is spread across 50 other villages and hamlets including the fringe areas of Newmarket, Suffolk. An indication of an approximate catchment area for Ely-based services is shown below using a 30-minute off-peak drivetime as a proxy for access.

Figure 9: 30-minute off-peak drivetime from Ely



East Cambridgeshire has the lowest population density in Cambridgeshire, a county which is itself relatively rural having a lower population density than the English average.

Although the area is not geographically large (it extends to 655km^2), the relative rurality and associated poor public transport, does create challenges in delivery of and access to, public services.

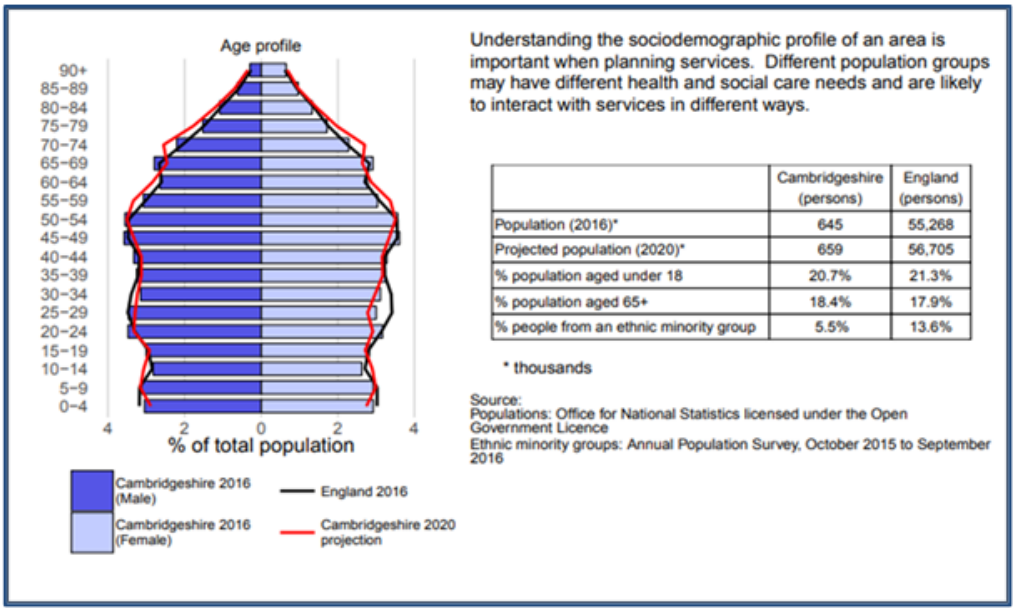
Implication for this business case

- The approximate catchment population for the hub is the 80,000 people living across the local authority district (subject to modest cross-boundary flows).
- The hub's location in Ely is well-placed to serve most people living within East Cambridgeshire.
- Local services will continue to need to find efficient and effective ways of delivering services across a rural area.
- Poor public transport makes attendance at any hub difficult for a significant proportion of the population. This will need to be addressed through a realistic approach to car parking provision and a commitment to preserving hospital transport services, as well as innovations such as digital service delivery.

3.2.1 Current population and demographic forecasts

The Cambridgeshire population has a gender and age population similar to the English average. The county has a lower proportion of people from ethnic minorities than England.

Figure 10: Cambridgeshire population pyramid 2016[8]



Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Cambridgeshire (persons)	England (persons)
Population (2016)*	645	55,268
Projected population (2020)*	659	56,705
% population aged under 18	20.7%	21.3%
% population aged 65+	18.4%	17.9%
% people from an ethnic minority group	5.5%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

The local PCNs' population (shown as Ely 1 and 2[9] below) is very similar in headline age profile as the rest of the county (shown as CCG below) and therefore England as a whole.

Figure 11: Population estimates by age group[10]

Age band	Ely 1		Ely 2		South Alliance	CCG	England
	Number	%	Number	%			
Total	37,386	-	35,906	-	427,084	973,981	54,409,696
0-4 years	2,138	5.70%	1,882	5.20%	5.00%	5.50%	5.50%
Under 18 years	8,040	21.50%	6,971	19.40%	18.80%	20.40%	20.40%
18-65	26,180	59.60%	22,506	62.70%	65.90%	63.30%	62.20%
65+ years	3,166	18.90%	6,429	17.90%	15.30%	16.30%	17.40%
75+ years	978	8.50%	2,828	7.90%	7.00%	7.30%	7.90%
85+ years	2,138	2.60%	804	2.20%	2.20%	2.20%	2.30%

Estimating population growth is not an exact science, particularly when writing a business case nine years after the last national census. Forecasts are further complicated by there being two population measures of direct relevance to health and social care:

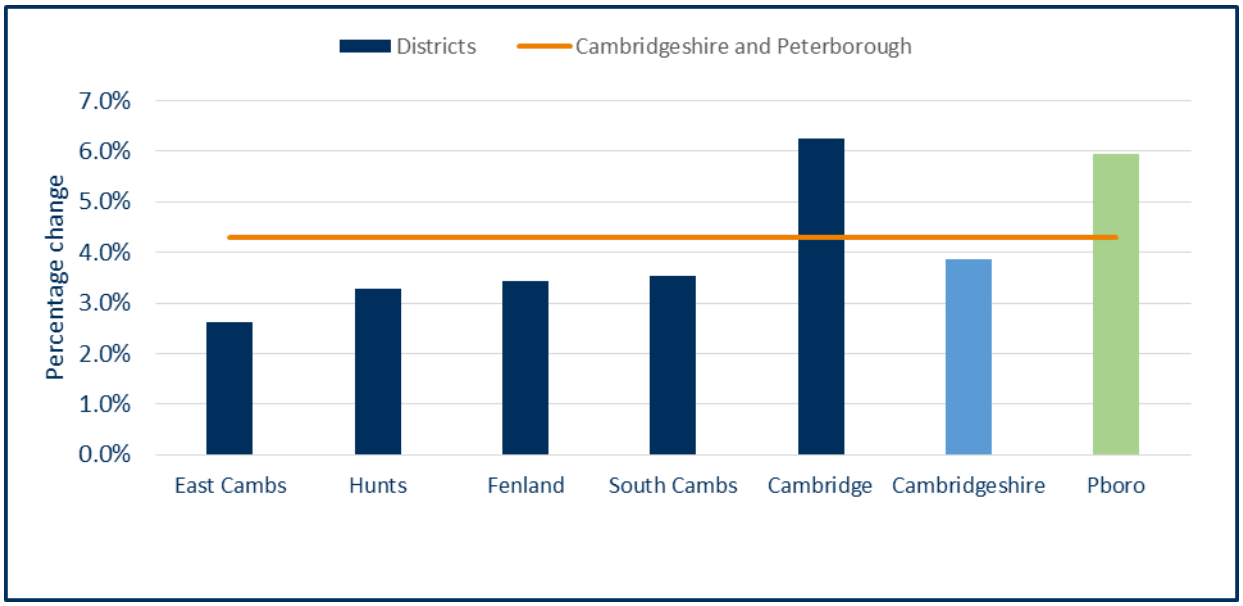
[8] Data Sources: Office of National Statistics.
[9] Ely 1 and 2 refers to the two local PCNs. South Alliance refers to the area of the STP which includes East Cambridgeshire.
[10] Data Sources: Public Health Modelling of population; Fingertips, Public Health England, https://fingertips.phe.org.uk

- The population resident within a geographical e.g. local authority area i.e. those people who could be expected to travel to their nearest health facility for urgent and emergency care and
- The population registered with GPs that form part of a CCG. This population will typically be referred to services within a CCG area and will travel sometimes across local authority boundaries, to attend their own GP.

Cambridgeshire and Peterborough is an area of high population growth as evidenced in historic trends and forecasts of new house building. This adds a further complication to forecasting because Office of National Statistic (ONS) population forecasts rely on historic trends in births, deaths and migration which can fail to pick-up local nuance in house building plans. This is particularly the case in areas of high population growth. Recognising this the CCG Research Group (CCGRG) produces its own population forecasts which take account of the same data as the ONS and local planning policy (housing building plans). The following tables and charts reference both ONS and CCGRG numbers, and in the case of the ONS, forecasts for both the local authority areas and the CCG. Where possible numbers focus on the East Cambridgeshire District Council area as being the most appropriate proxy for the POW's local population.

Whilst the population of Cambridgeshire and Peterborough's increased by 4.3% (35,170) people between 2011 and 2015, growth in East Cambridgeshire was the lowest in the county, in both absolute numbers and as a percentage.

Figure 12: Cambridgeshire and Peterborough - retrospective percentage population change, mid-2011 to mid-2015[11]



Whilst the district has experienced low growth relative to the rest of the county in recent years, it is predicted to have the second highest level of proportional growth of any Cambridgeshire district between 2016-2036. Looking forward to 2036, the CCGRG predicts a 25.4% increase in the population of East Cambridgeshire.

[11] Cambridgeshire & Peterborough Joint Strategic Needs Assessment, Core Dataset, 2019

Table 7: Cambridgeshire and Peterborough – CCCRG forecast absolute and proportional long term (20 year) population change, 2016 to 2036 (all ages)[12]

Area	Year					Abs change	% change
	2016	2021	2026	2031	2036	2016-2036	2016-2036
Cambridge	134,080	148,500	154,510	156,240	157,810	+23,730	17.7%
East Cambridgeshire	86,580	92,630	103,580	108,050	108,610	+22,030	25.4%
Fenland	99,200	107,630	113,260	116,180	118,590	+19,390	19.5%
Huntingdonshire	176,590	189,440	203,100	212,620	217,710	+41,120	23.3%
South Cambridgeshire	155,660	169,800	184,500	192,840	200,480	+44,820	28.8%
Cambridgeshire	652,110	708,000	758,950	785,930	803,200	+151,090	23.2%
Peterborough	198,130	216,420	231,520	240,220	240,830	+42,700	21.6%
Cambridgeshire and Peterborough	**850,240**	**924,420**	**990,470**	**1,026,150**	**1,044,030**	**+193,790**	**22.8%**

By contrast, ONS forecasts are far lower at +10.8% for the same period.

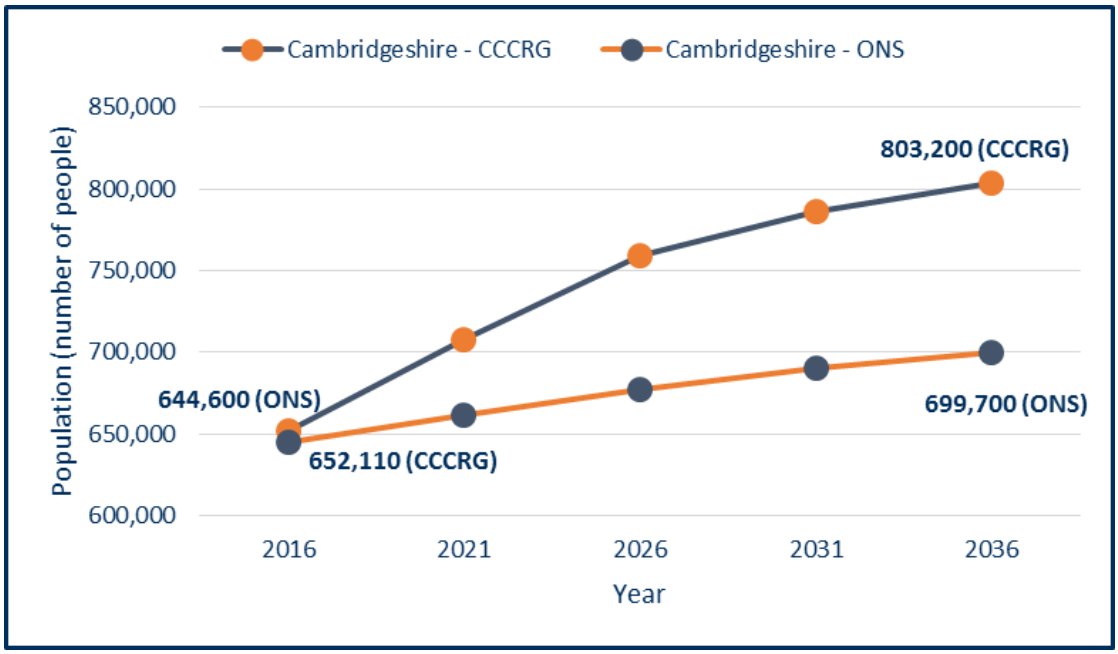
Table 8: Cambridgeshire and Peterborough – Office for National Statistics (ONS) projected absolute and proportional long term (20 year) population change, 2016 to 2036 (all ages)[13]

Area	Year					Abs change	% change
	2016	2021	2026	2031	2036	2016-2036	2016-2036
Cambridge	124,600	124,100	124,800	126,600	127,000	+2,400	1.9%
East Cambridgeshire	88,200	91,600	94,200	96,100	97,700	+9,500	10.8%
Fenland	99,600	102,900	105,800	108,400	110,700	+11,100	11.1%
Huntingdonshire	176,100	181,200	185,800	189,500	192,700	+16,600	9.4%
South Cambridgeshire	156,000	161,900	166,300	169,300	171,600	+15,600	10.0%
Cambridgeshire	644,600	661,700	677,000	690,000	699,700	+55,100	8.5%
Peterborough	196,700	206,000	212,600	217,700	222,000	+25,300	12.9%
Cambridgeshire and Peterborough	**841,300**	**867,700**	**889,600**	**907,700**	**921,700**	**+80,400**	**9.6%**

The difference of approximately 12,500 people between ONS and CCGRG estimates is material in health planning terms because it is equivalent to an average practice list size. The chart below illustrates the gap between ONS and CCGRG forecasts for the Cambridgeshire CCG as a whole.

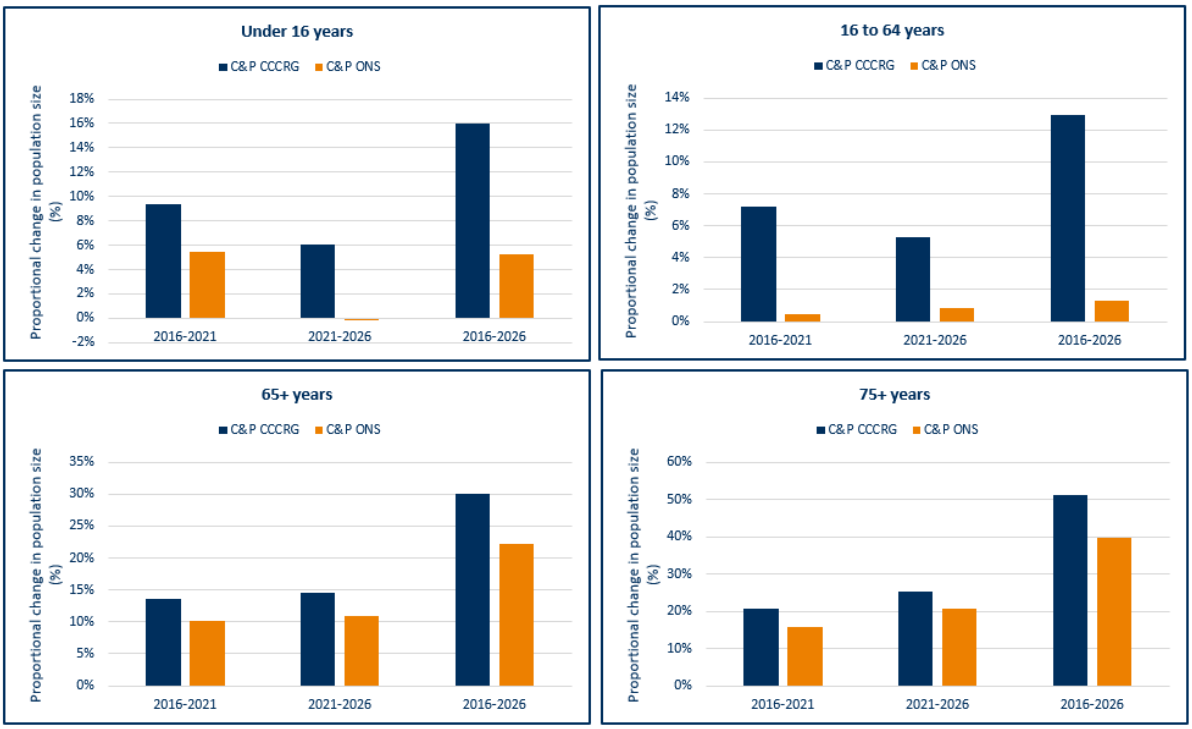
[12] Cambridgeshire County Council Research Group
[13] ONS 2014-based Subnational population projections

Figure 13: Cambridgeshire - 20-year population change, 2016 to 2036[14]



A detailed review of the variation indicates that the differences are more material for younger people and adults of working age – the charts below are for the whole of Cambridgeshire, but they do indicate that the variation in forecast population numbers is more pronounced amongst the age groups who typically make less use of health and care services than older people.

Figure 14: Cambridgeshire population growth forecasts by age band – CCGRG v ONS[15]



[14] ONS 2014-based Subnational population projections and CCCRG mid-2015 based population forecast
[15] Cambridgeshire & Peterborough Joint Strategic Needs Assessment, Core Dataset, 2019.

The growth in the older population is expected to lead to a significant increase in demand for health and care due to the correlation between ageing the likelihood of having one or more long-term conditions and/ or meeting the classification of "frail".

Figure 15: Age and the number of long-term conditions

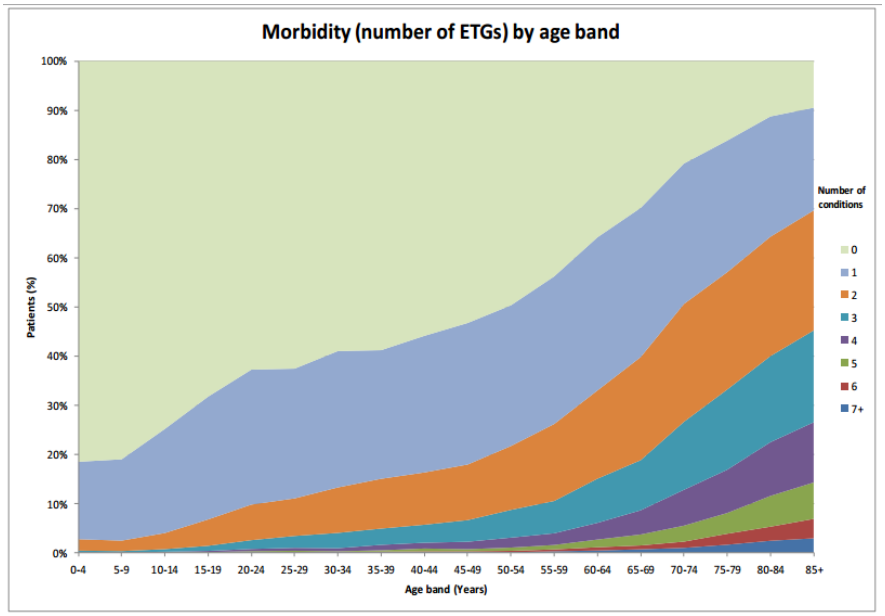


Figure 16: Age and the prevalence of frailty[16]

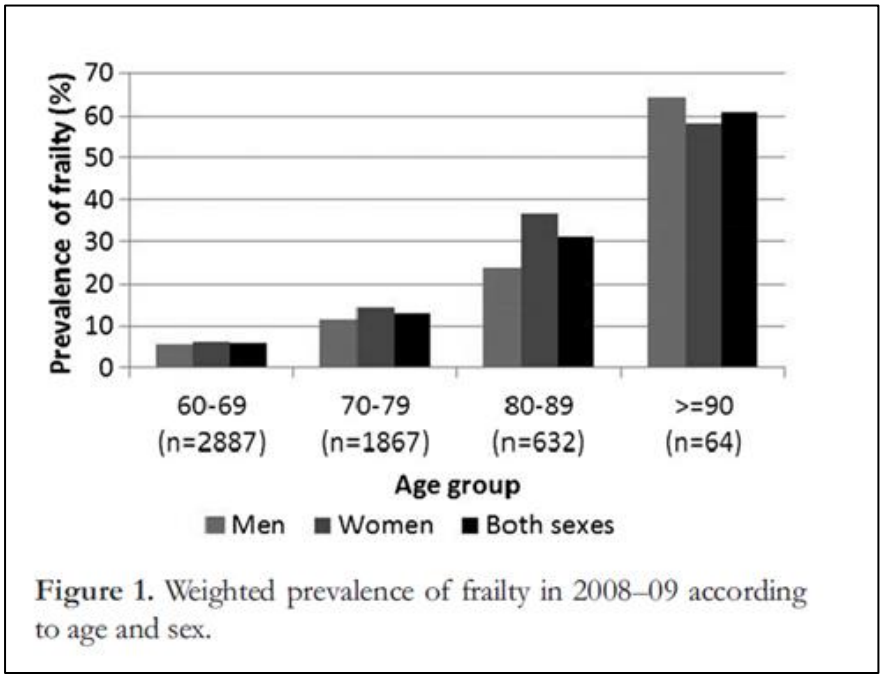
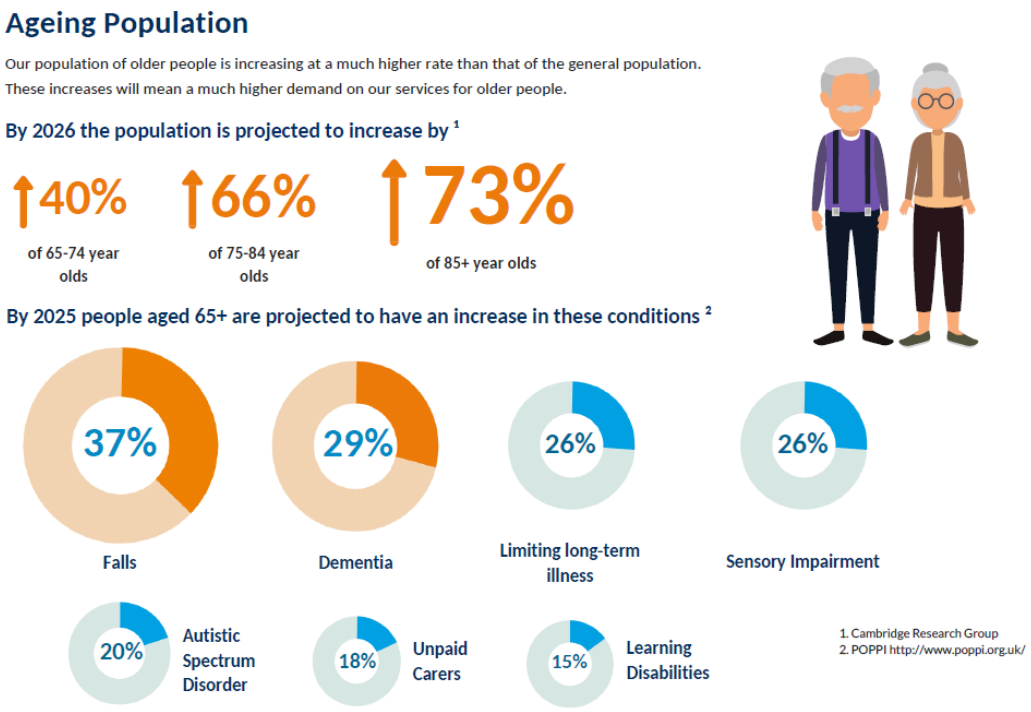


Figure 1. Weighted prevalence of frailty in 2008–09 according to age and sex.

The impact of these factors across C&P is illustrated below.

[16] Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing, 2014

Figure 17: The impact of the ageing population[17]



Implication for this business case

- Estimating future demand based on demographic forecasts and using these estimates to inform building design and capacity, is challenging at the best of times. The existence of two sets of demographic forecasts which differ so significantly, make this even harder for Cambridgeshire.
- The forecasts suggest that East Cambridgeshire will see one of the highest levels of population increase in the county (approximately +25% using what we believe are the more accurate local council forecasts.
- The older population is increasing faster as a percentage increase, although in absolute terms the largest increase is amongst working age adults. Understanding the detail of local forecasts is an important factor in modelling future likely activity and therefore capacity.
- Even though uncertainty exists and further detail is desirable, all indications are that the total number of people living within the POW catchment area, will increase meaning that everything else being equal, more capacity will be required in local services.
- The increase in population is skewed towards older people, who typically make greater use of health and care services.

3.2.2 Wider determinants of health

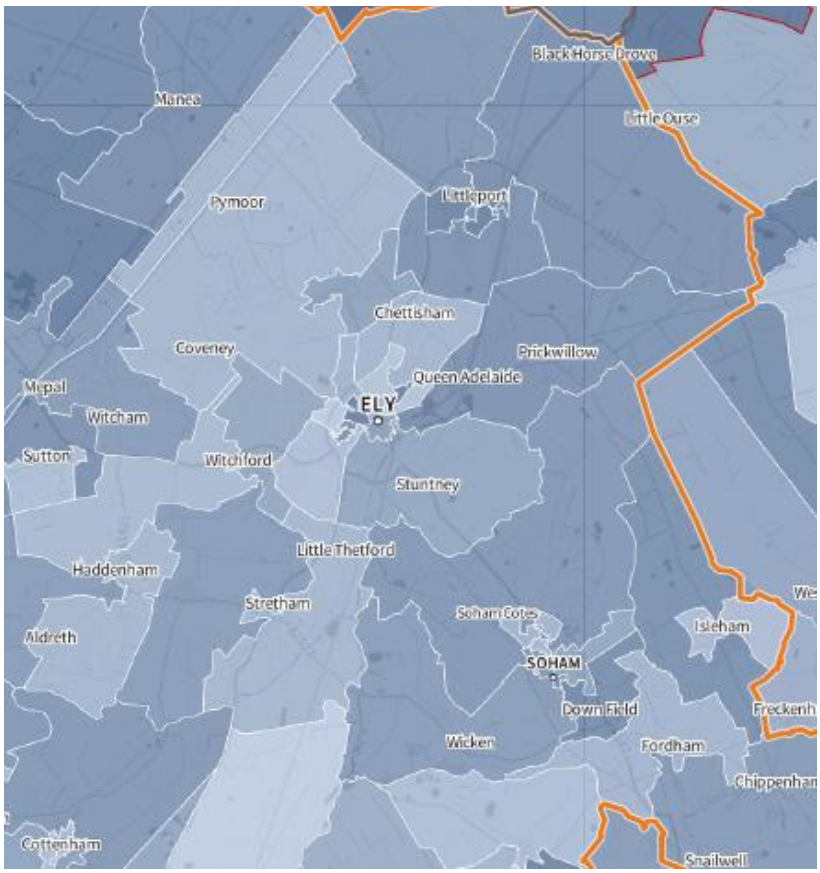
Need for health and care services is determined by more than population size and demographics – the following factors all influence local patterns of demand:

[17] Cambridgeshire and Peterborough Adult Social Care Market Position Statement 2018/19

- Health outcomes in East Cambridgeshire are broadly very good and often statistically significantly better than national averages.
- East Cambridgeshire is statistically significantly better than England for indicators including life expectancy at birth, prevalence of mental health conditions, and excess weight in children.
- East Cambridgeshire has statistically significantly lower rates of all-cause mortality for all ages and hospital admissions compared to Cambridgeshire, but statistically significantly higher rates of A&E attendances.
- Overall, socio-economic deprivation is low in East Cambridgeshire. None of its population are living in the most deprived fifth (20%) of areas nationally.
- East Cambridgeshire has statistically significantly high rates of self-harm, prevalence of high blood pressure, asthma, and cancer, and a lower than expected dementia diagnosis rate compared to England.

The figure below highlights areas of relative rural deprivation (to national averages) deprivation across the area around Ely. Rural deprivation is based on three domains within the overall index of multiple deprivation and is of most relevance to more rural areas of the country. In the map below, the most deprived areas are shown in darker blues.

Figure 18: Rural deprivation[18]



The East Cambridgeshire district displays an "average" level of deprivation, compared to the rest of England, overall with deprivation being lower in the city and areas close to Stowmarket, compared

[18] Source: UEA and PHE

to areas of the Fens where rural deprivation is a problem. The figure below provides a summary of key health and need indicators across the area.

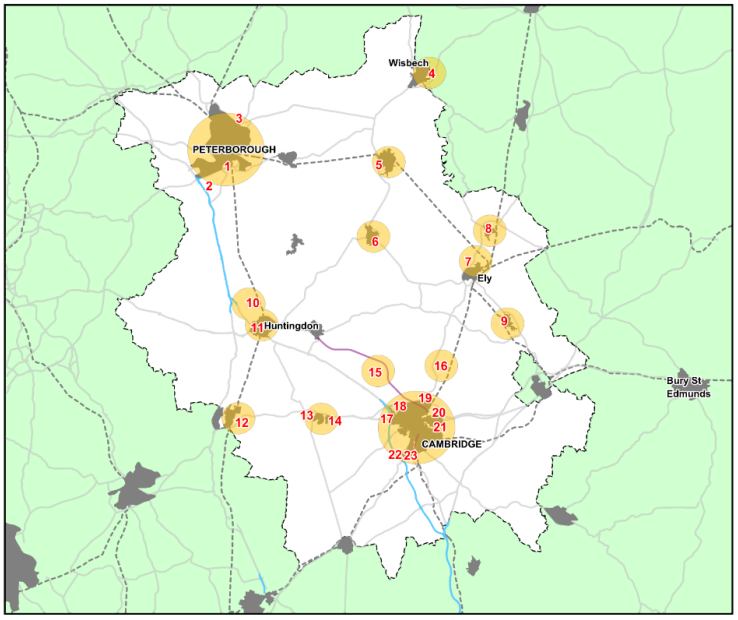
Implication for this business case

- The district compares well with the English average against most health and deprivation indicators.
- Whilst this suggests demand should be lower than the national average, having a healthier and wealthier population can lead to greater expectations of services.

3.2.3 Housing and the Local Plan

There are significant plans for new housing across the county as illustrated in the map below.

Figure 19: Areas of housing growth [19]



	Site	Indicative Number of Homes	Timescale
1	Hampton urban extension	3,632	By 2036
2	Great Haddon urban extension	5,300	By 2036
3	Norwood	2,300	By 2036
4	East Wisbech	1,450 (550 in Kings Lynn & West Norfolk)	By 2031
5	West March	2,000	By 2031
6	South Chatteris	1,000	By 2031
7	Ely (north)	3,000	By 2031
8	Littleport	1,850	By 2036
9	Soham	2,100	By 2036
10	Alconbury Weald	5,000	By 2036
11	Ermine Street (south), Huntingdon	1,050	By 2036
12	St Neots East (Wintringham Park and Loves Farm 2)	WP: 2,800 LF2: 1,020	By 2036
13	Cambourne West	1,655 935	By 2031 Post 2031
14	Bourne Airfield New Village	1,360 2,140	By 2031 Post 2031
15	Northstowe	3,203 6,784	By 2031 Post 2031
16	Waterbeach New Town	2,300 6,700	By 2031 Post 2031
17	Cambridge North-West (University site)	2,927	By 2031
18	NIAB (Darwin Green)	2,377 250	By 2031 Post 2031
19	Cambridge Northern Fringe East (AAP)	Potential for 7,600	Unknown
20	Cambridge East (north of Newmarket Road)	1,300	By 2031
21	Cambridge East (north of Cherry Hinton)	1,257	By 2031
22	Trumpington Meadows	637	By 2031
23	Glebe Farm, Clay Farm and Bell School	996	By 2031

As can be seen above three of the county's 23 development sites are in East Cambridgeshire and a fourth is nearby in Chatteris in the Fenland District.

The nearby city of Cambridge exerts a significant influence over the whole district. The success of the Cambridge economy has caused the East Cambridgeshire district to experience considerable recent pressure for housing growth. Rapid population growth has also placed pressure on local infrastructure and service provision – for example, education, transport, health services, recreation and utility services[20].

In February 2019, East Cambridgeshire District Council formally withdrew the emerging refreshed Local Plan meaning the current strategic plan for East Cambridgeshire is the local plan adopted in 2015. Because this plan is five years old, it is no longer being used to calculate the housing land

[19] Cambridgeshire & Peterborough Joint Strategic Needs Assessment, Core Dataset, 2019.
[20] East Cambridgeshire Authority's Monitoring Report 2018-19, East Cambridgeshire District Council, August 2019.

supply position - instead the 'local housing need' requirement is being used. The 2020 Five Year Land Supply Report[21] sets out a requirement for 3,610 (+9.5%) new homes over the five years to 31st March 2024, over the 2019 baseline of 38,175 households. Land supply has been identified sufficient to deliver 4,772 homes in the first five years (and a further 5,182 homes in the 15 years from 2024 to 2038). A large proportion of the available supply is linked to major developments most of which are in the north of Ely or Littleport. The Ely developments are relatively close to the hospital and are of sufficient size to warrant additional primary care capacity. These developments are a continuation of relatively substantial new housing growth in recent years, for example 2,099 dwellings (net) have been completed since 2011/12 across the district.

Although withdrawn the local plan provides a useful indicator of council thoughts about healthcare facilities in the area. The old plan referred to the importance of healthcare facilities and acknowledges that there is an overall desire to support new healthcare facilities on the POW site. The plan stated that there should be appropriate physical, social and green infrastructure in place to serve the needs of new development within the district and that new and improved infrastructure should delivered in a timely and proper manner. The plan explicitly stated that "*a new primary healthcare facility (Doctors) at Princess of Wales Hospital and the redevelopment and enhancement of facilities at Princess of Wales Hospital, Ely, are key infrastructure requirements relevant to growth within the District ".*

East Cambridgeshire District Council has confirmed that community infrastructure levy (CIL) monies are likely to be available as a contribution to the costs of any new healthcare premises required to meet demand arising from new homes in the Ely area. A total of £1.8m has already been set aside for health-related developments, from the CIL linked to the 2,099 new homes already constructed and CCS understands that £1.1m of this sum can be used for redeveloping the POW site.

Implication for this business case

- Local housing forecasts support the county council's view of likely population change rather than the ONS view – see above.
- As stated above more people equals greater demand, however, patterns of demand may vary if the new housing is disproportionately for a particular demographic e.g. for young families rather than retirees. Health services will therefore need to keep close to local planners to understand the likely demographic moving into the area.
- The need for new housing has created an opportunity for the NHS to sell surplus land thereby generating funds to contribute towards this scheme.
- The local council is supportive of proposals to expand and modernise the healthcare facilities at the POW Hospital.
- CIL funding is available to invest in any new healthcare premises required because of new housing.

[21] East Cambridgeshire District Council, April 2020.

3.3 The current configuration of services and estate in East Cambridgeshire

3.3.1 Current service provision

3.3.1.1 Main providers

The following NHS organisations provide most of the NHS commissioned health services for local people:

- Cambridgeshire Community Services NHS Trust (CCS which provides a range of children's and specialist community health services such as specialist dental, MSK and neurophysiology to Cambridgeshire and beyond. This trust also owns the POW Hospital and site.
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) which provides mental health and community physical health services. This trust operates the ward at the POW as well as local neighbourhood teams which combine mental health and physical health clinicians.
- Cambridge University Hospitals NHS Foundation Trust centred on Addenbrooke's Hospital in Cambridge. Addenbrooke's is the closest acute hospital to Ely. This trust provides outpatient clinics and day surgery at POW.
- North West Anglia NHS Foundation Trust which has three main sites, Peterborough, Stamford and Hinchingbrooke hospitals.

A small number of people from East Cambridgeshire will be referred to specialist services outside of the area and there are also some "cross boundary flows" to providers outside of the area, for example, some people living on the outskirts of Stowmarket use the West Suffolk Hospital in Bury St Edmunds for services such as ED and there is a flow north to the Queen Elizabeth hospital in Kings Lynn from the Littleport area.

3.3.1.2 General practice and PCNs

General medical practice and pharmacies across the CCG are organised into primary care networks (PCNs). There are seven general practices in East Cambridgeshire (and one private GP) and 12 pharmacies. The table below shows the list size for each and the split by PCN.

Table 9: General practice provision in East Cambridgeshire

	List size
Cathedral Medical Centre	11,049
St George's Medical Centre	11,636
St Mary's Surgery	15,710
Total Ely North PCN	**38,395**
Burwell Surgery	8,627
Haddenham Surgery and Stretham Surgery	7,325
Staploe Medical Centre	21,415
Total Ely South PCN	**37,367**
Priors Field (part of South Fenland PCN)	12,279
Total East Cambridgeshire list size	**88,041**

Overall Cambridgeshire has 2,236 people per full-time GP, which is worse than most CCGs in England[22] and the CCG also faces a greater challenge than most CCGs regarding an ageing GP workforce with almost 26% of GPs being aged 55 or over[23]. Although both metrics relate to the CCG as a whole, this does indicate long-term sustainability challenges for primary care provision which will only become more challenging with the growth in the population of the district.

Out of hours primary care is provided from the POW Hospital's minor injuries unit by Herts Urgent Care.

There are five pharmacies in Ely, one of which, Lloyds is at the POW Hospital, with a second branch of Lloyds operating alongside St Mary's surgery in the city centre.

The Cathedral Medical Centre is located on the POW site and this business case envisages the St Mary's practice moving some of its activity to the POW, whilst still maintaining its current premises in the centre of Ely. St Mary's has applied for estates and technology transformation fund (ETTF) monies to develop its current city centre premises – this ETTF scheme is not in scope for this business case. It is worth noting that the primary care estate across the two PCNs is generally poor i.e. too small and often in unsuitable premises. Although difficult to evidence, a poor-quality working environment does not assist with recruitment and retention of the primary care workforce.

3.3.1.3 Community health services

Community health services are provided by both CPFT and CCS. These include the following community teams – integrated neighbourhood teams (which integrate professionals from physical health, mental health and social care), the discharge to assess team, the older people's and joint emergency team, the learning disabilities team, the reablement team, the nursery nurse team, the best start team and health visitors.

The POW Hospital is a key venue for the delivery of community health services and services currently provided from the site include:

- 16 rehabilitation beds on Welney Ward
- Day surgery (two theatres in use)
- Minor injuries unit
- GP out of hours
- Outpatient clinics provided by community and acute providers
- Clinical dentistry for vulnerable children or adults with special needs
- Musculoskeletal and specialist physiotherapy
- The Oliver Zangwill Centre for Neuropsychological Rehabilitation
- Integrated Contraception and Sexual Health services
- Healthy Child Programme (Health Visitors and School Nurses)
- Children's Speech and Language Therapy
- Adult speech and language therapy
- Community Access Team
- Occupational therapy

[22] NHS Digital. 2019
[23] NHS Digital, 2019

- Supported Orthopaedic Discharge Team
- Audiology

3.3.1.4 Acute hospital services

The overwhelming majority of people requiring acute healthcare travel out of the immediate area to receive treatment whether planned activities such as surgery, outpatients and planned diagnostics or urgent and emergency activities such as A&E attendance and non-elective hospital admission. The tables below provide a snapshot of these patient flows[24].

Table 10: A&E flows

Accident and Emergency	CUHFT	NWAFT H	NWAFT P	QEHKL	Others
North	**7.91%**	**52.30%**	**34.24%**	**2.19%**	**3.37%**
Fenland PCN	**2.75%**	**40.72%**	**50.66%**	**2.76%**	**3.11%**
Cornerstone Practice	2.79%	31.73%	58.97%	3.60%	2.91%
Mercheford House	2.77%	27.03%	64.10%	3.11%	3.00%
Ramsey Health Centre	2.80%	78.61%	14.90%	0.57%	3.12%
Riverside Practice	2.65%	31.09%	59.58%	3.30%	3.38%
South Fenland PCN	**14.35%**	**66.74%**	**13.74%**	**1.47%**	**3.70%**
Fenland Group Practices	4.27%	66.74%	23.32%	1.96%	3.72%
George Clare	7.16%	79.03%	9.43%	1.39%	2.98%
Sutton	59.18%	33.77%	1.04%	0.44%	5.57%
South	79.74%	3.44%	0.46%	3.95%	12.40%
Ely North PCN	**83.26%**	**3.34%**	**0.56%**	**7.07%**	**5.77%**
Cathedral Medical Centre	87.10%	3.03%	0.46%	1.64%	7.76%
Littleport	71.76%	2.66%	0.47%	19.36%	5.75%
St Mary's	89.24%	4.02%	0.68%	1.48%	4.58%
Ely South PCN	**75.98%**	**3.55%**	**0.36%**	**0.63%**	**19.48%**
Burwell	78.07%	0.48%	0.12%	0.24%	21.09%
Haddenham	80.15%	13.38%	0.63%	0.82%	5.01%
Soham	73.35%	0.81%	0.34%	0.71%	24.78%
Ely & Fenland Total	**42.06%**	**29.07%**	**18.18%**	**3.03%**	**7.66%**

It is important to note that the A&E table above excludes the approximately 10,000 annual POW MIU attendances from the two Ely PCNs.

[24] Source: Cambridgeshire & Peterborough CCG Ely & Fenland PCNs Activity Flow Mapping, Apr 19 Mar 20

Table 11: Outpatient flows

Outpatients	CUHFT	NWAFT H	NWAFT P	QEHKL	RPHFT	DH	PoW	Others
North	**15.84%**	**31.91%**	**28.16%**	**1.59%**	**2.71%**	**5.74%**	**0.91%**	**13.15%**
Fenland PCN	**7.85%**	**27.83%**	**38.63%**	**2.04%**	**2.33%**	**6.29%**	**0.19%**	**14.84%**
Cornerstone Practice	7.85%	20.68%	42.49%	2.69%	1.90%	8.55%	0.21%	15.62%
Mercheford House	6.08%	21.00%	43.32%	2.82%	2.15%	7.27%	0.36%	17.00%
Ramsey HC	6.52%	16.05%	48.33%	1.92%	2.00%	7.05%	0.08%	18.05%
Riverside Practice	12.12%	62.32%	14.45%	0.08%	3.61%	0.74%	0.04%	6.64%
South Fenland PCN	**25.52%**	**36.85%**	**15.48%**	**1.04%**	**3.16%**	**5.07%**	**1.78%**	**11.10%**
Fenland Group	18.59%	44.40%	14.42%	1.17%	3.12%	6.47%	0.93%	10.90%
George Clare	12.41%	40.38%	23.12%	0.96%	3.48%	5.67%	0.35%	13.64%
Sutton	68.58%	13.29%	1.13%	0.93%	2.56%	0.81%	6.68%	6.01%
South	**72.64%**	**3.46%**	**0.28%**	**3.03%**	**2.42%**	**0.30%**	**5.62%**	**12.25%**
Ely North PCN	**72.29%**	**3.90%**	**0.37%**	**5.33%**	**2.36%**	**0.34%**	**7.55%**	**7.87%**
Cathedral	74.51%	4.54%	0.28%	1.67%	2.58%	0.57%	8.08%	7.77%
Littleport	63.75%	3.63%	0.28%	14.58%	2.59%	0.17%	6.65%	8.35%
St Mary's	78.01%	2.98%	0.64%	1.60%	1.64%	0.08%	7.54%	7.51%
Ely South PCN	**73.02%**	**2.97%**	**0.19%**	**0.54%**	**2.49%**	**0.26%**	**3.54%**	**16.99%**
Burwell	71.91%	9.22%	0.28%	0.73%	2.77%	0.98%	6.72%	7.38%
Haddenham	72.50%	1.08%	0.19%	0.61%	2.48%	0.02%	3.26%	19.86%
Soham	75.31%	0.29%	0.07%	0.18%	2.23%	0.00%	0.73%	21.20%
Ely & Fenland Total	**43.38%**	**18.11%**	**14.64%**	**2.29%**	**2.57%**	**3.10%**	**3.19%**	**12.72%**

As can be seen from the outpatient activity table above only slightly over 1 in 20 Ely residents who attend outpatients do so at the POW.

Table 12: Planned diagnostics flows

Diagnostic Imaging	CUHFT	NWAFT H	NWAFT P	QEHKL	RPHFT	DH	PoW	Others
North	**13.64%**	**27.45%**	**31.15%**	**1.33%**	**3.80%**	**17.23%**	**2.11%**	**3.29%**
Fenland PCN	**6.71%**	**24.27%**	**42.55%**	**1.92%**	**3.77%**	**17.17%**	**0.40%**	**3.21%**
Cornerstone Practice	4.84%	16.77%	46.87%	2.52%	3.82%	21.77%	0.65%	2.77%
Mercheford House	5.86%	12.26%	52.50%	1.96%	3.40%	20.88%	0.35%	2.80%
Ramsey HC	10.15%	59.01%	21.02%	0.15%	3.76%	2.79%	0.17%	2.95%
Riverside Practice	6.93%	16.12%	45.68%	2.62%	4.07%	19.92%	0.34%	4.32%
South Fenland PCN	**21.47%**	**31.05%**	**18.26%**	**0.66%**	**3.83%**	**17.30%**	**4.05%**	**3.38%**
Fenland Group	10.59%	33.54%	26.56%	0.70%	4.39%	20.44%	0.34%	3.44%
George Clare	13.58%	37.91%	17.61%	0.77%	3.81%	21.84%	0.65%	3.83%
Sutton	59.03%	12.39%	2.93%	0.36%	2.74%	1.94%	18.28%	2.33%
South	**66.48%**	**1.59%**	**0.34%**	**2.11%**	**2.96%**	**0.43%**	**15.33%**	**10.77%**
Ely North PCN	**69.58%**	**1.70%**	**0.39%**	**3.87%**	**2.62%**	**0.46%**	**18.27%**	**3.11%**
Cathedral	73.17%	1.40%	0.30%	0.42%	2.07%	0.65%	18.09%	3.91%
Littleport	61.89%	1.67%	0.44%	11.33%	2.70%	0.49%	19.03%	2.45%
St Mary's	72.60%	1.87%	0.41%	0.91%	2.83%	0.35%	17.89%	3.14%
Ely South PCN	**63.14%**	**1.46%**	**0.28%**	**0.22%**	**3.32%**	**0.39%**	**12.16%**	**19.03%**
Burwell	58.59%	0.23%	0.00%	0.18%	3.34%	0.15%	2.22%	35.29%
Haddenham	65.98%	5.01%	0.66%	0.18%	3.32%	0.84%	20.34%	3.67%
Soham	64.12%	0.41%	0.24%	0.26%	3.31%	0.31%	13.38%	17.96%
Ely & Fenland Total	**41.50%**	**13.81%**	**14.90%**	**1.74%**	**3.35%**	**8.37%**	**9.08%**	**7.23%**

Diagnostic services based at POW have a greater share of the local "diagnostic market", although again, the clear majority (almost 85%) of Ely residents needing diagnostic tests are travelling to more distant hospitals.

3.3.1.5 Mental health

CPFT is the mental health provider for the Ely area. Community mental health teams are based in the city and work in conjunction with community health and social care services. There are no mental health inpatient units in East Cambridgeshire.

3.3.1.6 Adult social care

Cambridgeshire County Council commissions and in some cases provides, social care for older people, people with learning disabilities and people with long-term mental health problems.

The C&P Adult Social Care Market Position Statement for 2018/19 states that across the county the cost of living as well as the high cost of land means there are currently a comparably low number of care homes able to manage the residential, nursing and dementia needs of service users and that this is impacting on the level of choice available to individuals and the financial cost of placements to the County Council. The East Cambridgeshire area is particularly short of nursing and nursing dementia placements (the more complex end of care home provision), homecare capacity and has a shortage of personal assistants. In response the county council has identified a requirement for a 65-bed nursing care home in Ely and is exploring the opportunity to develop such a facility on the POW campus.

3.3.1.7 Children's services

The county council also commissions children's social care services which interface with NHS paediatric services and via the public health budget, health visitors and school nurses provided by CCS under the Healthy Child Programme.

The Fenland and East Cambridgeshire Opportunity Area (OA) was launched by the government in January 2017 as one of 12 OAs across England. OAs aim to raise education standards and provide children and young people with the chance to reach their full potential. The OA has four priorities, once of which is to "*strengthen the effectiveness of support for children and young people with mental health concerns and those with Special Educational Needs*".

Implication for this business case

- The area benefits from a typical range of community and acute hospital services being provided from the POW site.
- The number of provider organisations operating from POW is relatively large. This creates complications in maximising the sue of the site, but also affords opportunities for greater integration of services.
- Local community and primary care services are coalescing around the two Ely PCNs which have a combined list size of 76,000 and which will grow as a result of new housing.
- The proposed health and care hub is geographically within the North Ely PCN area, so the system will need to make sure that services are accessed by people from the South Ely PCN and beyond.
- The volume of planned activities particularly outpatients and diagnostics, currently undertaken at nearby acute hospitals suggests that there is substantial opportunity to repatriate some work to the POW.

3.3.2 The public sector estate in Ely

Public sector services operate from a relatively limited estate in the city with the hospital being by some way, the largest facility apart from local schools. This limits alternate site options except if the local authority were to incorporate a new hospital into housing development plans – the council's expressed preference is to retain health services on their current POW Hospital site. The map below shows the location of the POW Hospital (in purple, number 2), six Ely schools/ colleges (in light brown), the two GP practices (green – one at the POW) and the ambulance station (red).

Not shown on the map are, the district council offices, the Ely library and the Hive Leisure Centre.

Figure 20: NHS and education estate in Ely[25]

As noted earlier, the primary care estate is generally not fit for purpose and the St Mary's practice has a separate plan to redevelop its city centre location. These plans will be aligned with the proposals in this business case.

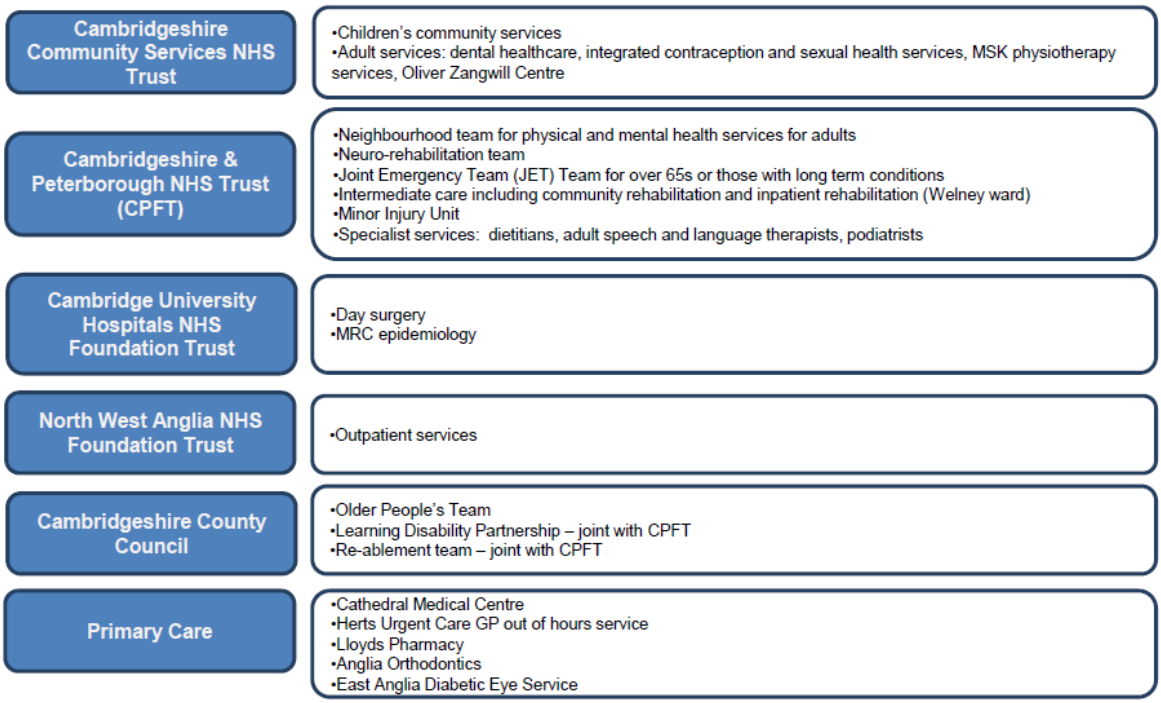
The Princess of Wales Hospital was constructed as a Royal Air Force (RAF) Hospital in 1939 and was renamed the Princess of Wales Hospital in 1987. It was closed by the RAF in 1992 but after much local pressure was taken over by the local NHS and developed as a community hospital. It is owned by CCS and is one of the Trust's larger sites in its portfolio of 160 buildings. The site is located to the east of the A10 in Ely and extends to 3.4 hectares and provides approximately 6,500m^2 of space.

[25] Source: SHAPE, Crown Copyright, Ordnance Survey, 2020

Situated within an urban location the site is surrounded by housing development to the north and west (including 35 units of extra care living known as Baird Lodge) and public open space to the east and south.

The following organisations provide the following services from the hospital.

Figure 21: Princess of Wales Hospital site users and services



Arrangements for use of the hospital by organisations other than the owner, CCS, are historic and varied (a mix of leases and licences) and these do not act to support moves to better integrate services. The range of services based at the POW has sometimes grown by accident rather than design with the opportunity to develop the hospital into a hub, not fully delivered.

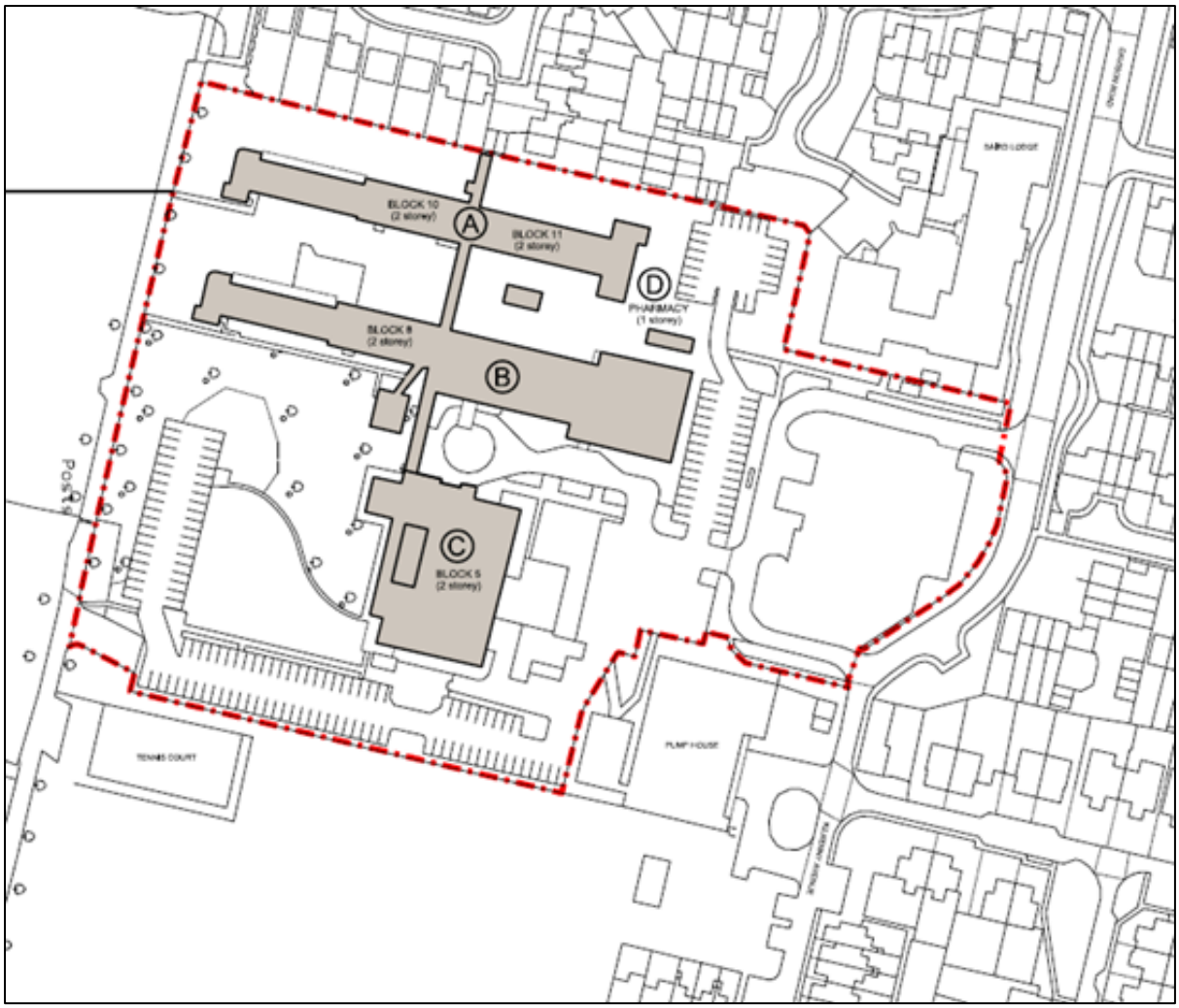
The buildings were originally designed to provide ward-based acute care to inpatients and as such do not lend themselves easily to the outpatient or day service activity that is the basis of a large proportion of today's modern community-based care pathways. These pathways require spaces that can be flexed to meet the needs of individual patients (e.g. providing extended opening hours) or to accommodate different styles of delivery such as group-based therapy. The layout of the hospital is extremely inefficient and incompatible with modern service delivery models and accommodation standards. Accommodation is highly segmented with excessive circulation space. The current configuration of long-narrow ex-ward buildings with multiple small spaces often leading on from each other, restricts professionals from offering these new ways of working to their patients (or rather restricts the extent that they are able to do so).

Modern healthcare services have been enhanced by the increasing use of technology across the care pathway from assessment and diagnosis, through to treatment or on-going monitoring of patients. The age and current state of the buildings on the POW site means that teams are currently unable to fully harness such technology for the benefits of their patients. For example, the rehabilitation physiotherapists can currently only view a patient's original x-ray if the x-ray was taken on site. If

the x-ray was taken at another hospital, they can only see the x-ray report (rather than view the original x-ray itself).

Wi-Fi is also not uniformly available across site, which will restrict the development of the A&E telemedicine links that are proposed as part of the urgent care pathway developments. Clearly, such technological gap will impact on the quality of clinical services that can be provided on site until all the buildings can be brought up to modern standards.

Figure 22: Princess of Wales site plan



The current buildings on site range in age from the 1940s to the early 21st century. Much of the original hospital estate remains which impedes the delivery of modern, 21st century healthcare and which, if not re-built or extensively re-built, will contribute to a slow deterioration in the quality of services over time. The age of many buildings means that the infrastructure is often beyond its expected useful life. This leads to an increase in reactive maintenance regardless of the efforts made to proactively maintain critical building infrastructure. The pictures below provide an illustration of the existing estate.

Figure 23: Princess of Wales buildings

There is one relatively modern building dating from 1989, which accommodates three day theatres (only two are currently used) and some therapy space.

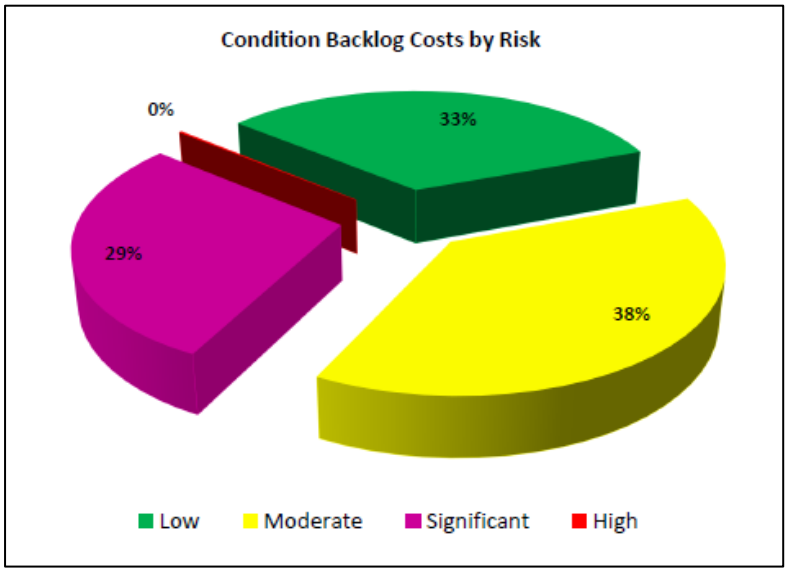
Figure 24: Princess of Wales day surgery building

CCS commissioned a survey of the physical condition and statutory compliance facets in 2018. The "target" score is an "A" or "B". For the purposes of the survey the POW site was divided into three sub-sections – the main hospital, the stores and the medical gases building:

- All three areas were rated as "B" demonstrating CCS' commitment to maintaining the estate to as good a condition as can be expected given its age.
- All three were rated a "B" for condition and "C" for statutory compliance.
- In total £4.5m including fees and VAT will need to be spent to eliminate existing backlog and carry out routine works over the next five-years.
- Existing backlog is £1.6m excluding fees and VAT divided, £1,020k building related, £488k mechanical and electrical, and £100k fire and statutory compliance.

The pie chart below divides the backlog by risk category.

Figure 25: Princess of Wales estate by backlog risk category



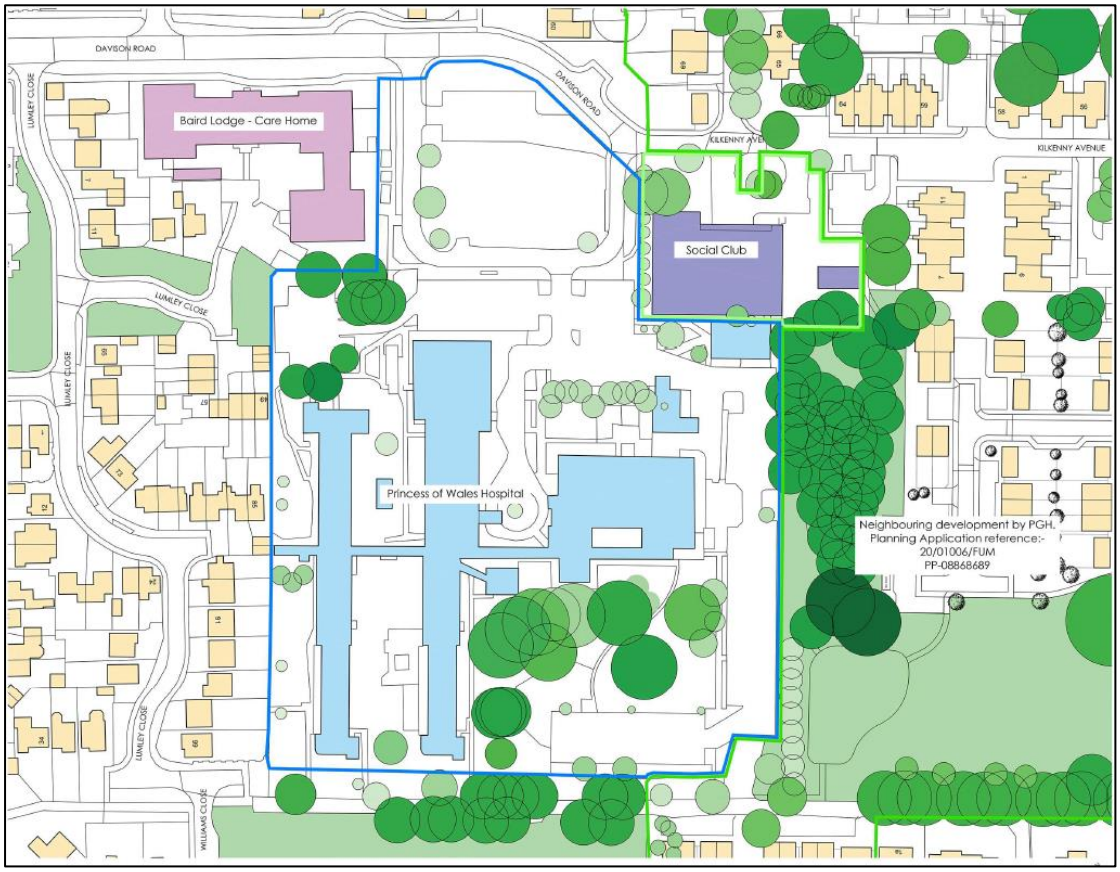
The POW backlog estimate of £1.6m represents 19% of the CCS-wide backlog cost. The six-facet survey dashboard for the POW is included in Appendix One.

3.3.3 Land adjacent to the hospital

Adjacent to the hospital are land and buildings that are being redeveloped by Palace Green Homes (PGH) which is East Cambridgeshire District Council's wholly owned housing development company. PGH acquired the site from the Ministry of Defence (MOD) who declared it surplus once it was no longer required for military domestic accommodation. CCS & PGH have exchanged legal contracts to formalise a landswap. The land acquired by CCS will allow a new healthcare development to be built with no interruption to the provision of service. CCS will use a surplus part of the site in lieu of payment for the land it acquires. PGH will then develop the land it acquires from CCS for housing.

The map below shows the existing hospital site curtilage in blue and part of the Palace Green Homes site outlined in green. The area occupied by the social club is the site acquired by the NHS in October 2020 in exchange for some of the current hospital site – see land swap discussion in the commercial case.

Figure 26: The POW site and adjacent land



Implication for this business case

- The wider public sector estate in Ely is relatively limited and none of the other sites are readily developable for a health facility.
- The primary care estate across both PNs is poor which is already causing challenges to service delivery and staff recruitment, challenges likely to get worse as the population

grows. There is a plan for the redevelopment of St Mary's surgery which will be aligned to any redevelopment of the POW site.

- The POW is used by a large number of NHS organisations, but this has not led to service integration or a site that is well-utilised.
- If the site is not redeveloped, CCS would need to invest to resolve backlog maintenance issues and areas of non-compliance with fire and, health and safety legislation. But this would not resolve all the unacceptable estate and environmental compromises nor the requirement for additional capacity to meet activity growth.
- The site is under-developed with opportunities to rationalise the NHS' land holding thereby freeing-up land for homes or alternate public sector use.

3.4 The national policy context

The NHS Long Term Plan (LTP) sets out the priorities for healthcare over the next ten years. The plan builds upon the Five Year Forward View and Vanguards and further signifies the shift in emphasis from competition to collaboration through integrated care systems. The plan also sets out changes to be made over the first five years of the planning period:

- Increasing the focus on population health and partnership with local authority-funded services through integrated care systems (ICS).
- Boosting 'out-of-hospital' care and ending the historic divide between primary and community health services.
- Redesign to reduce pressure on emergency hospital services.
- Giving individuals more control over their own health, and more personalised care.
- Mainstreaming digitally enabled primary and outpatient care.
- Better care for major conditions.

These changes will significantly influence the way POW-based services work in the future - the estate will need to facilitate the anticipated shift to a more joined-up model of care.

Each of the change areas is discussed below and we have drawn out what this means for this business case.

3.4.1 Population health and integrated systems

At the heart of this ambition is the national roll out of ICS which provide the structure within which local organisations come together to redesign care and improve population health, creating shared leadership and action. They are the delivery route for the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

An important element of reform associated with an ICS is changes to contractual form and how funding could flow between organisations, which is expected to see a move towards system financial control totals. Linked to this is the concept of the "Cambridgeshire and Peterborough Pound" and the recognition that the system cannot continue to allow individual organisation's financial interest to destabilise the system. This means we will need to potentially explore new ways of financing for example shared estate, and that agreements to occupy buildings must work in a way that is financially sustainable for the system as well as individual organisations

Continuing this theme, we want to see an estate which is ”easy to use” for all partners across the system meaning an estate available to all services on a fixed and an ad hoc basis, which is ICT enabled to allow any user to drop in and be able to access the digital services they require.

Implication for this business case

- The development of a new health and care hub in Ely must be accompanied by the system agreeing a new approach to funding the initial capital investment and paying for ongoing running costs.
- This system will need to identify responsibility for managing the new hub in the interests of all providers, making the facility “easy to use” whilst also incentivising a system-wide approach to maximising use.

3.4.2 Boosting out of hospital care

The LTP commits to increasing the share of the NHS budget spent on primary and community health. Primary Care Networks (PCN) represent the new organisational form to drive the boost to out of hospital care. PCNs will drive working at scale and integration with community-based health and care services. At a practical level this is resulting in community health teams being re-orientated to interface with PCNs, the practice based non-medical workforce being expanded, PCNs developing “at scale” services, GPs being incentivised to provide non-core GMS services such as Enhanced Health in Care Homes, GPs being embedded in urgent care pathway services such as urgent treatment centres and NHS111 and community health services delivering improved crisis response within two hours, and reablement care within two days. Across the country these service model changes are leading to investment in the estate to co-locate GP surgeries with other health and care services.

Implication for this business case

- The POW site already hosts one Ely practice (Cathedral) alongside community health services – we anticipate this aspect of LTP to drive greater service co-location as an enabler to improved joined-up working.

3.4.3 Redesign of urgent care pathways

The longstanding desire to reduce the number of people attending hospital emergency departments with conditions that can be treated elsewhere has led to a multitude of alternate services being rolled out. Unfortunately, this has led to a degree of confusion amongst the public about where to attend and service duplication. The LTP aims to redesign urgent and emergency care pathways to bring a greater degree of standardisation cross these community-based alternatives to ED whilst recognising that the aim of diverting activity from ED remains the goal. There are several initiatives within this element of the LTP:

- Embedding a single multidisciplinary clinical assessment service within integrated NHS 111, ambulance dispatch and GP out of hours services.

- Implementing the urgent treatment centre model to create a consistent offer for out-of-hospital urgent care.
- Reforming same day urgent and emergency care within acute hospitals.
- Reducing delays to discharge.

Implication for this business case

- The existing urgent care services at POW will need to be co-located with flexible use of space encouraged.
- The UTC must be supported by diagnostic capability. Currently limited opening times for radiology acts as a barrier to provision of effective local urgent care.
- The emphasis on faster patient discharge from hospital will have an impact on the POW-based rehabilitation and reablement teams – it will be important for these teams to be based close together.
- The aim of improving discharge pathways will also impact on bedded step-down services for those people not able to go straight home following an acute hospital admission. The step-down bedded model provided from the wider POW site will need to be rightsized to respond.

3.4.4 Personalised care

The LTP sets out a move from encouraging choice to a more personalised approach to medicine and therapeutic interventions enabled through advances in genomes etc. Overtime this suggests that the interventions available will change, so any new buildings need to be designed with future flexibility in mind. Personalised care also means that people will expect their care to be more joined-up as they receive packages of care from multiple services and organisations - the estate can help enable this more personalised and joined-up approach by providing facilities which co-locate services and which make no distinction between organisations, including providers from the non-statutory sector.

Implication for this business case

- Personalisation of care is likely to lead to people wanting to have care packages drawn from different services and providers. This mixed model of provision would be easier to delvier if all agencies involved were co-located.

3.4.5 Digitally enabled primary and outpatient care

Digital service delivery has made rapid advances across all sectors of the economy, but the NHS has lagged behind. However, the experience of Covid has demonstrated that a substantial proportion of traditionally face-to-face consultations done in both primary care and outpatient settings, can be done remotely by phone, video or online. The LTP set out an aspiration to reduce the number of face-to-face contacts through alternate delivery channels – this aspiration has already been achieved because of the pandemic. This significant shift will be recognised in the design of the new health and care hub.

Implication for this business case

- The new building should not be planned assuming the traditional face-to-face consultation model continues for large volumes of patients.
- Digital consultation suites will need to be provided for professionals.
- Those people who still do attend the health and care hub for a face-to-face consultation are more likely to do so for a "one stop shop" service combining consultation and diagnostic tests; the LTP ambition to improve cancer diagnosis is an example of how services will be expected to join-up pathways through a one-stop approach. The new hub must therefore have the appropriate diagnostic capability on-site to support outpatient clinics.

3.4.6 Better care for major health conditions

The LTP implementation framework sets out targets for delivering improved cancer outcomes, improved mental health services, and shorter waits for planned care. Of particular relevance to this business case are:

Cancer: The LTP commits to extending and improving screening and early detection, providing speedier access to treatment and an individualised care plan and support for their wider health and wellbeing, and a follow-up pathway tailored to their needs.

Cardiovascular disease: The LTP commits to the earlier detection and management of cardiovascular disease with better support for patients through multi-disciplinary teams as part of primary care networks to improve outcomes and reduce hospital admissions and unnecessary prescribing.

Diabetes: The LTP commits to taking action to prevent diabetes and supporting people with diabetes in managing their own health and supporting primary care delivery to minimise risks of complications.

Respiratory: Primary care networks will be used to enhance the diagnosis of respiratory conditions, expanded pulmonary rehabilitation services, support for self-management, improved use of medications, and delivering community-based care as an alternative to hospital admission where appropriate.

Adult mental health: The LTP makes a renewed commitment to growing investment in mental health services faster than the NHS budget overall for five years. Alongside a range of measures for people with severe mental health problems, the primary care led Improving Access to Psychological Therapies (IAPT) programme will be expanded to focus on people with long term conditions. The Community Mental Health Framework describes new integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses providing access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. This will include 24/7 community-based crisis response and crisis support services.

Implication for this business case

- Facilities need to enable integrated primary and community-based support for the management of major conditions including cancer care, cardiovascular disease, diabetes, respiratory conditions and mental health.

3.4.7 Diagnostics

The need for radical investment and reform of diagnostic services was recognised in the LTP. In October 2020 NHS England published "*Diagnostics: Recovery and Renewal*", which builds upon the LTP by outlining how the Covid-19 pandemic has further amplified the need for radical change in the provision of diagnostic services, whilst also providing an opportunity for change by recognising that Covid-19 led to many beneficial changes in diagnostic pathways, such as increased use of virtual consultations. The report recommends that emergency and elective diagnostics should be separated where possible and the establishment of Community Diagnostic Hubs (CDH) serving populations of approximately 333k people. CDHs would provide Covid-19 minimal, highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions. For patients with suspected cancer, these should incorporate the rapid diagnostic centre service model. Diagnostic modalities envisaged for CDHs include:

- Imaging: CT, MRI, ultrasound, plain X-ray.
- Cardiorespiratory: echocardiography, ECG and rhythm monitoring, spirometry and lung function tests, support for sleep studies, blood pressure monitoring, oximetry, blood gas analysis.
- Pathology: phlebotomy.
- Endoscopy (at some, but not all DCHs).

Implication for this business case

- The POW Hospital already provides some of the diagnostic modalities recommended for a CDH, although as referenced in Section 3.3.1.4 only 1 in 6 diagnostics tests for the local population are done at the POW.
- The recommended separation of emergency and elective diagnostics would be challenging to do at a small site such as POW and it is important for the development of an urgent treatment centre at the hub, that emergency/ urgent diagnostics is available.
- The modalities provided in the new hub will need to reflect current and anticipated new pathways, demand to avoid having diagnostic capacity under used. This could mean some more complex diagnostics, such as MRI would be provided on a mobile basis.

3.4.8 NHS policy regarding information technology

Technology, like the estate is an enabler of clinical service transformation. The LTP placed great emphasis on technology, highlighting its role in delivering transformation, such as enabling patients to access primary care in different ways. National information and communications technology (ICT) strategy focuses on using ICT to support:

- Joined-up care by providing technology that supports integration to place the patient at the centre of a web of care.
- Safe, effective and high-quality care by providing ICT that supports care delivery at the right time and in the right place.
- A sustainable health and care system by using ICT to drive efficiencies in service provision.
- Well-managed services by providing the data and information to aid decision making.
- Innovation by assisting research and continuous improvement.
- Digital delivery of consultations with patients and case discussions between clinicians.

The health industry has lagged other sections of the economy in its pace of adopting new technology, but there are several emerging themes and concepts spanning tele-medicine, tele-care and tele-health, which need to be considered in new building design:

- Making systems infrastructure robust and easy to use - this allows changes to systems to be made now and in the future. This includes cloud and video conferencing.
- Digitally empowered patients. This includes making available digital tools to encourage self-care and active engagement with healthcare services using concepts such as 'hospital without walls'. This Includes patient monitoring and reporting over hand-held and wrist worn devices.
- Digitally enabled staff through making available tools for staff which allow them to work more efficiently and effectively regardless of location. This allows for more effective home working, patient management, staff communications and it reduces the reliance of office space.
- Clinically Enhanced Systems. Clinical systems that support patient management and diagnostics including integrated systems such as radiological information and picture archive and communication systems, room booking and theatre scheduling.
- Smart buildings incorporating technology in facilities to support building operations and security. Smart buildings allow for the management and control of the internal environment such as heating, lighting, humidity and noise.
- Integration of the internet of things and sensor technology for the purpose of connecting and exchanging data with other devices and systems over the internet. Sensor technology can be used to remotely monitor patients in their homes.

The Covid pandemic demonstrated how new technologies can lead to rapid changes in the way that services are delivered, for example the shift to online consultations across primary care and outpatient services achieved in just a few weeks the degree of transformation the NHS had planned to achieve over several years.

Implication for this business case

- The key impact on this business case is that ICT as an enabler of a modernised estate. The C&P system will need to invest in ICT to effect service transformation and new ways of working which will maximise space utilisation in buildings.
- Spatial planning for the hub should reflect the shift to mobile and home working and the resulting reduction in the need for desk space.
- The hub should become a centre for multi-disciplinary team meetings which use

technology to bring colleagues together virtually.

- The hub could also be the monitoring centre for patients supported at home using remote technology.
- The recent Covid experience of how technological change can facilitate changes to the way services are delivered must not be lost and instead, should be used to inform the design of the new health and care hub.

3.4.9 NHS policy regarding the estate

In March 2017 Sir Robert Naylor published his review[26] into the NHS estate which sets out how the NHS can release up to £2bn of surplus estate to fund the investment required to support plans set out by STPs. The report highlights an STP estate investment need of up to £10bn, made up of £5bn to resolve backlog maintenance issues and a further £5bn to support transformation. The review also makes recommendations about aligning the interests of individual trusts with health communities via STPs and prioritising land vacated by the NHS for the development of residential homes for NHS staff, where there is a need to do so.

Looking beyond the NHS, the One Public Estate programme is a national programme delivered in partnership by the LGA and the Cabinet Office Government Property Unit which seeks to, create economic growth, deliver more integrated, customer-focused services and generate efficiencies, through capital receipts and reduced running costs in line with the Carter Review recommendations. Locally the OPE focus is on seeking opportunities to share estate across public sector partners.

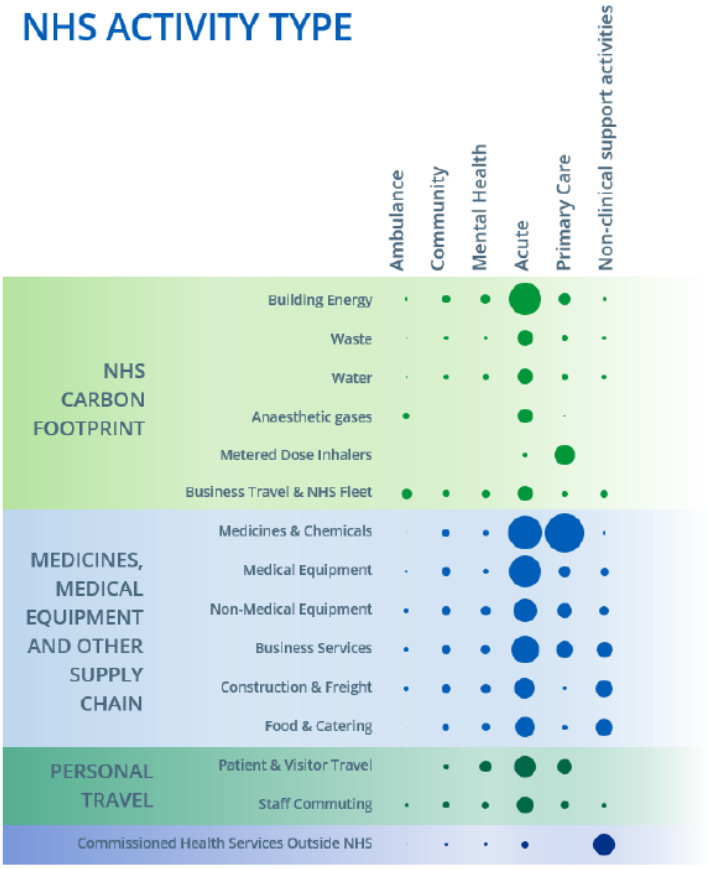
In October 2020 *Delivering a 'Net Zero' National Health Service* was published by NHSEI. This strategy sets out the NHS' response to the health emergency associated with climate change and sets two clear targets:

- For the emissions the NHS directly controls (the NHS Carbon Footprint), a target of net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions the NHS can influence (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The figure below illustrates the relative scale of carbon emissions associated with health buildings and indicates that for all categories of provider buildings are the largest source of carbon emissions.

[26] NHS Property and Estates, Sir Robert Naylor, March 2017.

Figure 27: NHS related sources of carbon emissions by setting of care and activity type[27]



Eight immediate steps are set out, one of which is the construction of 40 new 'net zero hospitals' as part of the government's Health Infrastructure Plan (HIP) - this ambition makes it clear that new hospitals will be expected to be carbon neutral.

Linked to the aim to reduce carbon, the Department of Health and Social Care and NHSEI have adopted a "presumption in favour of modern methods of construction (MMC)" as part of the business case approvals process. Expectations are that new healthcare premises will be designed and constructed using flexible repeatable design and off-site manufactured components (see Section 5.4).

At both a national and local level, it is recognised that improving the NHS estate is a key enabler to being able to deliver the new models of care outlined in the LTP. There is an explicit awareness that this investment is not just needed to improve or extend existing facilities to bring them up to modern standards and meet increasing demand, but also to be able to develop new spaces that have the flexibility to accommodate new multi-disciplinary teams, innovations in care for patients and the increasing use of technology in healthcare delivery.

Both CCS and the wider STP have already delivered estate rationalisation in support of the Naylor initiative. Recent CCS disposals have been leased rather than owned premises, although the Trust

[27] Source: Delivering a Net Zero National Health Service, NHS England and Improvement, 2020

anticipates a joint disposal of a small freehold site in St Ives in conjunction with the Cambridgeshire Fire and Rescue Service who own the adjoining site and looking further ahead land will become surplus with the reconfiguration of the North Cambridgeshire Hospital in Wisbech. CCS is also actively exploring opportunities to consolidate its estate footprint in central Cambridge, working jointly with the City Council who own neighbouring property.

Currently CCS is achieving the 35% Carter target for non – clinical space (CCS 30.67%) and the 2.5% target for unoccupied floor space (CCS 0.64%) based on 2018/2019 ERIC data.

Reflecting national policy, the redevelopment of the POW site has been formally identified and confirmed as a C&P system priority project in the STP Estate Plan. The STP has also acknowledged that a 'community scheme' (rather than an acute scheme) should be the highest priority if a further round of STP funding becomes available and the POW is the highest priority community scheme within the C&P STP area. Given that the site is poorly configured and designed, and given its age, there is an opportunity to release land for residential purposes with the land sale receipt becoming available to part fund the capital required for the new hub.

Implication for this business case

- The POW proposal is entirely consistent with the ambitions set out in the Naylor report including releasing land for housing.
- The development creates wider opportunities across the public sector estate in Ely and supports OPE aims.
- New facilities will need to be designed to reflect changing models of care and with sufficient flexibility to be adapted in the future as pathways continue to evolve.
- The development is a priority for the STP.
- The new development will need to be carbon emissions net neutral.

3.4.10 Healing environments

Research has identified a range of positive outcomes including reductions in falls, medical errors, pain and patient stress as well as improvements in staff satisfaction arising from better physical environments. For example:

- Reducing pain, stress and depression through exposure to views of nature, to higher levels of daylight, displaying visual art and reducing environmental stressors such as noise.
- Reducing falls through design of floors, doorways, handrails and toilets, and decentralised nurse stations.

There is evidence that art, design and environmental enhancements can have a positive impact on health and well-being of patients and staff. For example:

- Architectural design, internally and externally, can be especially important for patients with dementia, helping to simplify wayfinding, reduce anxiety and control "wandering".
- Exposure to art in healthcare environments has been found to reduce anxiety and depression.

With an ageing local population, it is inevitable that the proportion of patients who have dementia will increase – the Kings Fund estimate that 25% of people accessing acute hospital services have dementia and the number of people with dementia is expected to double during the next 30 years. Research into how health facilities need to be redesigned to make them "dementia friendly" has demonstrated that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved wayfinding, can have a significant impact.

Implication for this business case

- Good environments can influence health and wellbeing, so this development should incorporate design features such as natural light and art.
- The design of the hub should consider the need for aspects of 'dementia friendly environments' to be built in.

3.5 Local health and care strategy

Cambridgeshire and Peterborough is one of the most, if not the most, challenged health systems in England. In response, commissioners and providers across the local health and care system have formed the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) which is leading local implementation of national policy and local efforts to respond to the following specific challenges:

- Quality shortcomings, including consistent failure to meet some key targets.
- High levels of delayed transfers of care and stranded patients.
- Overuse of acute hospitals to delvier care that could and should be provided in community settings or in patient's own homes.
- Unwarranted variation in operational performance, and patient experience and outcomes.
- Capacity that is not always aligned to demand.
- Workforce shortages in key areas
- Significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities.
- Rising demand linked to an ageing population and population growth from countywide plans for 100,000+ new homes.
- The need to achieve system-wide financial balance.

The STP-led response to these challenges is a programme of work which has ten priorities for change.

Figure 28: STP priorities for change

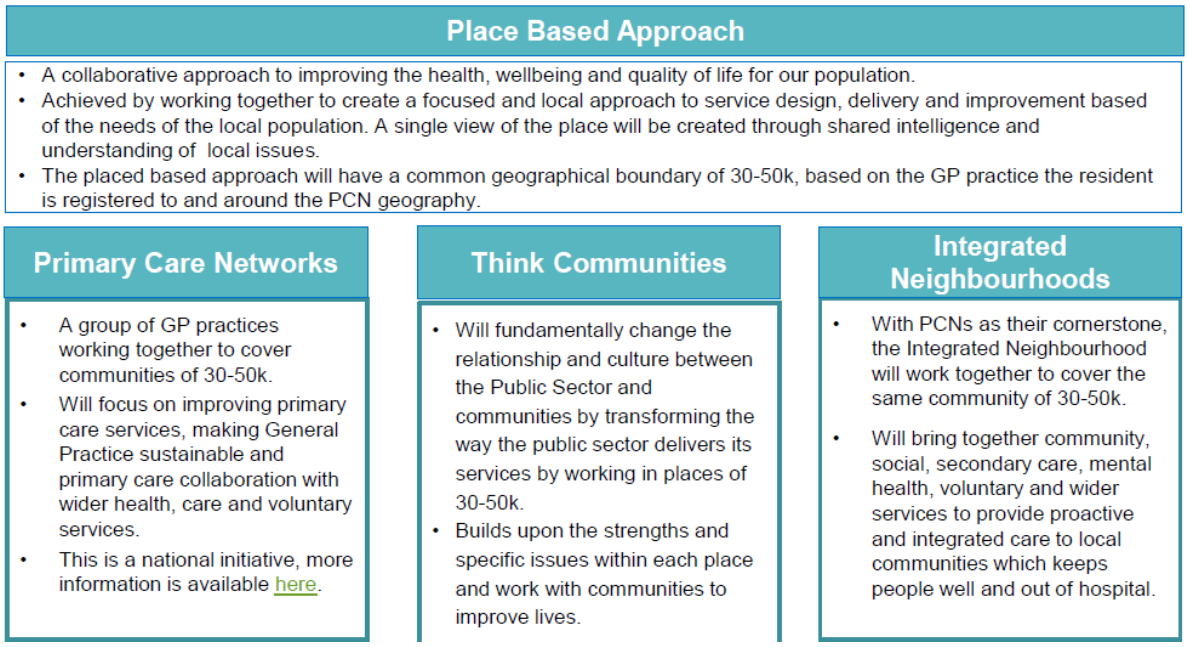
Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

Within the ten-point plan, some solutions are common across the NHS, whilst others are specific to C&P:

- Improving outcomes for older people through building social capital, integrated neighbourhood teams, and a community-based rapid response to deteriorating patients.
- Care networks designed to move knowledge and not patients wherever possible.
- Collective leadership at system level, including the sharing of financial risk.
- Exploiting the benefits of new developments aspects such as healthy environments to optimise the health of our new residents and employees.

The system has adopted a "Place Based Approach" to implementation of the element of its plans that focus on primary and community care. A "Place" is typically a distinct geographical entity, such as Ely, with a population of 30-50,000. Each Place will have services delivered through PCNs and integrated neighbourhood teams with links to the "Think Communities" initiative led by the local authorities.

Figure 29: The C&P Place Based Approach



The PCN element of the Place Based Approach is tasked with providing "primary care at scale" which includes, extended access and extended hours in primary care, as well as primary care support to redesign of outpatients and the urgent care pathway. Working alongside PCNs are two "provider alliances" which bring together the providers who would deliver integrated neighbourhood services alongside the PCNs – Ely is part of the South Alliance.

The local authorities' Think Communities initiative will work alongside PCNs and the provider alliances to identify integration opportunities. The county council's stated aim is to explore how the services they provide and / or commission can be further integrated with NHS services to improve the support available to help people remain living in their own homes. Integration includes working through the Better Care Fund, the local Learning Disability Partnership and, continuing health and funded nursing care arrangements, as well as joint service delivery for people with mental health issues, of community occupational therapy and, of community equipment and technology enabled care.

Investing in a modern, fit for purpose estate is regarded as a key enabler to these plans and the STP estates plan highlights the community hospitals in Ely and Wisbech as being the sites with the most potential to be transformed into neighbourhood hubs and the sites most in need of investment to resolved existing condition and functional suitability problems. Neighbourhood hubs (now renamed Local Health and Care Hubs) have the potential to provide facilities:

- **That support the transfer of planned care work away from acute hospitals** to more locally accessible site. Examples include large volumes of existing outpatient activity, some planned diagnostics e.g. plain file x-ray, ultrasound and potential more complex modalities such as CT. A health and care hub could also be the venue for some day attendance-based services such as IV therapies including chemotherapy. By shifting activity, acute trusts such as CUH would be better placed to focus on the more complex activity suitable for a major acute hospital – this is of particular relevance to CUH's plans for a new children's hospital and cancer centre at Addenbrooke's because by achieving a meaningful 'left shift' of acute-based

activity into community settings, CUH will be better able to redevelop its Addenbrooke's site.

- **That support the redesign of urgent care pathways**. The POW Hospital already hosts a minor injuries clinic and the GP out of hours service; the opportunity is to enhance the service with GP and diagnostic support to shift activity away from local emergency departments by creating an urgent care/ urgent treatment centre. Hubs would also provide a location for other community services which form part of the urgent care pathway e.g. health and social care community rapid response, and mental health crisis services.
- **That help enable "primary care at scale"** which the STP has defined as services delivered over combined lists of 30 – 50,000. The POW site offers the potential for both Ely practices to have an on-site presence enabling them to collaborate to provide extended and out of hours services. Primary care would also benefit from being co-located with the pharmacy already at the POW, as well as being co-located with community nursing and therapy teams. The site could also be the base for PCN-level services for both Ely North and Ely South.
- **That support the further integration of services** particularly those focused on proactive support for the elderly and frail population and people with chronic conditions. For example, the local integrated neighbourhood team set-up under the United Care Partnership initiative would be based in hubs alongside teams from social care and other specialist health services. The neighbourhood teams provide physical and mental health care for older people aged 65 and over and adults requiring community services. Each of the 16 teams cover a group of local GP practices and support populations of people aged 65 and over of between 5,000 and 14,000. By co-locating the neighbourhood teams with colleagues from the local authority older people's teams and the joint emergency team, joined-up care becomes much easier to deliver. The final benefit of being on a hub site is that community teams are then also able to access facilities such as physio gyms for their patients.
- **That provide accommodation that can be used by "living well" and other services** commissioned and / or provided by local authorities. Hubs can be venues for drop-in services, advice centres etc. There is a 'Living Well' partnerships in East Cambridgeshire which links the district council, local communities, multi-agency neighbourhood teams, primary care networks and locality wellbeing initiatives, such as support for carers and promoting physical activity.

The POW site is sufficiently large to create an opportunity for part of the site to be made available for the county council to commission a nursing home to help address the lack of capacity in East Cambridgeshire.

Implication for this business case

- Establishing a local heath and care (neighbourhood) hub in Ely is one of the strategic aims of the local STP.
- A hub would provide the venue for services to come together to provide care that is more joined-up as per the STP and national ambitions to provide more proactive care to the elderly frail and people with long-term conditions.
- Integration will be driven by PCNs and the South Alliance and should be informed by the Think Communities initiative.

- A hub could also provide the additional physical capacity required to shift activity out of acute settings. Services that can be delivered in their current form within a hub would include day attenders such as chemotherapy, day surgery, urgent care and outpatients. The hub could also be the venue for redesigned services also aimed at shifting activity out of acute hospitals e.g. online consultations and remote diagnostics.
- A hub would also need to be "right-sized" to meet anticipated additional demand resulting from new homes being built in and around Ely.

3.6 Covid lessons

The East of England Clinical Senate has published an initial "lessons learned" report into Covid[28]. The report makes several recommendations divided between changes arising from the Covid experience that should be "adopted" permanently, "adapted" or "abandoned". The recommendations of most relevance to this business case are set out below:

- Adopt: retain and adopt this practice:
  - Increased focus on infection prevention and control across primary and secondary care, social and community care settings.
  - Continue with the protected or 'Green' (non-COVID-19) elective facilities within sites, providing protected elective facilities and pathways.
  - Remote tele-consultation. Tele-consultations should be encouraged, supported by improved patient record sharing, multi-agency and inter-agency working. This has the ability to offer a much more convenient service for many patients with the additional benefits to the environment in terms of carbon footprint and in terms of the requirement for expensive healthcare facilities and estates. Flexibility may enable more staff to offer out of hours appointments and weekend working with a move towards better seven-day provision.
- Adapt: practice should be retained subject to some further development or refinement:
  - Empowering health and care professionals to reduce the 'over medicalisation' of care, particularly for the frail elderly, and to understand what the ideal level of care is for the individual.
  - The use of sophisticated methods for prioritisation of care, enabling treatment to be delivered on a priority of need basis rather than a time on a waiting list basis. We need to reconsider the effectiveness of current referral pathways and refine them where necessary to deliver the best outcomes in particular to support the management of early stage diagnosis in cancer.
  - Continue the use of tele-conferencing for team meetings, training etc.
- Abandon:
  - Public fear that attending any healthcare facility had a high risk of resulting in infection. We must ensure that a strong message regarding the safety of protected diagnostic and elective pathways is communicated to the public.
  - Complete separation of frail elderly and other shielded groups from other patient groups.

[28] The Regional COVID-19 pandemic response and system learning. What have we learned about how health care can be delivered during the last twelve weeks? The East of England Clinical Senate.

The report also makes specific recommendations about diagnostic facilities which could impact on this business case:

- We must ensure that we have adequate molecular diagnostic pathology services to ensure sufficient capacity to deliver timely results that, through information technology systems, are accessible across all relevant health and care settings.
- We must ensure that we have adequate diagnostic capacity, including radiological and endoscopic facilities, which is designed to deliver services for patients affected by infectious diseases during pandemics and for protected facilities for those with other conditions.

Building related themes that are emerging which have a direct impact upon this development are:

- Anticipate fewer face-to-face consultations - 40% non-face-to-face, should be the lower end, with 60% being attainable.
- An increased proportion of activity, particularly at outpatient level, should be conducted in primary care and community care settings.
- Increasing the area allowed for corridors, lifts and stairwells.
- Single directional corridors supporting in- and-out flows.
- Possibly a re-evaluation of outpatient design with patients entering from one side and clinical teams the other.

Implication for this business case

- The design of the new hub will need to reflect changes to service delivery such as:
    - The increase in the use of virtual consultations.
    - Video conferencing for meetings.
    - The need to be able to separate out “Green” activities.
- The move away from “medicalised” care suggests a greater need to provide facilities for social care services.
- Sufficient capacity for local diagnostic service delivery needs to be designed in.

3.7 Summary case for change and vision for a health and care hub

The system cannot “do nothing” in response to the challenges described in this strategic case. There are population growth, integration, estate and financial imperatives to do something radical to alter how services are delivered and this requires investment in the estate.

The C&P system is already one of the most challenged in England (see Section 3.5) and the pressures anticipated as a result of one of the fastest growing populations in the country (see Section 3.2) make it all the more difficult to implement the new models of care called for in national policy (see Section 3.4). The experience of Covid and the almost certain need to make significant changes to the physical estate to protect against future pandemics (see Section 3.6) bring into even greater focus how unsuited the current estate is to modern heath and care service delivery (see Section 3.3.2).

The existing hospital facilities at the POW are out dated; they are not functionally suitable for modern health service delivery and even though CCS has maintained the buildings to the best of its

ability, backlog maintenance requirements are accumulating and the Trust is increasingly firefighting through reactive maintenance issues. The hospital is no longer fit for purpose and given the projected population increase of 25% across the district, the ageing physical environment will increasingly fail to meet demand. Activity growth and the resulting pressure of the estate is not limited to community health services at the hospital, both Ely GP practices are already struggling for space and require capacity to expand into as the local population increases. Across the wider local primary care environment, we know that:

- C&P starts from a position of having fewer GPs per 1,000 people than the English average and that this situation is likely to get worse because the GP workforce is older than average. This challenging situation becomes even more challenging because the county's and specifically the district's population is growing faster than the national average. Taken together these factors threaten the resilience of primary care in East Cambridgeshire.
- The system has responded by recruiting new primary care staff (20 in the last year) and by changing the way primary care is delivered, but there is more to do if service quality is to be protected. 'More' includes working through the PCN to deliver primary care at scale and making a career in local primary care more attractive.
- A purpose built hub in Ely (and separate ETTF investment in the St Mary's practice), will help facilitate the integration needed to deliver at scale primary care and by providing a better working environment, will make primary care in Ely a more attractive place to work.

The local social care workforce is also short of staff leading to delay in discharging people home. Community health services also experience problems recruiting staff with CCS highlighting Cambridgeshire Children's Services as an area of particular difficulty. Nationally and locally we also know there is a shortage of key community staff such as community nurses.

Community hospitals such as the POW, have always played a role as a local care hub in the wider NHS system, but the role has been piecemeal and, despite policy for the last 20 years or so being focused on reducing the use of acute hospitals, the development of community hospitals into hubs has been hampered by organisational autonomy and a lack of joined-up systemwide planning. There is now an opportunity to change this because the move towards ICS creates a structure to promote integration and joined-up planning. This is very important for the C&P system because if CUH's plans to redevelop its estate to provide more tertiary services such as cancer and paediatrics are to succeed, capacity at Addenbrooke's will need to be freed-up. This can happen if the system achieves a meaningful 'left shift' of activity out of acute settings into local communities including into hubs. Our plans for Ely therefore deliver on the need to make primary care more resilient, but also provide the estate needed to enable a managed transfer of meaningful levels of activity away from acute hospitals.

To date, although a large number of services are currently located on-site, their co-location in itself has not led to greater integration. The layout of the hospital is traditional with each service having its own demise and no incentivisation of integration through the use of shared space; site occupancy arrangements can also act as a barrier to occupation by services other than those operated by the site owner. Although there is a primary care presence on-site both in and out of hours, much more could be done by transferring much of the second Ely practices activity to the site and by using the site as the venue for PCN "at scale services". Greater collaboration between the two Ely practices is

essential to being able to meet rising demand and the expectations of primary sector set out in the LTP, and will help make local primary care sustainable in the face of the area having an already low GP to patient list ratio and having a significant number of GPs approaching retirement age.

By co-locating at scale primary care services with team bases for local community health, social care and mental health teams, the triple integration of primary and specialist care, physical and mental health services, and health with social care, could be facilitated. New providers and partners, such as the ambulance trust, local authority services or the third sector could be encouraged to deliver part/all of their services from the same site, so that the hospital becomes a true, one-stop, care hub for local people. The site also offers the opportunity to support the redesign of urgent and emergency care pathways across the system by providing facilities to bring together same day primary care, primary care out of hours, the MIU/UTC, diagnostics and the joint health and social service emergency team. By enabling these services to share space the urgent care offer to local people will be enhanced which in turn should result in more people accessing urgent care in Ely instead of travelling to Cambridge.

The existing hospital also hosts a wide range of outpatient clinics, most of which although physically present on-site, could be much better utilised – only one in 20 outpatient appointments for local people happen at the POW. The site's "market share" for diagnostics and day case surgery is also low creating a huge opportunity for the system to repatriate activity from acute hospital settings. This repatriation is a "must do" for the system because without a meaningful shift of activity out of acutes, hospitals such as Addenbrooke's will be unable to deliver their strategic goal of focusing on the more specialist work envisaged in CUH plans for a new children's hospital and cancer centre. Although patient flows are far more modest, a redeveloped POW could also contribute to right sizing Hinchingbrooke and Queen Elizabeth Hospital, King's Lynn.

The current site extends to 3.4 hectares and because of the low-rise sprawl of hospital buildings, the site is not particularly well-utilised. Land disposal is, therefore, an opportunity thereby fitting with national policy, as per Naylor and making a substantial contribution towards achieving the delivery of new homes in Ely.

Land disposal opportunities are not limited to housing; CCS is aware that the county council is short of nursing care home capacity in East Cambridgeshire and that previous site searches have not resulted in suitable sites being identified. There is, therefore, also an opportunity for some of the surplus land to be sold for the development of a care home. This development would, create an option of transferring the 16 community beds at the POW Hospital into improved accommodation within a new care home. In-reach from the local neighbourhood team based out of the POW health and care hub would then be possible. Evidence from elsewhere e.g. the Somerset Pathway 2 model, indicates that a person's recovery and outcomes can be better if their rehabilitation is carried out in the more homely environment of a care home instead of a traditional hospital ward. Proximity to the local health and care hub and nearby services such as Baird Lodge Extra Care Sheltered Housing Scheme will make the POW site particularly attractive to potential care home operators.

The opportunities described above have been available in the past and national policy has encouraged 'care closer to home' for some time, but these opportunities have not been converted into meaningful change in the past because of the structure of health services being fragmented between organisations previously encouraged to compete as much as collaborate. The introduction

of STPs and the move towards an ICS provide a key enabler to transforming the POW into a system hub able to offer part of the solution to the challenges facing services throughout the whole system. For example, to deliver our vision, the STP will need to agree financial and occupancy arrangements which work for the system and the hub owner (CCS) and which disincentivise any one organisation reducing their use of the facility to the disadvantage of the C&P system.

The vision for the system hub of the future is also a health and care facility which is 'easy to use' for all health and care staff (as well as patients); this means a hub which encourages integration through design e.g. shared multi-use space with areas ring-fenced for individual services kept to a minimum; Wifi and IT connections that enable any member of staff to access the systems they need remotely; sufficient car parking and good links to public transport; bookable rooms and a single person with overall responsibility for the building.

3.8 Response to the case for change

3.8.1 Desired outcomes

This project responds to the case for change by delivering investment in the estate. The **outcomes** the STP wants to achieve from the project are:

- Improved clinical outcomes of the local population through the adoption of more joined-up models of urgent and planned care.
- More people treated closer to home resulting from new integrated care models supported by a sufficient community-based workforce to enable people who can be cared for in their own home to be so, and to repatriate services from acute hospitals to community hubs such as that proposed for Ely.
- Improved management of long-term conditions through the provision of care that is better joined up facilitated in part, by a fit for purpose estate.
- Value for money as represented by the optimal balance of investment in new estate and service models set against savings from no longer operating an old estate and quantifiable wider benefits to the system and society resulting from the proposed hub.

3.8.2 Project aims and objectives

The aim of the investment is ***'develop a new local health and care hub which will provide accommodation for a wide range of health and related services for people living in and close to Ely'.***

The SMART investment objectives for this project are:

- **Objective one** - to facilitate the introduction of new models of care as set out in the STP's clinical model "Home is Best" including facilitation of 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
- **Objective two** - to provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design.
- **Objective three** - to deliver sufficient physical capacity to meet the forecast health needs of the growing and ageing population.
- **Objective four** - to enable the transfer of work done elsewhere back to Ely.

- **Objective five** - to release land for development in support of local housing plans.
- **Objective six** - to maximise estate value for money by optimising clinical use of new facilities e.g. achieving at least 75% clinical use for new facilities, 85% utilisation of clinical space Monday to Friday 9-5 and additional out of hours use over the current baseline.

The objectives are described in more detail in the table below.

Investment objective	Explanation
To facilitate the introduction of new models of care as set out in the STP's clinical model “Home is Best” including facilitation of ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care	• An Urgent Care Centre, building upon the current minor injuries service, but equipped e.g. with diagnostics, to meet the majority of urgent care needs without the need to refer onto the acute sector. • Primary care working 'at scale' e.g. longer opening hours and enhanced primary care support for urgent care services. • The hub development negates the need for primary care developments elsewhere. • Integration of primary care with specialist health services • Integration of physical and mental health • Integration of health and social care • Allowing new providers and partners, such as the ambulance trust, local authority services or the third sector to deliver part/all of their services from the same site, so that the hospital becomes a true, one-stop, care hub for local people. • Integrated neighbourhood teams e.g. Isle of Ely team which would need a team base and ability to see some patients in a clinical environment e.g. for geriatric assessment. • Primary care practices embedded at the heart of the new facility • Potential co-location of community team bases • Neighbourhood hubs • Links to the One Public Sector Estate initiative
To provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design	• Facilities designed to allow for multiple use and shared space to improve the quality of service relationships and departmental links by creating opportunities for different organisations and teams to come together both formally and informally • Flexible space enabling easy change of use and the ability to flex capacity up and down as needed • Beneficial clinical adjacencies to optimise joint working and easy/ rapid transfer of patients between services

Investment objective	Explanation
	• New facilities fully compliant e.g. with health building notices including modern spatial standards • Reduced travel times for patients as services are repatriated to Ely • Good public transport links – bus routes • Sufficient car parking • Facilities enable provision of technology-enabled services e.g. digital consultations
To deliver sufficient physical capacity to meet the forecast needs of the growing and ageing population	• Capacity based on forecast population need including new housing • Capacity also sufficient to repatriate work to Ely • Using the site efficiently to manage fluctuations in demand by creating more multi-purpose clinical spaces • Releasing land for housing • Releasing land for a new nursing home
To enable the transfer of work done elsewhere back to Ely	• Capacity sufficient to repatriate work to Ely from acute trusts e.g. sufficient outpatient and urgent care capacity • Supports CUH's development plans for the Addenbrooke's site by enabling the transfer of work to Ely • Expansion of POW day surgery at the POW • Expand range of on-site diagnostics including mobile as well as static equipment e.g. MRI • Facilities that support key national initiatives such as one-stop shop for cancer diagnosis and treatment • Reduced travel times for patients as services are repatriated to Ely
To release land for development in support of local housing plans	• The Naylor Review called for surplus NHS assets to be released for new housing • The 2015 Local Plan for East Cambridgeshire highlights a need for 575 additional houses each year to 2031 • Need for key worker housing identified in Naylor Review

Investment objective	Explanation
To maximise estate value for money by achieving at least 75% clinical use for new facilities	• Links to Carter and Naylor metrics around estate use • Clinical space is more expensive to build, so maximising clinical use is essential • Covid learning is that administrative functions can often be done away from clinical environments

3.8.3 Benefits

The desired benefits associated with the investment have been identified and the links between these benefits and the investment objectives are shown in the table below. Each benefit has been assigned a category from the following list:

- CRB - cash releasing benefits (e.g. reduced maintenance costs).
- Non-CRB - financial benefits, but not cash releasing (e.g. staff time saved).
- QB - quantifiable benefits to the NHS and/ or society (e.g. reduced waiting times, improved health and wellbeing).
- Qual - non-quantifiable or qualitative benefits (e.g. improvement in patient experience).

Investment objective	Desired outcome	Benefits	Measurement	Benefits to
To facilitate the introduction of new models of care	Improved clinical outcomes of the local population More people treated closer to home Improved management of long-term conditions through the provision of care that is better joined-up Value for money	Improves health and wellbeing of local people – addressing combined health and social care needs Facilitates triple integration of primary and specialist care, physical and mental health services, and health with social care Supports delivery of primary care at scale New pathways enable for urgent & emergency care New pathways enable for pro-active care of people with LTCs Faster access to the right services because of easier referral and joint working Patients managed more effectively, enabled to stay healthy and reducing dependency Easier navigation and better awareness of what is available and how to access	Clinical KPIs e.g. avoidable hospital admissions/ readmissions, A&E attendances and acute length of stay PROMs Duration of treatment Number of handovers/ onward referrals Patient satisfaction measures Increased number of primary care extended access hours offered Number of LES/ DES primary care services available	Patients - QB/Qual Carers and families - Qual Staff - QB/ Qual Providers - Non-CRB Commissioners - Non-CRB Local community - Qual

Investment objective	Desired outcome	Benefits	Measurement	Benefits to
		it Estate available for partners to use Delivers national and local system objectives to support more people with multiple health needs, long term conditions and mental health needs in their local community		
To provide accommodation that is accessible, high quality and fit for purpose	More people treated closer to home Value for money	More flexible, shared space usable by different services Estate which is flexible in use and can be easily adapted as needs change by time of day, day of the week and over time Opportunity to increase the range of services and number of organisations operating from the site Facility for technology enabled care leading to more remote consultations and less need to travel Beneficial clinical adjacencies in place e.g. diagnostics close to urgent care Physical environment meets all	Quantum of backlog maintenance 6-facet scores Building utilisation Carter/ Model Hospital estate metrics Compliance with health building standards (HBNs/ HTMs) Dementia informed environment Accessibility – drivetimes/ public transport links Number of services on-site Carbon reduction target	Patients- Qual Carers and families - Qual Staff - Qual Providers - CRB/ non-CRB/ QB Commissioners - Qual Local community - Qual

Investment objective	Desired outcome	Benefits	Measurement	Benefits to
		relevant standards Physical environment promotes healing and wellbeing Buildings that meet Net Zero carbon and sustainability targets Estate where people want to work making recruitment and retention easier Elimination of backlog maintenance Site easily accessible by public transport Sufficient car parking whilst minimising impact of additional car journeys on local residents Improved infection control Compliance with sustainability standards e.g. Net Neutral NHS Improves Trust's ongoing efficiency in asset utilisation Improved security and safety on-site		

Investment objective	Desired outcome	Benefits	Measurement	Benefits to
To deliver sufficient physical capacity to meet the forecast needs of the growing and ageing population	Improved clinical outcomes of the local population More people treated closer to home Improved management of long-term conditions through the provision of care that is better joined-up Value for money	Sufficient physical capacity in place to meet demand resulting from population growth Sufficient physical capacity in place to meet demand resulting from the ageing population Reduction in need for people to travel to Cambridge and other acutes to access treatment	Activity trends at POW Estate utilisation	Patients- Qual Carers and families - Qual Staff - Qual Providers - CRB/ non-CRB/ QB Commissioners – Non-CRB/ Qual Local community - Qual
To enable the transfer of work done elsewhere back to Ely	More people treated closer to home Improved management of long-term conditions through the provision of care that is better joined-up Value for money	Greater volume of outpatients, planned diagnostics and day cases/ treatments undertaken in Ely Reduced demand for planed and unplanned treatment and care at acute hospitals Frees-up space in acutes to meet growth in acute activity and to pursue ambitions such as the cancer centre and children's hospital	Number of patients still accessing acute sites Activity levels at POW – POW 'market share' for Ely PCNs' outpatient, planned diagnostic and day surgery activity Patient travel time/ distance Space freed-up at Addenbrooke's and other acutes	Patients- Qual Carers and families - Qual Staff - Qual Providers - Non-CRB Commissioners – Non-CRB/ Qual Local community - Qual
To release land for development in support of local	Value for money	Land released for housing	Amount of land retained by NHS	Patients – n/a

Investment objective	Desired outcome	Benefits	Measurement	Benefits to
housing plans		Land released for nursing care home Delivers national objectives for NHS estate	Amount of land sold Number of new houses built on ex-NHS land	Carers and families – n/a Staff – n/a Providers - CRB Commissioners – n/a Local community – QB / Qual
To maximise estate value for money	Value for money	New estate meets Carter and Model Hospital metrics Economies in reception and administration activities Lower facilities management costs per square metre of space Zero backlog maintenance Shared facilities, reduced proportion of the estate ring-fenced for single use.	Estate utilisation Ratio of clinical to non-clinical estate Estate / facilities costs (total and per square metre)	Patients – n/a Carers and families – n/a Staff – n/a Providers – CRB/ non-CRB Commissioners – n/a Local community – n/a

3.8.4 Constraints

Key project constraints are:

- The scope of the business case is limited to all publicly funded health, social care and public health services.
- The new facility must be delivered within four years to comply with the land swap deal and associated leaseback arrangements.
- The following existing service providers must commit to taking space within the facility:
    - CPFT
    - CCS
    - CUH
    - St Mary's practice
    - Cathedral practice
- The new facility will only derogate from relevant standards e.g. HBNs and HTMs, were agreed by the STP Estates Group.
- The new facility must provide sufficient capacity (for in-scope services) to meet forecast demand.
- The building must be fully utilised.
- The new facility will be owned by CCS.
- The revenue consequences of the scheme must be affordable to the C&P health and care system.
- The solution must improve service and environmental quality.
- The solution must pass an Equalities Impact Assessment test.
- Existing hospital services need to be kept operational throughout the project

3.8.5 Dependencies

The project dependencies are:

- Business case approval by the STP and NHSEI.
- The solution must be supported by the Joint Health and Wellbeing Board.
- Sufficient capital funding being identified.
- Planning consent being received.

3.8.6 Critical Success Factors

Derived from the aims and constraints, and in line with NHSEI guidance, the project critical success factors (CSFs) are:

- Likely Acceptability: will the option be acceptable to key stakeholders?
- Likely Achievability: will the option be achievable? This might include, for example considerations such as physical space; likely planning constraints; deliverability of the works...
- Likely Strategic Fit: how well does the option fit with the strategic direction of travel for the STP and CCS?
- Likely Affordability: is the option likely to be affordable from both a capital and ongoing revenue perspective?

3.8.7 Risks

The key risks have been identified below.

Table 13: Summary of key risks

Risk	Mitigation
Lack of available capital / capital affordability	• Design incorporates shared, flexible use space and minimises number of ring-fenced rooms • Maximise use of existing accommodation if fit for purpose • Modern methods of construction to keep costs under control • Intention to bid for NHSEI funding e.g. Wave 5 • High priory scheme within STP (local support)
Revenue affordability	• Existing estate costs released • Hub will facilitate new models of care and encourage joint working • Avoids backlog costs and lower cost than building at Addenbrooke's
Scheme not approved by NHSEI / delays in securing approvals from NHSEI	• Liaison with NHSEI from SOC
Redevelopment takes longer than expected	• Project management processes
Design requirements change because of changes to service requirements	• Involvement of service leads in design
Facilities designed before implications of changes arising because of Covid-19 are fully understood	• Design team keeping close to emerging Covid lessons
Scheme does not receive planning consent	• Pre-application submitted • District Council is supportive
Logistical challenges in executing redevelopment on site	• Land swap enables development to take largely a turnkey approach

4 The Economic Case

4.1 Introduction to the economic case

At SOC the economic case demonstrates that the Trust has a viable set of options that can deliver the project objectives – the 'short list' which will be taken forward to OBC.

The economic case starts with a brief recap of SOC options, changes since approval of the 2017 SOC.

4.2 2017 SOC options

In the 2017 SOC the following options were longlisted.

Option number	Description
Do nothing	The hospital would continue to operate its current services and models of care from the existing buildings with minimal change.
Do minimum	Retain the existing hospital buildings and maintain/update space as required.
Option 3	Rebuild all existing services to modern HBN compliant standards (except day surgery which is already in a modern facility). Creates a local community hub including urgent treatment centre, fully integrate Cathedral Surgery. Reprovision of one intermediate care ward. Generic clinical, diagnostic and administrative space would be clustered appropriately.
Option 4	As per Option 3 but also including St Mary's surgery.
Option 5	As per Option 4 except beds. Beds purchased from a care/ nursing home provider.
Option 6	As per Option 3 except beds. Beds purchased from a care/ nursing home provider.
Option 7	As per Option 4, but expansion of the Addenbrookes day surgery unit on site.

Option 1 was ruled out at SOC because the option does not allow for the development of services to meet increasing local need or for the re-design of local models of care that are required in order to meet the objectives of the STP programme and the national strategic vision for the future of health and care services. The age, condition and configuration of the existing buildings severely restrict opportunities to increase capacity and ability to maintain a safe environment for staff and patients. The current footprint and does not provide sufficient flexibility to use available space as required by the new care pathways. Additionally, the 'do nothing' option does not support the development of

a nursing home on site. Which has been identified as highly desirable by Cambridgeshire County Council.

The remaining six options were retained for further work-up.

4.3 Changes since the SOC

Since the SOC was approved by the CCS Board in 2017 NHSEI has published new business case guidance which increases the level of detail required at SOC and which mandates the use of the options framework to determine the shortlist of options to be appraised at OBC. Because the options framework was not used at SOC in 2017, we have refreshed the SOC – the results of this process are described below.

4.4 Longlist to shortlist – the options framework

The options framework is the approach now (post-2018) required by NHSEI to define a list of realistic options that can deliver a project's objectives. The options framework approach works by identifying the choices available and for each choice, defining the related options. Choices consider issues such as "what is to be provided", "where is it to be provided", "how" and "when"?

The use of the options framework can be retrofitted to the SOC shortlisting process as per the table below, to bring the work done to date in line with the latest NHSEI expectation for option appraisals.

SOC shortlist	Options framework choice(s)
Option 2 - Do minimum	This becomes the business as usual (BAU) comparator using the updated business case process.
Option 3 - Rebuild all existing services to modern HBN compliant standards (except day surgery which is already in a modern facility). Creates a local community hub including urgent treatment centre, fully integrate Cathedral Surgery. Reprovision of one intermediate care ward. Generic clinical, diagnostic and administrative space would be clustered appropriately	Choice one focuses on whether to have beds in the hub Choice two focuses on the range of new services Choice three focuses on location and based on this choice, the options of refurbishment (current POW site) versus new build (other site options)
As per Option 4 but also including St Mary's surgery	Suggest taking inclusion of both GP practices as a given. Without this co-location, the scheme does not delivery on strategy and risks becoming little more than a "lift and shift", so suggest no choice is offered
Option 5 - As per Option 4 except no beds. Beds would be purchased from a care/ nursing home provider	Choice one focuses on whether to have beds in the hub

SOC shortlist	Options framework choice(s)
Option 6 - As per Option 3 except no beds. Beds would be purchased from a care/ nursing home provider.	Choice one focuses on whether to have beds in the hub
Option 7 - As per Option 4, but expansion of the Addenbrookes day surgery unit on site	Sub-options will be worked up to allow for more day case surgery to be done at the POW.

The choices relating to this stage of the POW project are:

1. Choice of delivery model for inpatient services.
2. Choice of service scope i.e. which other services should be accommodated in the new hub facility.
3. Choice of the extent of day surgery done at the POW.
4. Choice of location for the new facility.

The options under each choice are tested against the project investment objectives (see Section 3.8.2) and CSFs (see Section 3.8.6). Options that fail to meet objectives and CSFs have been eliminated; those meeting both have been shortlisted to form part of the OBC options and where possible a 'preferred way forward' has been identified (the preferred way forward is not the same as the preferred option which will be decided at OBC).

There are further choices relating to funding of the scheme (NHS funding versus private partner funding), phasing (single, two phases etc) and procurement route (tender, framework, competitive dialogue etc) which will need to be worked through in the OBC, but these are second order questions the answers to which, will be informed by the selection of a preferred option from the short list.

4.4.1 Choice one – delivery model for inpatient services

This choice is specifically about the future delivery model for the existing bedded services provided at the POW and other community hospitals. The choice is about whether there are to be beds within the local health and care hub, not whether there are to be beds on the wider POW campus. The working assumption is that bed numbers will remain at 16 for the purpose of the appraisal process.

It is important to separate it out because of the impact on the overall design of the proposed new facility if beds are or are not included. The long list of service scope choices is:

- BAU i.e. the hub facility would incorporate one ward of intermediate care beds.
- Step-up beds only in the hub. Step down (intermediate care) beds contracted out to a care home which would be located on the POW campus.
- No beds in the hub – the whole inpatient service (clinical staff & hotel services) would be contracted out to a care home which would be located on the POW campus.
- No beds in the hub. Beds in a care home located on the POW campus. The beds would be within a separate demise within the care home rented by CPFT and CPFT will provide the service.

The evaluation of the long list options against the project objectives and CSFs is shown below.

Table 14: Options Framework – Inpatient provision delivery model

Programme	**BAU**	**Intermediate**	**Intermediate 2**	**Maximum**
1. Inpatient delivery model	1.0 No change i.e. inpatient services provided from the new health & care hub facility (16 beds)	1.1 Step-up beds only in the hub. Step down (intermediate care) beds contracted out to care home	1.2 No beds in the hub – whole service (clinical staff & hotel services) contracted out to care home	1.3 No beds in the hub. Beds in care home, CPFT provide the service
To facilitate the introduction of new models of care e.g. D2A Pathway 2, as set out in the STP's clinical model "Home is Best" including facilitation of integrated working across health and social care	Yes, CPFT able to implement new model of care (100% under NHS control) Experienced provider	Yes, a new service specification would be required for both step-up and step-down beds. Step-up beds would need to be supported by other news services e.g. rapid assessment unit Division into step-up and step down is artificial, so no benefit	Uncertain, a new service specification would be required for inpatient beds. Clinical staffing would be outsourced, so more difficult to achieve eg subject to contract negotiation with inde sector provider Care home delivery offers more flexibility to commissioners e.g. contract beds on a cost per case basis, but less control	Yes, CPFT able to implement new model of care (100% under NHS control) Experienced provider NHS beds in care home potentially could benefit from being co-located with 65 social care beds
To provide accommodation	Uncertain – beds for the Ely	Yes – beds for the Ely and	Yes – beds for the Ely and	Yes – beds for the Ely and

Programme	BAU	Intermediate	Intermediate 2	Maximum
1. Inpatient delivery model	1.0 No change i.e. inpatient services provided from the new health & care hub facility (16 beds)	1.1 Step-up beds only in the hub. Step down (intermediate care) beds contracted out to care home	1.2 No beds in the hub – whole service (clinical staff & hotel services) contracted out to care home	1.3 No beds in the hub. Beds in care home, CPFT provide the service
that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design	and surrounds population, would be provided from modern, fit for purpose environment – schedule of accommodation would reflect standards and functional content required by service. But local health and care hub will be a busy hub with a different ethos to a care home environment	surrounds population, would be provided from modern, fit for purpose environment – schedule of accommodation would reflect standards and functional content required by service	surrounds population, would be provided from modern, fit for purpose environment – schedule of accommodation would reflect standards and functional content required by service (would be specified in contract Rehab would be in a more home-like environment Assumes care home is on POW campus, so accessibility criteria met	surrounds population, would be provided from modern, fit for purpose environment – schedule of accommodation would reflect standards and functional content required by service (would be specified in contract Rehab would be in a more home-like environment Assumes care home is on POW campus, so accessibility criteria met
To deliver sufficient physical capacity to meet the forecast health needs of the	Yes – bed number would be initially fixed based on current capacity, although	Yes. Additional beds could be commissioned on a flexible basis from care homes if the care	Yes. Additional beds could be commissioned on a flexible basis from care	Yes. Additional beds could be commissioned on a flexible basis from care

Programme **1. Inpatient delivery model**	**BAU** 1.0 No change i.e. inpatient services provided from the new health & care hub facility (16 beds)	**Intermediate** 1.1 Step-up beds only in the hub. Step down (intermediate care) beds contracted out to care home	**Intermediate 2** 1.2 No beds in the hub – whole service (clinical staff & hotel services) contracted out to care home	**Maximum** 1.3 No beds in the hub. Beds in care home, CPFT provide the service
growing and ageing population	building could be expanded (sufficient land exists)	home capacity existed (risk of competing for extra capacity with social care) Care home could be physically extended	homes if the care home capacity existed (risk of competing for extra capacity with social care) Care home could be physically extended	homes if the care home capacity existed (risk of competing for extra capacity with social care) Care home could be physically extended
To enable the transfer of work done elsewhere back to Ely	As per discussion of physical capacity above	As per discussion of physical capacity above	As per discussion of physical capacity above	As per discussion of physical capacity above
Likely Acceptability	Yes, meets need to have beds in the area and no change to the delivery location	Potential opposition to perceived loss of community hospital beds Some engagement may be required	Potential opposition to perceived loss of community hospital beds Perception of services being privatised Some engagement may be required	Yes

Programme	**BAU**	**Intermediate**	**Intermediate 2**	**Maximum**
1. Inpatient delivery model	1.0 No change i.e. inpatient services provided from the new health & care hub facility (16 beds)	1.1 Step-up beds only in the hub. Step down (intermediate care) beds contracted out to care home	1.2 No beds in the hub – whole service (clinical staff & hotel services) contracted out to care home	1.3 No beds in the hub. Beds in care home, CPFT provide the service
Likely Achievability/ deliverability	Yes, least change so most achievable	Step-down service needs to be market tested and staff would need to be TUPEd to care home provider Division of beds into step-up and step down is likely to be difficult Step-up facility likely to be too small to be viable Care home needs to exist before existing hospital can be closed – county council is committed to the care home development	Service needs to be market tested Care home needs to exist before existing hospital can be closed – county council is committed to the care home development Staff would need to be TUPEd to care home provider	Care home needs to exist before existing hospital can be closed – county council is committed to the care home development Clinical service would be operated by CCS, so no significant barriers for this element
Likely Strategic Fit	Yes	Uncertain – strategy does not call for division of step-up from step down	Yes	Yes
Likely affordability	Requires NHS capital to	Less NHS capital required than	No NHS capital required	No NHS capital required

Programme	BAU	Intermediate	Intermediate 2	Maximum
1. Inpatient delivery model	1.0 No change i.e. inpatient services provided from the new health & care hub facility (16 beds)	1.1 Step-up beds only in the hub. Step down (intermediate care) beds contracted out to care home	1.2 No beds in the hub – whole service (clinical staff & hotel services) contracted out to care home	1.3 No beds in the hub. Beds in care home, CPFT provide the service
	reprovide ward VFM to be determined	BAU Option likely to lead to diseconomies VFM to be determined	VFM to be determined	VFM to be determined
Conclusion	Shortlist	Reject	Reject	Shortlist

4.4.2 Choice two - service scope within the hub

This choice considers the range of services within the new health and care hub (the question of whether beds are to be provided is considered separately in choice one). Relatively small scale increases in the range of services (e.g. additional outpatients) are not considered because these would be unlikely to have a material impact on the design and size of the proposed hub especially because the facility will be designed with flexibility of use as a key principle.

The long list of service scope choices is:

- BAU i.e. the current range of services.
- A reduction in services (it is not necessary at SOC to state which services would not be reprovided in the new facility).
- Current service mix plus St Mary's primary care and PCN primary care services.

The evaluation of the long list options against the project objectives and CSFs is shown below.

Table 15: Options Framework – Service scope

Programme **2. Service scope**	**BAU** 2.0 Current service mix	**BAU Minus** 2.1 Reduction in services	**Do Minimum** 2.2 As 2.0/ 2.1 plus St Mary's & PCN
To facilitate the introduction of new models of care as set out in the STP's clinical model "Home is Best" including facilitation of integrated working across health and social care	Does not stop new models of care, but not as good as other options	Unlikely to meet this objective (would depend on which services are withdrawn)	Enables introduction of new urgent care model and working at scale across both practices
To provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design	N/A	N/A	N/A
To deliver sufficient physical capacity to meet the forecast health needs of the growing and ageing population	N/A	N/A	N/A
To enable the transfer of work done elsewhere back to Ely	Enables repatriation of more outpatients and potentially day cases	Uncertain - depends upon which services are withdrawn from POW	As BAU plus bringing second GP practice and PCN services on-site should enable integration of same day urgent care leading to opportunity to reduce urgent care going to acutes
Likely Acceptability	Yes	No – local people have campaigned to	Yes, provided St Mary's retains a city

Programme **2. Service scope**	**BAU** 2.0 Current service mix	**BAU Minus** 2.1 Reduction in services	**Do Minimum** 2.2 As 2.0/ 2.1 plus St Mary's & PCN
		maintain services in Ely	centre presence given its catchment area
Likely Achievability	Yes	Uncertain – public consultation potentially required	Yes, although St Mary's will need to engage with their existing patients
Likely Strategic Fit	Uncertain – misses out of potential to delvier more primary care at scale	No	Yes, supports primary care at scale
Likely affordability	Yes?	Yes? Likely to be cheapest option	Yes? But needs to work through capital cost
Conclusion	Retain as BAU	Reject	Preferred way forward (PWF)

4.4.3 Choice three – choice of the extent of day surgery done at the POW

In addition to the choice concerning bringing more services on-site, there is a choice concerning the amount of day surgery done at the POW. It is important to assess this choice at SOC because the expansion of day surgery activity being suggested would have a material impact on capital costs because it would be dependent on the provision of a new 23-hour ward and bringing back into use the third theatre at the POW Hospital.

The long list of options is:

- BAU – continue to use two theatres for day surgery.
- Expansion – expand day surgery activity by opening a 23-hour ward and using the third theatre.

Table 16: Options Framework – day surgery

Programme **3. Day surgery**	**BAU** 3.0 Two theatres	**Maximum** 3.1 Three theatres and 23-hour ward
To facilitate the introduction of new models of care as set out in the STP's clinical model "Home is Best" including facilitation of integrated working across health and social care	Uncertain – only supports current strategy	Yes – consistent with strategic direction
To provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical location; parking and building access; and flexible design	Yes	Yes – facility would be invested in to provide fit for purpose theatres and 23-hour ward
To deliver sufficient physical capacity to meet the forecast health needs of the growing and ageing population	Uncertain – some capacity exists to increase activity, but not sufficient to meet anticipated growth in demand	Yes – reopening of third theatre plus existing unused capacity will be sufficient to meet rising demand
To enable the transfer of work done elsewhere back to Ely	No – minimal capacity available to support repatriation	Yes – reopening of third theatre plus existing unused capacity will support repatriation Opening of new 23-hour ward allows CUH to expand the range of surgeries offered at POW

Programme 3. Day surgery	BAU 3.0 Two theatres	Maximum 3.1 Three theatres and 23-hour ward
Likely Acceptability	Yes	Yes
Likely Achievability	Yes, as no change	Yes
Likely Strategic Fit	Uncertain	Yes
Likely affordability	Yes, as no change	To be confirmed via CUH business case
Conclusion	Retain as BAU	PWF

4.4.4 Choice four – choice of location for the facility

At this stage, the location choices are presented at a relatively high level. Location choices also create de-facto choices between refurbishment and new build i.e. any options not using existing buildings must be new builds, whilst options at existing sites could be a mix of refurbishment and new build. The long list of options is:

- BAU – no change of site. The existing hospital site would be used and a solution consisting of mixed refurbishment, adaptation and new build would be implemented.
- Mix new build / refurb on mix of current site and adjacent ex-MOD land – this option would utilise some of the existing site and adjacent MOD land.
- 100% new build on mix of current site and ex-MOD land - similar to the previous option, but 100% new build.
- New build/ refurb on alternative public sector estate site elsewhere in Ely – this option would require existing public sector estate elsewhere in Ely (or nearby) to be made available for the hub.
- New build on alternate green/ brownfield site in the Ely area – this is similar to the previous option but refers to non-public sector land.

The evaluation of the long list options against the project objectives and CSFs is shown below.

Table 17: Options Framework – location

Programme	**BAU**	**Do Minimum**	**Do Minimum plus**	**Intermediate**	**Maximum**
4. Location	4.0 No change i.e. current POW hospital site. Mixed refurb/ new build solution on site	4.1 Mix new build / refurb on mix of current site and adjacent ex-MOD land	4.2 100% new build on mix of current site and ex-MOD land	4.3 New build/ refurb on alternative public sector estate site elsewhere in Ely	4.4 New build on alternate green/ brownfield site in the Ely area
Project objectives					
To facilitate the introduction of new models of care as set out in the STP's clinical model "Home is Best" including facilitation of integrated working across health and social care	Unlikely to meet objective – this was a major factor in ruling out "do nothing" at SOC	Would achieve objective	Would achieve objective	Would achieve objective if site identified	Would achieve objective if site identified
To provide accommodation that is accessible, high quality and fit for purpose. This should take into consideration: physical	Fails this objective because the existing accommodation is not fit for purpose	Would achieve objective	Would achieve objective	Would achieve objective if site identified	Would achieve objective if site identified

Programme 4. Location	BAU 4.0 No change i.e. current POW hospital site. Mixed refurb/ new build solution on site	Do Minimum 4.1 Mix new build / refurb on mix of current site and adjacent ex-MOD land	Do Minimum plus 4.2 100% new build on mix of current site and ex-MOD land	Intermediate 4.3 New build/ refurb on alternative public sector estate site elsewhere in Ely	Maximum 4.4 New build on alternate green/ brownfield site in the Ely area
location; parking and building access; and flexible design					
To deliver sufficient physical capacity to meet the forecast health needs of the growing and ageing population	Should be possible to create additional capacity through extensions and refurbishment	Would achieve objective	Would achieve objective	Would achieve objective if suitably sized site identified	Would achieve objective if suitably sized site identified
To enable the transfer of work done elsewhere back to Ely	Should be possible to create additional capacity through extensions and refurbishment	Would achieve objective	Would achieve objective	Would achieve objective if suitably sized site identified	Would achieve objective if suitably sized site identified
CSFs					
Likely Acceptability	No – STP has committed to a	Yes, retains link to	Yes, retains link to	Possibly – may face some opposition due to loss of	Possibly – may face some opposition due to

Programme 4. Location	BAU 4.0 No change i.e. current POW hospital site. Mixed refurb/ new build solution on site	Do Minimum 4.1 Mix new build / refurb on mix of current site and adjacent ex-MOD land	Do Minimum plus 4.2 100% new build on mix of current site and ex-MOD land	Intermediate 4.3 New build/ refurb on alternative public sector estate site elsewhere in Ely	Maximum 4.4 New build on alternate green/ brownfield site in the Ely area
	new facility in at the POW Hospital in Ely	existing site	existing site	link with historic hospital site, but site would be in Ely Local authority has committed to POW site	loss of link with historic hospital site, but site would be in Ely Local authority has committed to POW site
Likely Achievability	Unlikely due to difficulty of substantially rebuilding/ refurbishing a live hospital environment. Extent of decant required = complex programme of works	Yes largely "clean" site would be available	Yes "clean" site would be available	No viable alternate public sector sites identified. The public sector estate in Ely is limited and is primarily made up of schools. The only other site large enough to accommodate a hub is the Hive Leisure Centre, but our understanding is that the CIC running the site are unlikely to be willing to	Site not identified, so delay likely due to need to find suitable site Planning risk

Programme **4. Location**	**BAU** 4.0 No change i.e. current POW hospital site. Mixed refurb/ new build solution on site	**Do Minimum** 4.1 Mix new build / refurb on mix of current site and adjacent ex-MOD land	**Do Minimum plus** 4.2 100% new build on mix of current site and ex-MOD land	**Intermediate** 4.3 New build/ refurb on alternative public sector estate site elsewhere in Ely	**Maximum** 4.4 New build on alternate green/ brownfield site in the Ely area
				give up land for a hospital	
Likely Strategic Fit	Uncertain – fails to achieve land disposal	Yes – achieves disposal of most of the current site (although new site would need to be acquired)	Yes – achieves disposal of most of the current site (although new site would need to be acquired)	Yes – achieves disposal of current site and no site acquisition needed	Yes – achieves disposal of current site (although new site would need to be acquired)
Likely affordability	Unknown	Unknown	Unknown – likely to be more expensive than mixed new build/ refurb in terms of capital	Unknown	Unknown – likely to be more expensive than mixed new build/ refurb in terms of capital
Conclusion	Reject (but retained as BAU comparator)	PWF	Shortlist	Reject	Reject

4.4.5 The resulting short-list of options

The outcome of the options framework appraisal of the longlist for each choice is combined to derive a shortlist of options.

Table 18: Options Framework – Summary of short-listed options

Options	BAU	Preferred Way Forward	Rejected	More ambitious preferred way forward
Inpatient service solution	1.0		1.1 and 1.2	1.3
Service scope	2.0	2.2	2.1	
Day surgery	3.0	3.1		
Location	4.0	4.1	4.3 and 4.4	4.2

Based on the summary above, the shortlist of options recommended to be taken forward to OBC is therefore:

- BAU (as the comparator only – this option does not deliver the investment objectives)
- Option 1 – Expanded service scope (with St Mary's), with expanded day surgery and inpatient beds on mix of current site and MOD land adjacent (100% new build)
- Option 2 – Expanded service scope (with St Mary's), with expanded day surgery and inpatient beds on mix of current site and MOD land adjacent to POW Hospital (mix refurb and new build).
- Option 3 – Expanded service scope (with St Mary's), with expanded day surgery, but without beds mix of current site and MOD land adjacent (100% new build)
- Option 4 – Expanded service scope (with St Mary's), with expanded day surgery, but without beds on mix of current site and MOD land adjacent to POW Hospital (mix refurb and new build).

The table below illustrates the commonality and differences between the options.

Table 19: Summary of options

Option	Beds in hub	2 x GP	Urgent care centre	Expanded day care	Expanded outpatients	Expanded diagnostics	100% new build	Element of refurb
BAU	✓	×	×	×	×	×	×	✓
Option 1	✓	✓	✓	✓	✓	✓	✓	×

Option	Beds in hub	2 x GP	Urgent care centre	Expanded day care	Expanded outpatients	Expanded diagnostics	100% new build	Element of refurb
Option 2	✓	✓	✓	✓	✓	✓	×	✓
Option 3	×	✓	✓	✓	✓	✓	✓	×
Option 4	×	✓	✓	✓	✓	✓	×	✓

Options 2 and 4 are effectively both 'preferred way forwards' at this stage. The only difference between these two options is the location of the 16 rehabilitation beds i.e. **in the new health and care hub or in the new care home on the POW campus.**

The rationale behind the shortlist of options is that:

- The St Mary's practice (all or part) is always within the hub.
- Expanding day surgery fits with STP strategy so is within all options.
- The site is always a combination of the existing POW Hospital site and adjacent ex-MOD land.
- There is a choice as to whether beds are in or out of the hub building (if 'out' the beds will be in the care home on the POW campus site).
- There is a choice about the mix of new build and refurbished buildings.

4.5 Wider societal benefits

HM Treasury updated their guidance to developing project business cases in 2018[29] and the new guidance was rolled out to the NHS in 2019. The refreshed guidance places greater emphasis on demonstrating wider societal benefits and where possible monetising or quantifying these benefits. Business cases should monetise, where possible, all benefits associated with the capital investment – applicable benefits are those arising due to increased efficiencies and costs savings, as well as health benefits to the population and wider societal benefits.

Table 20: Wider societal benefits

Benefit to	Benefit
"UK PLC" – the economy	"Gross Value Add" – the economic impact of the construction and wider project Tax revenues Employment

[29] Guide to Developing the Project Business Case, Better Business Cases for Better Outcomes, HM Treasury, 2018.

Benefit to	Benefit
Local people	Employment Improved environment
People who use our services and their families	Health impacts

5 The Commercial Case

5.1 Introduction to the commercial case

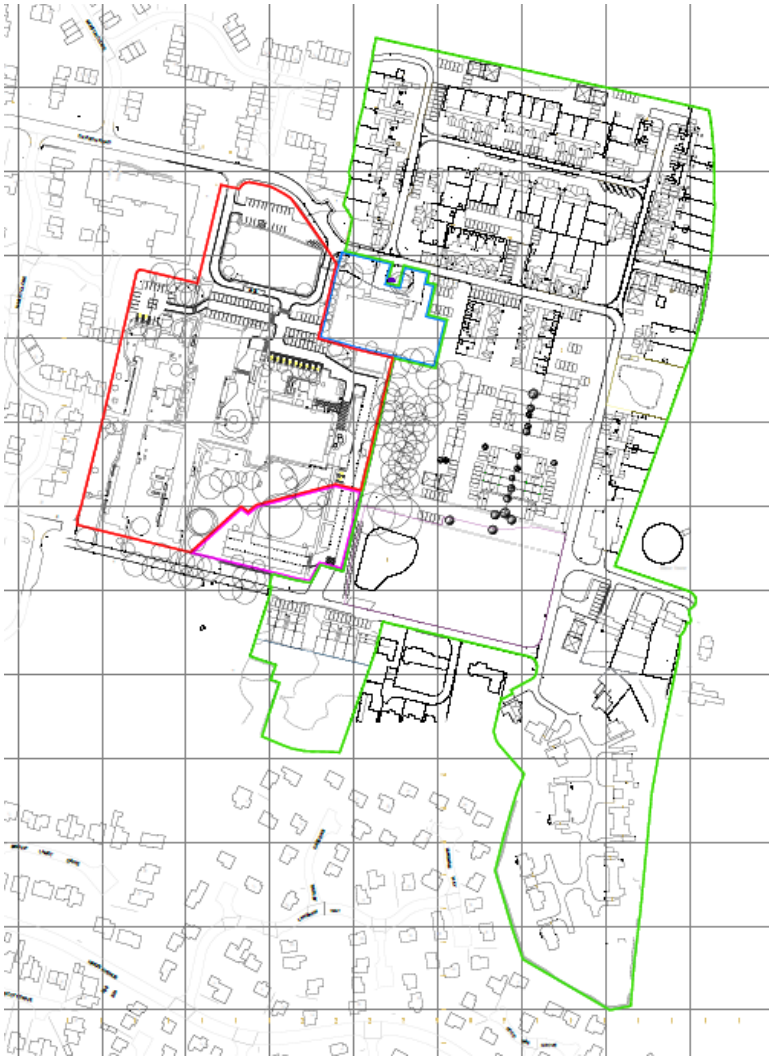
The commercial case sets out procurement and contractual issues associated with the preferred option.

5.2 Land issues

CCS and PGH entered into land swap and leaseback agreements on 16th October 2020 under which the two parties swap two parcels of land (parcels A and B) with CCS taking out a lease on Parcel B for four years. The map below illustrates the two parcels of land swapped:

- Parcel A outlined in blue is the plot on which the social club is situated – this land has been acquired by CCS.
- Parcel B outlined in pink was transferred to PGH and is being leased back by CCS for four years.

Figure 30: The land swap



The acquisition of Parcel A combined with adjacent existing areas of the POW site, creates a developable plot of land sufficient for CCS to build the new hub.

5.3 Scope of works to be procured

The scope of works is:

- The construction and fit out of the new local health and care hub.
- The construction of a multi-storey car park.
- Refurbishment works on the retained day surgery centre and co-located therapies suite.
- Associated site infrastructure works.

The scope of works does not apply the proposed nursing home (to be procured by the county council) or any potential phase two expansion of the health and care hub.

The Trust will issue a design brief, describing the Trust's objectives for the project. The brief will combine the outcomes of:

- Trust agreement of the project objectives and functional requirements.
- Development of an agreed building proposal including floor plans showing departmental / room layouts and adjacencies.
- Engagement with the users.
- Reviews by other stakeholders on issues such as fire, health and safety, infection control etc.
- Advice received following consultation with the local planning authority.
- Development of the RIBA Stage 2 feasibility design including concept structural and, mechanical and electrical engineering which targets a BREEAM "Excellent" accreditation.

The design brief will also confirm the Trust's requirements to comply with statutory obligations and other specific publications and standards including:

- Department of Health and Social Care design standards.
- Other relevant healthcare related design standards.
- Over-arching Trust policies.
- Specific project or department related operational policies and requirements.
- Room data sheets and environmental criteria for internal spaces.

5.3.1 Procurement options

There are a wide range of procurement options open to the trust to deliver the project. The options are summarised in the table below.

Table 21: Procurement options

Procurement option	Detail
Competitive dialogue	Competitive dialogue is an EU compliant tendering process whereby Trusts can allow for bidders to develop creative solutions in response to outline requirements. The trust would need to have a set specification of what it wanted to achieve with specific outputs, but it can then negotiate with the bidders around flexible aspects of the tender. Competitive dialogue is the most drawn out procurement procedures,

Procurement option	Detail
	taking on average six to nine months. It is suitable for contracts where some aspects are fixed and some aspects are up for discussion. Risks - if the tender is too open to negotiation the process becomes never-ending as the options are not comparable with each other and cannot be evaluated against each other. The process is time consuming and complicated which means that if the tendering was started and then faltered or failed, the Trust would risk frustrating the market and losing the interest of potential suppliers.
Open tender	An open tender is a standard OJEU compliant tendering process whereby the open EU market is approach for a fixed set of deliverables (the contract). This differs from a competitive dialogue as the contract deliverables are set from the tender date and are not changed or discussed through the process. As this is a more straight-forward process it is usually a much quicker and more simple process to follow than competitive dialogue. Open OJEU tenders can be completed within three to four months. It is suitable for contracts where the client has specific set deliverables that will not change. The risks of this approach are that because deliverables cannot change once the contract is tendered, these need to be 100% fit for purpose before the tendering process starts or the client risks the contract let not meeting requirements. If deliverables change, the client must start the tendering process afresh.
Framework	The use of a framework is an even quicker procurement approach because they consist of pre-selected suppliers who have been appointed to the framework through an earlier selection process. In effect the use of a framework short cuts the pre-qualification element of an open tender. Contracts are awarded after either a mini competition amongst framework suppliers or via a direct award to one supplier. The contract is also for a fixed set of deliverables.

The procurement route will be confirmed at OBC.

5.4 Modern methods of construction

In accordance with guidance, Modern Methods of Construction (MMC) are presumed for this project. It is expected that maximum practical use will be made of offsite manufacturing of components and modules, for transport and assembly on site.

The expected benefits of MMC include reductions in time and cost, the size of on-site construction teams, service disruption, health and safety risk and post completion defects. They will also help to overcome the construction skills shortage during a period when many NHS construction projects will be under way.

5.5 Risk transfer

Each risk has been allocated to the party best able to manage it.

Table 22: Risk Transfer

Risk Category	Potential allocation		
	Trust	Construction partner	Shared
Design risk		✓	
Construction and development risk		✓	
Transition and implementation risk			✓
Availability and performance risk			✓
Operating risk	✓		
Variability of revenue risks	✓		
Control risks	✓		
Residual value risks	✓		
Financing risks	✓		
Legislative risks			✓
Other project risks			✓

5.6 Planning

5.6.1 Planning permission

The Trust submitted a planning pre-application in August 2020 – a copy of this document can be found as Appendix Two.

5.6.2 Surveys

The surveys undertaken in support of the planning process, are listed below:

- Preliminary ecology
- Preliminary arborcultural
- Highways
- Drainage
- Noise and ventilation

5.7 Compliance with government and NHS standards and guidance

5.7.1 Sustainability

Climate change is recognised as a serious risk to health and wellbeing and the NHS Sustainable Development Unit expects all new builds to gain a Building Research Establishment Environmental Assessment Method (BREEAM) "Excellent" rating[30], which is the second highest rating possible. BREEAM sets standards for the environmental performance of buildings through the design, specification, construction and operation phases and can be applied to new developments or refurbishment schemes. A BREEAM assessment measures the procurement, design, construction and operation of a development against a range of targets based on performance benchmarks. It focuses on sustainable value across range of categories including energy, land use and ecology, water, health and wellbeing, pollution, transport, materials and waste management. Ratings are issued based on the assessment.

The Trust is targeting a BREEAM 'Excellent' rating. The sustainability of the proposed new inpatient building has been considered in the following ways:

- Targeting as closely as feasible the BREEAM Outstanding standard.
- Aiming to reducing operational energy to RIBA 2030 targets.
- Taking a whole life cycle cost approach.
- Minimum removal of site spoil to landfill by working with site levels to avoid bulk off-site materials removal.
- Preferential selection of materials with responsible product stewardship through a sustainable procurement plan.
- Using construction methods that will reduce site waste.
- Low use of Volatile Organic Compound materials.
- Maximum substitution of cement with up to 30% Pulverised Fuel Ash (PFA) or up to 90% Ground Granulated Blast-furnace Slag (GGBS).
- Use of recycled materials where possible, for example, we are proposing to reuse timber from felled trees for the woodland walk,
- Reduction of waste and resources required through resource efficiency workshops.
- Looking at reducing the embodied carbon of materials and systems chosen though lifecycle assessment.
- Low energy light fittings.
- Water efficient sanitary fittings.
- Use of carbon reduction strategies such as good employment of passive design principles, to achieve 'near to zero' net carbon emissions.
- Responsible management of construction.

[30] NHS Property Services Sustainable Development Management Plan 2014 – 2018.

- Allowing for post occupancy input from the design team (soft landings approach).
- Targeting net biodiversity improvement on the site.
- The construction contractors to demonstrate how they will aim to use a local workforce and small and medium size enterprises.

The Trust has also produced a travel plan setting out the package of measures aimed at addressing transport and travel issues associated with operations on the POW site.

5.7.2 Patient Environment and Consumerism

A Staff and Patient Environment Calibration Toolkit (ASPECT) is a tool for evaluating the impact of environmental factors in healthcare environments. It is based on a database of over 600 pieces of research highlighting the way the environment can impact on levels of staff and patient satisfaction, and on the health outcomes of patients and the performance of staff. An ASPECT workshop will be undertaken to produce the assessment.

5.7.3 Design Review

A 'Design Quality Indicator for Health' (DQIfH) review will be undertaken to assess the detailed design of the plans. DQIfH replaces the old Achieving Excellence Design Evaluation Tool (AEDET) process. The DQIfH process consists of stages which align to the NHS project and business case phases as illustrated below.

Figure 31: Design Quality Indictor for Health stages

5.8 Impact on other site users

The preferred option will result in the complete replacement or refurbishment (day surgery/ therapy block) of all services and blocks at the POW Hospital. The scheme minimises disruption to 'busines a usual' by developing a new block for most services on one edge of the site. There will however be an impact on day surgery and therapies as work is carried out within this block.

There are no other site users as such, but the Trust will manage the project to minimise disruption to neighbours including Baird Lodge and disruption to PCH's development of their adjacent site.

5.9 Associated disposals

The following assets will be disposed of:

- The existing POW Hospital except of the day surgery block.
- Land at the POW hospital:
    - A landswap has been entered into with PGH.
    - Additional areas of land will be sold to develop the new care home and to a developer for new housing.

5.10 Accounting treatment

The asset will be owned and operated by CCS meaning there is no unusual accounting treatment involved in this scheme. Further details of the financial impact are shown in the financial case.

6 The Financial Case

6.1 Financial impact of the shortlisted options

The financial impact of each shortlisted option on the system will be determined and appraised as part of the work on the OBC.

6.1.1 Capital costs and revenue consequences

The initial investment (capital costs) has been estimated for the four shortlisted 'change' options (options 1 to 4) above. The table below shows the inclusions and exclusions from the costing.

Table 23: Capital costing – elements included/ excluded

Option	Health & care hub	Theatres/ therapy	Multi-storey care park	Demolition of Day theatre block	Main hospital
Option 1	✓	✓	✓	✓	×
Option 2	✓	✓ (refurb)	✓	n/a as refurb	×
Option 3	✓	✓	✓	✓	×
Option 4	✓	✓ (refurb)	✓	n/a as refurb	×

The cost of demolishing the main hospital buildings has been excluded from all options because this is not a requirement of any option. Once the extent of surplus land is determined, an optimum disposal strategy will be developed. Demolition costs will only be included if they enhanced the land value e.g. best value is achieved by clearing the site - there could be an alternate scenario where land value may benefit from the retention of some of the buildings.

The cost of demolishing the existing theatre block and the cost of a temporary decant facility, have been included in options 2 and 4 where the theatres will be replaced by a new build three theatre and 23-hour ward block.

At this stage, the following high-level indication of capital costs can be provided.

Table 24: Initial capital cost estimate

Option	Total capital	Capital at today's prices	Equipment allowance	Contingency	Optimism bias
BAU	£9.33m				
Option 1	£70.7m	£60.5m	£3.3m	6%	5.3%

Option	Total capital	Capital at today's prices	Equipment allowance	Contingency	Optimism bias
Option 2	£54.7m	£47.6m	£2.5m	6%	6.9%
Option 3	£65.9m	£56.4m	£3.2m	6%	5.3%
Option 4	£50.0m	£43.5m	£2.3m	6%	6.9%

The capital costs in the table above include construction costs, on-costs, fees, contingency and optimism bias, and VAT plus an allowance for equipment. Costs are shown at both today's prices (PUBSEC 250) and at estimated price levels for the mid-point of the works.

Assuming a 'traditional' NHS capital funding route e.g. public dividend capital (PDC), the revenue consequence of capital investment will be made up of:

- 3.5% interest on the net asset value payable from the point at which PDC is drawn down i.e. PDC interest is payable on assets under construction as well as the eventual net book value of the new assets.
- Depreciation on the 'in use' value of the new assets. The in use value will need to be determined by the District valuer using a modern equivalent assets (MEA) valuation and based on schemes elsewhere, is typically 70% of the project cost for new builds and 50% for refurbishments. Any impairment of value on assets being taken into sue which result from the MEA will be written-off against the CCS statement of comprehensive income.

The depreciation charge will also reflect CCS depreciation policies on asset lives with different building elements being depreciated over different periods. Again, based on projects elsewhere the average depreciation period is typically 30 years on this type of community development based on a weighted average of building element lives.

The revenue consequences (capital charges) of the investment can, therefore, be estimated as per the table below – numbers are presented without any MEA adjustment.

Table 25: Revenue consequences of capital investment

Option	Total capital	PDC int @ 3.5%	Depreciation pre MEA adjustment	Total capital charge pre MEA adjustment
BAU	£9.33m	£0.32m	£0.41m	£0.73m
Option 1	£70.7m	£2.5m	£2.4m	£4.8m
Option 2	£54.7m	£1.9m	£1.8m	£3.7m

Option	Total capital	PDC int @ 3.5%	Depreciation pre MEA adjustment	Total capital charge pre MEA adjustment
Option 3	£65.9m	£2.3m	£2.2m	£4.5m
Option 4	£50.0m	£1.8m	£1.7m	£3.4m

The cost pressure associated with capital charges on the new asset shown in the table above, will be offset, at least in part, by capital charge savings on the existing buildings. Any net book value remaining on existing assets will need to be written off as an impairment against the CCS statement of comprehensive income.

In addition to the initial capital investment, the scheme will incur a lifecycle cost that will be incurred over the 60-year life assumed for the building structure.

6.1.2 Source of capital funds

At this stage it is not possible to confirm the affordability of this scheme in capital terms. This business case is being prepared to allow the STP to submit a bid for capital funding in the next funding round – we understand that there will be a Wave Five.

Central funding will be needed for the bulk of the investment needed, but additional funding sources are available:

- Developer levy – as noted earlier, the East Cambridgeshire District Council has offered £1.1m CIL funding for the scheme.
- Land sale receipts – CCS intends selling part of the existing land at the POW for housing and a second plot for the proposed new care home (see above for discussion on demolition and preparing land for sale).
- Internally generate capital from CCS and potentially other system partners.
- Primary care funding sources – although the ETTF is ending, any new primary care capital funding routes could be a source of a contribution recognising the primary care elements of the scheme.

6.1.3 Other revenue costs

The revenue consequences of capital investment are discussed above. This scheme will impact upon hard and soft facilities management (FM) costs. Changes to FM costs will be worked through at OBC, however experience from other projects suggests that whilst a new facility will have lower costs per m^2 due to better design and improved energy efficiency, these savings are often cancelled out by costs resulting from new facilities being larger than the facilities being replaced due to spatial allowances within health building notices (HBNs) being more generous than before.

The new hub creates opportunities for efficiencies in administrative services ranging from reception costs to sharing of back office services – these will be considered at OBC.

The new hub provides an environment to support changes to pathways. The financial implications of pathway changes are out of scope for this business case except for the impact of carrying out more day surgery at the POW. The financial impact will need to be worked-up by CUH as part of the OBC.

6.1.4 Economic comparison to the BAU

The OBC economic appraisal will test the financial impact of each shortlisted option against the BAU. It is important to recognise that the BAU is different from the current cost or a 'do nothing' – total costs will inevitably rise, if only because of population growth. The BAU financial and economic model will need to incorporate the cost of meeting rising demand from existing assets/ outsourcing to the independent sector to ensure a consistency of assumptions with other shortlisted options.

The economic appraisal will consider capital and revenue costs and the following monetisable benefits as per NHSEI guidance:

- Cash releasing benefits such as savings from closing existing estate.
- Non-cash releasing benefits such staffing efficiencies.
- Quantifiable wider societal benefits such as reductions in travel resulting from repatriation of activity to Ely and the benefit to the local economy from creating jobs in the construction industry.

6.1.5 Future charging arrangements

The OBC will also need to consider how the ongoing operating costs of the new hub are to be paid for. The new hub will be owned by CCS, but it is a system asset making it important that financial arrangements for using space in the hub work for the system and for CCS as the 'landlord'. Hubs in other health communities have failed as a result of short-term financial decisions made by individual organisations which destabilise the financial viability of individual assets, often by leaving the landlord with void risk and these decisions have often caused an overall cost pressure to the taxpayer. The financial viability of the hub relies on embedding the concept of the Cambridgeshire Pound and the associated focus on costs to the system or taxpayer rather than costs to individual NHS bodies. The inclusion of two primary care practices in the hub add complications to be resolved because of Primary Care Premises Cost Directions which set out how costs borne by practices (which are independent businesses) are reimbursed by the NHS. Potential charges to social services and other council funded services add further complication. At this stage, the system needs to commit to working through these issues and a principle of not passing undue risk to CCS as the property owner.

7 The Management Case

7.1 Introduction to the management case

The management case describes how the project will be successfully achieved, the timescale for delivery and corporate governance arrangements. It demonstrates that the project is well managed, is likely to be delivered successfully and will enable the project objectives and benefits to be fully realised.

7.2 Project governance arrangements

The POW project is led by the POW Project Board which includes representatives from all affected organisations. Reporting to the Project Board is the POW Project Team.

The project board is responsible for:

- Overseeing the implementation of the POW redevelopment project.
- Supporting the STP Estates Group by monitoring the delivery of the POW redevelopment project which is a key service development in the STP's strategic plan.

The board's main responsibilities are:

- Ensuring the project delivers within agreed parameters in terms of costs, organisational impact, rate and scale of adoption and expected/actual benefits realisation.
- Agreeing any changes to scope, deliverables and timelines through a managed change control process.
- Ensuring the appropriate governance arrangements are in place for all proposed changes.
- Ensuring that mechanisms are in place to coproduce service redesign with patients, service users and stakeholders.
- Ensuring that mechanisms to support staff implement changes are in place and core each supporting project.
- Linking projects, where appropriate, and identifying any interdependencies or gaps.
- Resolving strategic and directional issues between workstreams, which need input and agreement of senior stakeholders to ensure the progress of the project.
- Defining the acceptable risk profile and risk thresholds for the project and their constituent projects.
- Ensuring quality management systems are in place to provide assurance that service quality and effectiveness will be maintained through the life of the project and proposed changes are quality assured, monitored and reviewed.
- Ensuring a comprehensive stakeholder communications and engagement plan is in place and is implemented.
- Ensuring the project remains aligned with STP plans and priorities.

The Project Board's membership is set out below.

Table 26: Project Board membership

Name	Role

Name	Role
Rachel Hawkins	Project Senior Responsible Officer (Chair)
Mark Robbins	CCS Director of Finance, (Vice Chair)
Richard Dickson	Project Director
David Hudson	Project Manager
Alison Manton	STP Estates Strategy Lead
Scott Haldane	CPFT Director of Finance
Ashling Bannon	Change Manager Sustainability and Transformation Partnership System Delivery Unit
TBA	CCG Director of Strategy and Planning
Louis Kamfer	CCG Director of Finance
Richard Brixley	South Alliance PCN Director
Claire Stoneham	CUH Director of Strategy & Major Projects
Emma Grima	EC&F District Council
TBC	Cambridgeshire County Council

7.3 Project plan

The key project milestones are shown in the table below.

Table 27: Project milestones

Activity	Milestone date
Strategic Outline Case completion	November 2020
Outline Business Case completion	January 2021
Planning submission	January 2021
Concept Design	Until February 2021
Planning approval	April 2021
Detailed Design	March to September 2021
Full Business Case completion	September 2021
Start on Site	December 2021
Construction completion	October 2023

Activity	Milestone date
Trust commissioning	October 2023 to December 2023
Building 'Go-Live'	December 2023

7.4 Benefits realisation

Benefits realisation is concerned with putting in place the management arrangements required to ensure that the benefits detailed in the economic case are delivered. A detailed benefits realisation plan is being developed alongside this business case. The high-level benefits realisation plan is designed to:

- Identify the benefits and responsibility for their delivery.
- Establish baseline measurement where possible.
- Quantify benefits.
- Assign responsibility for the actual realisation of benefits throughout the key phases of the project.
- Periodically assess realisation and initiate any actions required.
- Record further expected benefits identified during the project.
- Measure outcomes.

The benefits realisation plan will be developed at OBC.

7.5 Project quality management

The quality of project delivery will be managed through the risk management and change control processes.

7.5.1 Risks and risk management

Risks to the project will be assessed and quantified by a cross section of stakeholders in a workshop at OBC. Our initial focus is on:

- Project management risks e.g. delay in production or approval of the business case, or delay in securing planning consent.
- Delivery risks e.g. changes in the design requirements or disruption caused to services by construction.
- Financial risks e.g. capital affordability.

The Trust uses the RAID (risks, assumptions, issues and dependencies) management process to manage risks. RAID has a simple step by step process of:

- Raising a risk, assumption, issue or dependency item.
- Registering the item in the RAID register with a description of the item and the impact.
- Assessing the probability of the item occurring, the severity if it were to occur and the proximity i.e. likely timescale of occurrence.
- Assigning actions including actions relating to dependencies.
- Implementing actions.
- Monitoring and reporting RAID.

The table below presents the “Red” rated risks from the project risk register.

Table 28: Summary of key risks

Risk	Mitigation
Lack of available capital / capital affordability	• Design incorporates shared, flexible use space and minimises number of ring-fenced rooms • Maximise use of existing accommodation if fit for purpose • Modern methods of construction to keep costs under control • Intention to bid for NHSEI funding e.g. Wave 5 • High priory scheme within STP (local support)
Revenue affordability	• Existing estate costs released • Hub will facilitate new models of care and encourage joint working • Avoids backlog costs and lower cost than building at Addenbrooke’s
Scheme not approved by NHSEI / delays in securing approvals from NHSEI	• Liaison with NHSEI from SOC
Redevelopment takes longer than expected	• Project management processes
Design requirements change because of changes to service requirements	• Involvement of service leads in design
Facilities designed before implications of changes arising because of Covid-19 are fully understood	• Design team keeping close to emerging Covid lessons
Scheme does not receive planning consent	• Pre-application submitted • District Council is supportive
Logistical challenges in executing redevelopment on site	• Land swap enables development to take largely a turnkey approach

7.5.2 Change control

The control of changes (or variations) within a project and each phase, is vital to enable suitable control of the scope and budget. The project manager will maintain a log of all potential and instructed changes to project.

Divergence from the design brief or tendered design, or the increase or decrease in monies required to fund the design or construction of the works, shall constitute a change to the project.

All changes to the project required by the users or any officer of the Trust will need to be authorised by the project director and project manager. The project manager in turn communicate changes to the contractor.

7.6 Equality impact

The Trust will carry out an equalities impact assessment for the scheme.

7.7 Communications and engagement

Business engagement is defined as the framework that enables effective stakeholder engagement and communication throughout the life of the project. It is recognised as integral and critical success. The project team will develop a communications strategy to facilitate messaging (what will be communicated, by whom, how and when) as a key vehicle for delivering the engagement strategy.

It is important to note that business/stakeholder engagement, communications and the stakeholder landscape itself will evolve throughout the life of the project and it is therefore essential that the project establishes a flexible approach to business engagement and communications that is maintained and re-visited at each phase of the project.

7.8 Post-project evaluation

This section sets out how the various phases of the project will be reviewed. Firstly, a project evaluation review will be carried out to improve project management at all stages of preparation of the business case through to the design, management and implementation of each phase of the scheme.

Secondly, a post-implementation review will be carried out to assess the implementation of the completed working solution. It usually takes place between six weeks and six months after the completion. The objectives of the review will be to:

- Identify how well the project and individual aims and objectives of each phase have been achieved.
- Determine if the timescales were met, both overall and for each key milestone, and what corrective actions, if any, were taken.
- Determine if the project costs were controlled and were within budget, both overall and for each of the phase of the project, and what corrective actions, if any, were taken.
- Against the benefits realisation plan identify what benefits have been achieved (both cash releasing and non-cash releasing) and seek the realisation of any outstanding benefits, including the implementation of any procedural and process changes.
- Assess the efficiency of the acquisition process and document the shortcomings for the benefit of future programmes and projects.

8 Conclusion

This SOC demonstrates that there are at least four realistic and achievable options by which the POW project objectives can be delivered and the strategic development of services in Ely taken forward. This will represent a major contribution to the STP's strategic response to the case for change set out in this document.

The Project Board now requests approval to move forward to OBC at which stage, the shortlisted options will be worked-up in more detail and carry a full cost-benefit-risk appraisal carried out to determine the preferred option to deliver the POW redevelopment project.

9 Appendices

Appendix One – Six Facet Survey Dashboard POW Hospital

Appendix Two – Pre-planning Application Submission

Appendix One – Six Facet Survey Dashboard POW Hospital

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NHS Cambridgeshire Community Services NHS Trust	Princess of Wales Hospital Lynn Rd Ely, CB6 1DN	Backlog Cost	£1,609,900	Backlog Summary	£s	Facet Grade Summary	Grade
		Year 1 Cost	£36,000	Low Risk	£533,400	Facet 1 Physical Condition	B
		Year 2 Cost	£186,100	Moderate Risk	£614,400	Facet 2 Functional Suitability	Not Applicable
		Year 3 Cost	£232,925	Significant Risk	£459,100	Facet 3 Space Utilisation	Not Applicable
		Year 4 Cost	£92,500	High Risk	£3,000	Facet 4 Quality	Not Applicable
Survey Date	14th November 2018	Year 5 Cost	£685,000	Risk Adjusted Backlog	£502,023	Facet 5 Statutory Compliance	C

Overall Grade: **B**

Noted to be in reasonable condition

This dashboard summaries the following blocks: PW05 Physio, OT & Day Surgery, PW06 OPD, X-Ray, Dental & Offices, PW07 Staff Room & Office, PW08 Cottage Day Hospital & Wicken, PW10 Primary Care Block, PW11 Oliver Zangwill & Welney, PW13 Corridor & Social Services and PW14 Plant Room.

Condition Backlog Maintenance Works

Total remedial work required for the BUILDING, M&E & STAT Elements:

Building	£1,020,500
M&E	£487,900
Statutory Compliance	£10,000
Fire Safety	£91,500
Backlog Total Cost	£1,609,900

Condition Future Planned Costs for Future Maintenance Works (5 years)

Total remedial work likely to be required within a 5 year period for the BUILDING, M&E & STAT Elements:

Building	£526,000
M&E	£698,525
Statutory Compliance	£8,000
Fire Safety	£0
Future Planned Total Cost	£1,232,525

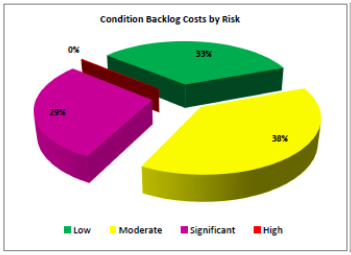
Combined Total Costs	£2,842,425
Combined Total Costs (Incl. On Costs)	£4,377,335

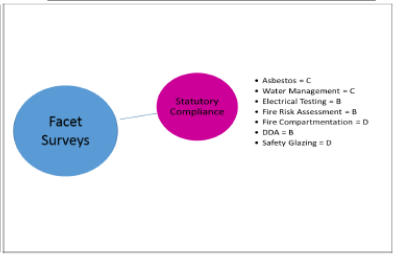
The On-costs include for Fees (12%), VAT (20%), Builder Preliminaries (12%) & Optimism Bias Contingencies (10%).

Cost Breakdown by Year and Element

Element	Backlog (Year 0)	Year 1	Year 2	Year 3	Year 4	Year 5	Grand Total
A - Building - Physical Structure	£100,000.00	£0.00	£0.00	£0.00	£0.00	£0.00	£100,000.00
B1 - Building - External Fabric	£12,050.00	£0.00	£0.00	£0.00	£0.00	£500.00	£12,550.00
B2 - Building - External Fabric	£143,000.00	£0.00	£0.00	£50,000.00	£0.00	£0.00	£193,000.00
C - Building - Internal Fabric	£542,350.00	£28,000.00	£58,000.00	£151,000.00	£0.00	£168,500.00	£947,850.00
D - Building - Roof - Flat	£223,100.00	£0.00	£0.00	£0.00	£0.00	£70,000.00	£293,100.00
D - Building - Roof - Pitched	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
F - Building - External Works	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
I - Engineering - Heating Systems	£25,800.00	£0.00	£32,000.00	£5,000.00	£22,000.00	£185,000.00	£269,800.00
K - Engineering - Vent & Cooling	£233,100.00	£0.00	£38,600.00	£1,500.00	£10,000.00	£35,000.00	£318,200.00
M - Engineering - Hot/Cold Water	£0.00	£0.00	£0.00	£1,600.00	£0.00	£0.00	£1,600.00
O - Engineering - Medical Systems	£2,000.00	£0.00	£0.00	£0.00	£0.00	£0.00	£2,000.00
R - Engineering - Electrical	£217,000.00	£0.00	£35,000.00	£14,825.00	£38,500.00	£168,000.00	£473,325.00
V - Engineering - Fire Systems	£10,000.00	£0.00	£22,500.00	£9,000.00	£22,000.00	£58,000.00	£121,500.00
Statutory Compliance	£101,500.00	£8,000.00	£0.00	£0.00	£0.00	£0.00	£109,500.00
TOTAL	£1,609,900.00	£36,000.00	£186,100.00	£232,925.00	£92,500.00	£685,000.00	£2,842,425.00

Environmental Facet	Building Volume m3	Total Energy GJ	Energy Result GJ/100m3	Energy Rating
	TBC	TBC	TBC	TBC





Facet Key

Physical Condition:	Functional Suitability	Quality	Statutory Compliance
A - Good. Performing as intended.	A - Very satisfactory, no change needed.	A - A facility of excellent quality.	A - Building complies with all statutory regulation for the required statutory issue.
B - Satisfactory. Performing as intended, minor deterioration.	B - Satisfactory, minor change needed.	B - A facility requiring general maintenance investment only.	B - Building has a Risk Assessment/Survey in place however there may be minor issues.
C - Poor. Exhibiting defects and/or not operating as intended.	C - Not satisfactory, major change needed.	C - A less than acceptable facility requiring major capital investment or replacement.	C - Required regulation is within 3 months of expiring or there are areas where major issues exist.
D - Bad. Life expired and/or serious risk of imminent failure.	D - Unacceptable in its present condition.	D - A very poor facility requiring major capital investment or replacement.	D - Building Risk assessment does not exist/expired or areas of the building are dangerously below level B.

Appendix Two – Pre-planning Application Submission

Available under separate cover