Turner & Townsend

February 2020

Strategic Outline Case

Report

Kempston MCCC and Wootton GP surgery
Bedford Borough Council

making the **difference**

Christopher Roe
Senior Consultant

Turner & Townsend Consulting Limited
One New Change
London
EC4M 9AF

t: +44 (0)20 7544 4000
e: christopher.roe@turntown.com
w: turnerandtownsend.com

BEDFORD BOROUGH COUNCIL

Contents

Rev	Status	Originator	Approved	Date
1.0	Final Draft	Christopher Roe	Claire Colgan	05 February 2020
1.1	Final Draft	Christopher Roe	Claire Colgan	24 February 2020

1 Introduction

1.1 Executive Summary

Bedford Borough Council (BBC), in partnership with Bedfordshire Clinical Commissioning Group (BCCG) have commissioned this Strategic Outline Case (SOC) to identify a viable way of addressing constraints within the delivery and capacity of primary care in Kempston.

This study has identified that delivery of a multi-speciality community care centre (MCCC) would address an existing under-provision of GP and primary care space and facilities in Kempston whilst simultaneously improving the robustness of the existing Primary Care Network (PCN).

A detailed study of the existing services, patient numbers and services that are planned to be delivered through the PCN in the community has established that a significantly larger primary care estate is needed to enable adequate healthcare to be offered to local residents. Having reviewed the existing estate and the need to provide 2.5 times more primary care space in Kempston than currently exists, it has been confirmed that none of the existing sites are suitable, or able to be expanded/modified to meet the current and future needs of patients and healthcare professionals.

As a result, this SOC has study all potential development sites in Kempston and concluded that the Kempston Police Station, located in the town's centre provides an ideal location for a new MCCC. The Police have commenced preparations to decommission this site which will culminate in its disposal by mid-2022. The site benefits from good transport links, a central location and is the appropriate size for the proposed MCCC development. This SOC has also considered other sites including the former Robert Bruce site. Although offering a cleared site, its complex land negotiations, multiple stakeholders and sub-prime town centre location mean that on balance it is not favoured by this SOC.

This SOC concludes by assessing the initial viability of the site and setting out the next steps needed to be taken at the Outline Business Case (OBC) and Full Business Case (FBC) stages to build on the scope set out in this document.

1.2 Background to this document

Through significant housing development across Bedfordshire over the last 20 years, demand for all healthcare services, including primary care, has increased. Due to the complexities that surround primary care provision, it has not been possible to maintain adequate primary care services, which are now out striped by demand. Recognising this shortfall, and the benefits that can be attained through collaboration, BBC and BCCG came together and jointly prepared the BCCG Primary Care Estate Strategy (May 2019).

The strategy highlighted identifies the key care needs of the Borough including:

- The high level approaches to delivering a primary care network
- The key care 'Hubs' across the Borough, one of which would be in the town of Kempston.
- The potential benefits to be gained from the "relocation of King Street, Cater Street and St Johns Street Surgeries into one Hub facility in Kempston, with potential to provide a range of other health and community services from the same building".

1.3 Purpose of this document

This document is structured in the format of a 'Strategic Outline Case' (SOC) detailing the strategic argument for the development of a MCCC as a means of addressing an existing under provision of GP and primary care service in Kempston.

A SOC should specifically address the following:

Appraisal element	Key questions
Function	▪ What services will be provided? ▪ Which GPs will be present? ▪ What other health or social care providers will use the building?
Size	▪ How big is the population? ▪ How many people will use the service? ▪ How many clinical rooms? ▪ How much office space (including meeting rooms and ancillary space)? ▪ How many car parking spaces? ▪ Projected growth in population and how that growth will be accommodated by the Hub.
Location	▪ Where will it be? ▪ How will people get there? ▪ Are the public transport routes suitable? ▪ Are there any abnormal characteristics of selected sites? ▪ What remedial works will be required in order to provide the space?
Funding routes	▪ Which funding routes are available to support the development? ▪ How much S106 contribution monies will be available? ▪ What is the gap? ▪ What work needs to be done in order to support funding applications?
Ownership	▪ What ownership models are available to support the development? ▪ Are there any other interested partners in the Public Sector? ▪ Are there any opportunities for third party developers?

Table 1 – Focus of SOC

To do so, the SOC will present the case for developing the MCCC hub in Kempston by identifying the possible uses and operation of this building together with the potential size and location of the MCCC. This information will be presented with sufficient facts and insights to allow the BCCG Governing Body and BBC to decide if the concept is feasible and capable of being taken forward, leading to the production of an outline business cases and in turn a full business case.

The principle of a MCCC has previously been considered by the Bedford Borough Primary Care Estate Strategy. This is in response to, and in recognition of, the local imperative, reflecting the national position, to take positive action in respect of the growing demand faced by health and care services in the coming years. The estate strategy identified that this demand was generated by, but not exclusively the result of, a significant increase in the local population of Kempston.

Whilst this work considers the requirement for existing primary care services to work more collaboratively, as these are existing services, greater concentration has been given to identifying an estate solution that is capable of meeting the needs of Kempston.

There are four key strategic questions for consideration:

1. Can the MCCC provide a facility where services can come together, locally, to match support to individuals' needs avoiding the present requirement to refer patients to a number of services in different buildings, hospital and using local information to help identify needs sooner, to improve people's health and wellbeing?

2. Can a MCCC improve the ability of health and care organisations to attract and retain staff, whilst using their existing workforce more efficiently through the benefits of economies of scale?

3. Is the MCCC able to operate to a higher degree of cost efficiency than the existing estate, reducing overheads, improving service delivery and long-term viability?

4. Will the MCCC be able to maximise value from the investment to ensure it is able to respond to changes and new developments in the primary care sector with minimal changes to the building?

1.4 How this document was produced

This document has been produced in partnership between the Local Authority, BBC and BCCG with input from local stakeholders, including GPs and primary care providers.

Information from these groups and organisations was combined with local data, such as demographic, property and health information to develop this SOC. All data sources and minutes of meetings with organisations and individuals have been included in this SOC to enable verification to take place at the Outline Business Case (OBC) and Full Business Case (FBC) stages.

The diagram below illustrates the process followed to develop this SOC:

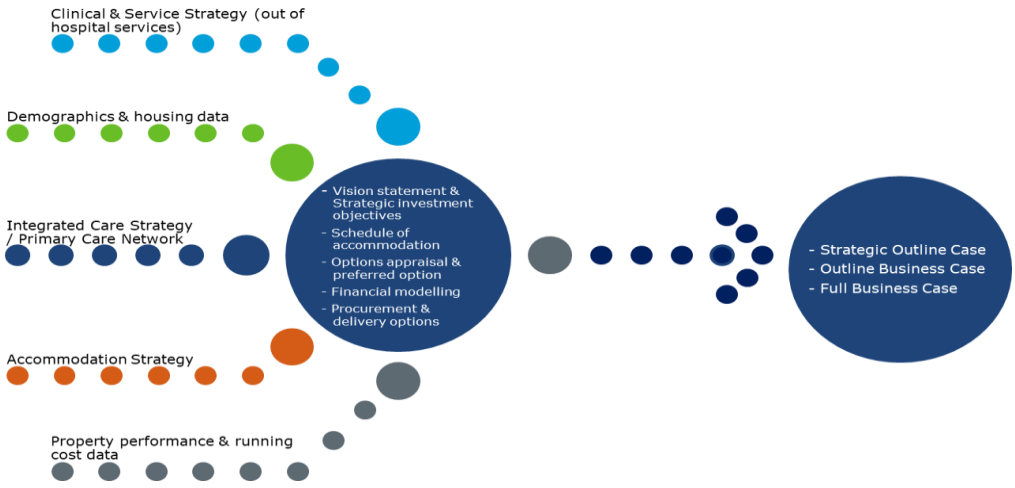


Figure 1 – How this document was produced

2 Strategic Case

In this section of the SOC we illustrate how the MCCC proposal aligns and meets national and local healthcare priorities. This is achieved by examining national guidance form the NHS and local objectives as set out by the Local Authority, CCG and Sustainable Transformation Partnership (STP).

2.1 Policy

2.1.1 Strategic context

2.1.1.1 National policies

NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the Government's objectives and any requirements for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS and helps ensure the NHS is accountable to Parliament and the public.

Every year, the Secretary of State must publish a mandate to ensure that NHS England's objectives remain up to date. This mandate is based on the shared priorities of Government and its partner organisations for health and care – the priorities we believe are central to delivering the changes needed to ensure the NHS is always there whenever people need it most. As leader of the commissioning system, but working with others, NHS England has a central role to play.

This mandate sets objectives for NHS England that reflects its contribution to these ambitions to 2020.

NHS England has seven key ambitions that underpin their operational activities:

i Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.

ii Help create the safest, highest quality health and care service.

iii Balance the NHS budget and improve efficiency and productivity.

iv Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

v Maintain and improve performance against core standards

vi Improve out-of-hospital care

vii Support research, innovation and growth.

The MCCC is set to fulfil many of these objectives by significantly enhancing the capacity of primary care in Kempston with modern facilities and at a scale that will unlock cost-effective primary care treatment in the community, without the need to rely on hospital services.

2.1.1.2 NHS Long Term Plan

The NHS Long Term Plan sets out the vision for the provision of health services over the coming decade. It identifies where and how changes need to be made to keep it in pace with those requiring is services. Part of this focus is on providing more support and a joined up approach to care at the right time, in the optimal setting.

The Plan aims to achieve this by focusing at a PCN level to encourage GPs to work more collaboratively in commissioning a range of services to meet the needs of the local population. These newly expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. Within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector.

The MCCC will allow more people to receive a wider range of healthcare services in their home and community by becoming a focal point for the local PCN. By providing a facility to GPs and other community and healthcare practitioners to work in a single facility, care will be more coordinated and tailored to the needs of the individual.

2.1.1.3 GP Contracts (2019)

In 2019 GP's contracts were updated to reflect the Long Term Plan as well as respond to current and emerging needs within the health environment. Central to this is how GP's and their contracts respond to the rollout of PCNs across the country. Most notably within this was the drive to increase staffing numbers to meet these news services. In total 22,000 additional staff are expected to be working within primary care by 2024. At an individual surgery level this translates to an average 3 additional healthcare practitioners per surgery.

The proposed MCCC has been developed specifically to the new requirements that the PCN creates. By advocating the provision of more services at a local level, and increasing staffing levels of primary care it is essential that the estate is enlarged to support these expanded provisions. This SOC has calculated the expected amount of clinical space needed to support GMS and PCN services.

2.1.1.4 One Public Estate (OPE)

The production of this SOC has been funded through OPE. Established to provide practical, technical support and funding to public sector organisations to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners. This SOC will propose how the identified primary care health care improvements will fulfil the objectives of OPE of economic growth, integrated services and generating efficiencies.

This SOC sets out a more integrated, and patient focused approach to health care, made possible by the bringing together of geographically disparate services into a coordinated hub.

2.1.1.5 Primary Care Networks (PCN)

BCCG is in the process of rolling out its PCN across Bedfordshire. Refreshing NHS Plans for 2018-19 set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network so that these cover the whole country as far as possible by the end of 2018/19.

Primary care networks contain geographic populations of 30-50,000 patients and consequently around 1,300 have been created across England. They will be expected to think about the wider health of their population, taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support.

In time, the PCN will be required to delivery seven national service specifications. To do this they are expected to work more collaboratively to provide services that might otherwise not be possible

from a standalone surgery through joint commissioning. This has already commenced and roles such as social prescribers are being fulfilled at a PCN level.

The three GP surgeries that service Kempston are within the **Caritas Medical PCN** which supports approximately 44,000 people residents through its five surgeries of:

- Shortstown
- King Street
- Queens Park
- St John
- Cater Street
- Wootton Vale.

The three surgeries of Cater Street, King Street and St John have been identified in this document as they are all within Kempston. The remaining three surgeries are in neighbouring villages and whilst part of the same PCN, do not have the same estate related issues as their Kempston counterparts. Local strategies discussed below have identified that addressing the estate issues in Kempston will alleviate the challenges faced by these surgeries and provide a central hub from which a wider range of services can be brought forward and shared by the whole PCN.

This SOC aims to set out the case for bringing these surgeries into a single central location and providing them with the facilities needed to deliver the wide range of PCN and out of hospital services the community requires.

2.1.1.6 Primary Care Home Model

Developed by the National Association of Primary Care (NAPC), the model advocates the colocation of and health and social care to provide personalised services better equipped to offer preventative care for the local community.

In the model health care professionals come together to provide GP, mental health, social and acute care. It is also provides a formal route for the voluntary sector to provide services. Sitting within the PCN, the mix of services can be refined according to the needs of the local community.

The proposal set out in the document aims to achieve these objectives by bringing together GPs and other primary health care professionals in a new purpose-built facility with sufficient space to meet the needs of the local community.

2.1.1.7 Other National Policies

Additional applicable Government and NHS documents have been included Appendix 1.

2.1.2 Aligning with local/regional strategic priorities

2.1.2.1 Bedford, Luton, Milton Keynes Integrated Care System (BMLK ICS)

BCCG oversee the three Kempston surgeries in the Caritas PCN. In turn, it has recently joined the BLMK ICS which also includes the local councils and CCGs for Luton, Milton Keynes and Central Bedfordshire. The ICS has set out the following objectives:

i **Illness prevention and health promotion** - Preventing ill health and promoting good health by giving people the knowledge and ability, individually and through local communities, to manage their own health effectively.

ii **Primary, community and social care** - Delivering high quality and resilient primary, community and social care services across Bedfordshire, Luton and Milton Keynes.

iii **Secondary care** - Delivering high quality and sustainable secondary (hospital) care services across Bedfordshire, Luton and Milton Keynes.

iv **Digital programme** - Design and deliver a digital programme, maximising the use of information technology to support the delivery of care and services in the community and in primary and secondary care.

v **Demand management and commissioning** – Making the right services are available in the right place, at the right time for everyone using health and social care in Bedfordshire, Luton and Milton Keynes.

The proposed health care Hub in Kempston will fulfil these objectives through the provision of a more robust and expanded primary care service that is able to address more of people's needs without referral to hospital and tackling problem at an early stage, near their home, before they are able to develop into more complex medical conditions requiring secondary care intervention.

2.1.2.2 Bedfordshire CCG draft 'Straw Man' Clinical Model

In addition to operational configuration, there are a number of local strategies that inform the format of the MCCC. The 'Straw-man' Clinical Model provides a draft of a clinical model for the BLMK Hub Programme. The Model has been developed by a small group of clinicians, professionals and managers across the system in Bedfordshire. The model indicates the range of services which might be offered from a Hub based on the size of the population served and provides flexibility for each location to be tailored to the needs of local population.

The relevant extract from the Clinical Model is show the following:

Service Line	Neighbourhood Hubs - (30k+ population)
Unscheduled Care	▪ Minor illness and minor injury ▪ Near-patient testing (NPT) ▪ Pharmacy Dispensary ▪ 8:00-20:00 weekdays, plus some weekend provision ▪ GMS Urgent Care from practices based in Hub / shared same day access service across practices, plus extended access
Prevention/ early intervention Services	▪ Lifestyle services, e.g. smoking cessation, weight loss ▪ Voluntary services
Maternity	▪ Antenatal care ▪ Post-natal community care
Other	▪ IM&T interoperability to allow Hub clinicians to view diagnostic results/imaging ▪ Commercial and community facilities
Enhanced Primary Care	▪ Core primary care – potential to be delivered at scale ▪ Proactive management of long term conditions (LTCs) ▪ Near-patient testing and phlebotomy ▪ Care navigation/ health coaching/ social prescribing ▪ Medical care/complex care support for care homes

	▪ Group education (e.g. DESMOND, DAPHNE) ▪ MDT risk stratification & case management ▪ Comprehensive Geriatric Assessments ▪ Community clinics – e.g. wound care/tissue viability, podiatry, continence ▪ Base for adult community nursing team ▪ Base for 0-19 team ▪ Base for social care practitioners ▪ Primary care mental health workers ▪ Psychological support for people with LTCs

Table 2 - Extract form Bedfordshire CCG's Straw Man Strategy

2.1.2.3 Bedford Borough - Health & Care Estate Infrastructure Framework

The identification of Kempston as a suitable location for a Hub has been widely considered by the Council and CCG, but it was formally set out as a in the Health & Care Estate Infrastructure Framework document, in which it identified that an under provision of primary care services in Kempston could be resolved through the development of a MCCC (aka. Hub).

The document proposes consolidation of the Caritas Medical PCN onto 4 locations. Shortstown, Wootton and Queens Park would remain in their current location. Meanwhile Cater Street, King Street and St Johns surgeries would co-locate onto a new site to serve Kempston. The new facility would be sized to meet the immediate lack of space experienced by all surgeries and ensure that the area's significant house building plans could also be accommodated in a single location. Making use of the expanded range of services being provided form Kempston, Wootton would act as a spoke, utilising the services of the Hub to supplement its existing service offer to patients.

In addition to addressing the lack of space, bringing the practices closer together physically, as well as administratively through the PCN improves the robustness of Primary Care services for the whole of Bedford. As two of the practices have one or two partners, failure of one practice, combined with the current space shortfall would mean the other practices would be unable to expand to meet the displaced patients.

2.1.3 Existing service configuration

The three Kempston Surgeries are all well-established organisationally and within the community. They all provide similar services, with the two key exceptions being Cater Street which does not undertake minor operations and King Street with has an onsite pharmacy. King Street is also a training practice.

All three surgeries are within the same PCN, although this is yet to launch. There are three other surgeries within the PCN, however these are outside of Kempston. However, of these three surgeries, Wootton's close proximity to Kempston means that it is being considered in conjunction with Kempston. Whilst it would not relocate from Kempston, it requires a new estate proposal (covered in its own PID, separately to this SOC) and through its historic ties is interested in operating as a spoke to the Kempston MCCC. The surgery in Wootton was established circa 15 years ago, prior to which residents of the village registered in Kempston. Creation of the MCCC in Kempston would allow Wootton residents to make use of out of hospital services which would not be economically viable to deliver in Wootton.

The PCN has enabled the three Kempston Surgeries to commence jointly commissioning new services. Notably this includes social prescribers who are partly based in the Cater Street surgery as it has some capacity, but supports patients from all three surgeries.

2.1.3.1 Impact on existing service configuration

Within all of the surgeries, space has become a major limiting factor in their ability to serve their registered patients and meet the needs of a modern primary care system requiring significantly more than the traditional GP consultation rooms.

Surgery	NIA of clinical space	Patients /sqm	Projected patients /sqm by 2030	Consequence
Cater Street	139	29	32	At 29 patients/sqm the practice is deemed constrained and will suffer from increased waiting times during peak times.
King Street	345	36	41	Over 29 patients/sqm the practice is severely constrained and will face long waits to see a GP at all times of the year. Its ability to provide services beyond its GMS contract is very difficult due to the space required.
St Johns	163	38	43	Over 29 patients/sqm the practice is severely constrained and will face long waits to see a GP at all times of the year. Its ability to provide services beyond its GMS contract is very difficult due to the space required.

Table 3 - Surgery Information

The lack of rooms for the provision of out of hospital services means that GP consultation rooms are used for these purposes where possible. Whilst this intensive use of space is beneficial, the lack of alterative space for GPs to work foreshortens any possible gains. None of the surgeries have alternative space for GPs to work beyond a consultation room. As a result, consultation rooms have to be used for telephone call appoints to patients when they could be conducted in more cost effective back of house space, had space been available.

2.1.4 Local body support

Although addressed separately in this section of the SOC, BBC and BCCG have had an equal role in the development of the SOC and recognise the need to improve capacity and robustness of the primary care network in Kempston.

2.1.4.1 Bedford Borough Council (BBC)

The Council has undertaken procurement of this SOC on behalf of BBC and BCCG to unlock OPE funding. Whilst the council is not responsible for the provision of primary care services, it recognises that it is an integral component in the range of public services that are provided to the town and the significance of having a fit for purpose healthcare system. The Project Team assembled to complete this SOC includes representatives from BBC, include Health, Property and Planning.

A number of Public Health bodies are expected to locate into the MCCC upon completion. Whilst their mobile nature of working makes it unlikely they will require back-office space, they have

recognised that the facility will be ideally positioned to provide a central point from which services can be provided.

Throughout the creation of this SOC the Mayor of Bedford and Chief Executive of the Borough Council have been directly involved at all stages.

2.1.4.2 Bedfordshire Clinical Commissioning Group (BCCG)

As the organisation responsible for commissioning and managing the GMS contracts in Kempston, the CCG is intrinsically involved in the creation of this SOC. A number of representatives are present on the Project Team and they have facilitated engagement with frontline care providers, including the three GP surgeries and other healthcare stakeholders.

As part of the adoption of this SOC the accountable CCG officer for Kempston MCCC SOC authorship has presented the completed document to the CCG Board.

2.1.5 Alignment with BBC strategic priorities

BBC has established the Bedford Borough Joint Health and Wellbeing Strategy (2018-2023) with the vision of facilitating "***residents [to be] able to live healthy and independent lives, in strong and safe communities with easy access to high quality and efficient public services when they need them.***"

The Joint Health and Wellbeing Strategy is informed by the Joint Strategic Needs Assessment of the health and wellbeing needs of Bedford Borough. It responds to the needs of local residents, but also acknowledges the ongoing evolution of service delivery whereby BCCG have come together with other CCGs, namely Luton and Milton Keynes to form a Sustainability and Transformation Partnership (BLMK STP). The BLMK STP has the 'triple aim' of improving health and wellbeing for residents, improving the quality of health and care services with more joined-up working, and tackling the financial and workforce challenges faced as a system.

The overarching ambition of the Health and Wellbeing Board remains to improve the health and wellbeing of residents and reduce health inequalities, and to achieve this a life course approach will be maintained, that is ensuring plans are targeted at critical points throughout life: giving children and young people the best start in life, and enabling adults and older people to live well and remain independent. However, the health of residents and communities is also shaped by the conditions in which they live, the extent of social connections, and whether they have stable and supportive work. These are some of the so-called wider determinants of health, and to promote efforts to tackling the wider determinants of health a third priority has been included: promoting strong, safe and healthy communities.

Three cross-cutting themes run through the three priorities of the Joint Health and Wellbeing Strategy:

1. The need to embed prevention and early intervention throughout services, in order to reduce the burden of ill health and need for costly health and care services.

2. Addressing mental health and ensuring lifelong mental wellbeing and resilience.

3. Tackling health inequalities, targeting resources proportionately towards the most disadvantaged and be mindful of the likely impacts of plans on the most vulnerable groups.

Whist it is recognised that greater emphasis on prevention may slow growth in demand for health and care services, it is imperative in the current financial climate that the actions agreed are delivered within the respective resource envelopes of the partner organisations.

Delivery of a MCCC in Kempston will support the achievement of these aspirations through improved access to primary care and the co-location of primary health services, reducing demand on in-hospital services. Whilst GPs will provide mental health support, it is in the intention of the MCCC to work with additional mental health support organisations who would provide access to mental health services in the MCCC. Their co-location would ensure a closer alignment of services tailored to the needs of the individual.

2.1.6 Alignment with BCCG strategic priorities

BCCG has set out a number of strategic priorities:

Objectives	Response
Commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice.	The existing primary care estate in Kempston is in need of modernisation to provide buildings and clinical spaces that meet current day standards. To ensure that it is sustainable, its capacity needs to be expanded, to address the significant increase in service users and the drive to provide more local healthcare targeting the causes of poor health. Reducing the causes of poor health not only leads to a healthier population, but reduce demand on secondary and tertiary levels of health care which are more costly to deliver. The MCCC follows the proven and documented approach of delivering a range of primary care services cooperatively between a range of healthcare professionals and patients.
Ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	Elaborated in further detail later in this document, the MCCC financial models demonstrates the overall viability of the proposal.
Engage with both local councils and also our partners across the wider health economy working on plans to strengthen primary care, improve outcomes and integrate services for the populations we serve.	Throughout this project the collaborative approach between the Council and CCG has supported the development of a viable and deliverable option.
Support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	Although the Project Team chose not to consult with service users at this early stage in the development of the MCCC, service providers have been consulted and around 30 different services are anticipated to be delivered from the MCCC. In addition, these services will be provided in a range of spaces including

	consultation, treatment and multifunction rooms with sufficient capacity to meet the planned and evolutionary needs of service users.
Govern with transparency, comply with best practice and meet our statutory obligations.	This SOC will reviewed internally by the CCG and its outputs carried forward where appropriate.

2.1.7 Clinical Strategy and Commissioning Intentions

The proposal seeks to expand the range of services that can be accommodated in primary care buildings to reduce the need to attend hospital. To achieve this BCCG will continue its trend of commissioning services outside of the hospital environment. The current estate lacks the space within surgeries to provide these services whilst continuing to meet requirements of GMS Contracts. As a result, services have been provided in a range of location and building types sourced by providers. Such practices are not conducive to overseeing the interconnected needs of patients, whilst provision of healthcare across a myriad of locations can be confusing and unreliable.

Explicitly excluding accommodation payments from future commissioned services and replacing with a stipulated location would be an effective way to consolidate services towards the MCCC. This would require further development and financial modelling at an OBC stage ascertain how the finances would operate for recharging of space. For their part, services contacted as part of this SOC were positive to idea of collocating with GPs where they didn't already. Those that already provided services from a surgery setting were keen to maintain and expand the arrangement, but were prevented by the estate. They also felt it increased the quality of the service provided.

2.1.8 Promoting integrated working between health, social care and public health

2.1.8.1 Integrated working

A number of services, including social prescribing are currently provided from the existing surgery estate. However, in the case of social prescribing, it can only be provided from Cater Street Surgery as the other surgeries lack the space to accommodate the service. The service was highly complementary of the opportunity to provide services from the Cater Street surgery, although as it is the smallest of the three surgeries, opportunities for interactions between other healthcare professionals within the PCN were limited and expanding the reach of this service was curtailed by the estate. All services contacted in the preparation of this SOC were supportive of opportunities to work closer with GPs.

As part of a separate proposal, discussions were held with Wootton Vale Healthy Living Centre regarding the re-provision of their current building. They Wootton surgery is part of the same PCN and has been working increasingly closer with the other Kempston surgeries in identifying how they could work with a higher degree of integration.

2.1.8.2 Improved access

Expanding access to the GMS elements of the building services is limited by the contractual constraints of the contract which provide a limited number of hours. However, it is envisaged that other services could easily expand and in the building model, have been calculated over a 12-hour day (0800 – 2000hrs), including some weekend access has the building open for 66 hours per week. Currently, the estate operates from 0800hrs to 1830hrs 5 days a week with one surgery

open every other Saturday morning and as a result the new MCCC will be operational for an additional 13 hours per week.

As expansion of the GMS contract is limited, it is envisaged that activity in the evenings will focus on Extended Hours, Extended Access and those services delivered by visiting healthcare professionals.

The NHS aspiration for 7-day services is possible, but currently there is no aspiration within the PCN partner to offer this service. The two smaller surgeries have limited numbers of existing staff and a move towards 7-day service would only be possible through additional recruitment. The CCG is actively engaged with these surgeries specifically around transitioning them towards a more robust service delivery model. Once complete, it will be possible to investigate increasing the number of operational days.

The role of the SOC is to test the overall viability of the proposal and it is not within the remit of this document to drive changes in how surgeries should be managed. However, it does note that increasing service provision across a 7-day working week would allow the proposed MCCC to operate more intensively and therefore be smaller and therefore cost less to deliver.

The current primary care estate within Kempston is comprised of three sites spread throughout the town. Provision of a single site will inevitably reduce the accessibility of services to those who live adjacent to the existing surgeries. However, it should be noted that older surgeries, such as in Kempston, where often sited where land or buildings permitted and the robust processes that is being enacted as part of this SOC were often not undertaken historically, or if they were, urban areas have often evolved to such an extent that the original considerations are now obsolete. Later sections of this document expand upon this point, quantifying impact of accessibility and ultimately concludes that some patients within a 15-minute walking radius of Cater and St John would be disadvantaged, however anyone traveling by public or private transport will be unaffected or benefit from increased accessibility.

2.1.8.3 Strong public and patient engagement

The Project Team, including the CCG felt it would be inappropriate to consult with patients or patient representative bodies at such an early stage in the process whilst there remains a significant number of variables and uncertainties. The Team agreed that it would only be appropriate to talk with these stakeholders from the OBC onwards.

However, all parties have been mindful of the impact on patients any major change to the existing surgery structure of Kempston. Key factors such as relocation distances service provision have been studied in detail.

2.1.8.4 Consistency with current and prospective need for patient choice

Development of a new MCCC in Kempston will alleviate the current constraints on the primary care estate that by enlarge prevent patients being offered a choice over their primary care. Shortfalls in the current estate mean that there are rolling closures of patient lists which prevent patients choosing which of the three Kempston surgeries they wish to register with. In addition, the under-provision of space within each surgery curtails the number of appointments each surgery is able to offer despite maximising the potential of the GMS contract. As a result, there are perpetual waiting times to get a GP appointment which substantially worsen during peak times. These restrictions on the primary care estate increase the risk of patients presenting themselves at A&E or walk-in centres, butting strain across the entire healthcare network.

2.1.8.5 Clear, clinical evidence base

The building model developed as part of this SOC are based on HBN11.01 guidance for the calculation of consultation and treatment rooms. The process calculates the number of appointments per annum needed to satisfy the needs of the patients and calculates the number of appropriate rooms needed to meet these needs. Room sizes are also based on HBN guidance.

The guidance does not provide a method for calculating the quantity of rooms needed to deliver the other services identified in this SOC. However, the same process has been applied by calculating the number of hours each service will be provided for from the building and ascertaining the appropriate number of rooms needed to fulfil this need.

As part of the OBC this will needed to be further developed and a 'timetable' developed showing hour-to-hour how each room is envisaged to be used. The OBC will also allow for percentages to be converted to fixed dimensions, specifically Circulation, Engineering and Planning spaces.

2.1.8.6 Support for proposals from commissioners

Bedfordshire CCG has been heavily involved throughout the development of this SOC. This has included attending all team meetings and being present during meetings with stakeholders. The CCG has also reviewed the content of this document at an officer and Board level.

2.2 Location

2.2.1 Geography

Kempston is town located on the edge of Bedford, within Bedfordshire. Neighbouring major developments include Milton Keynes and Luton.

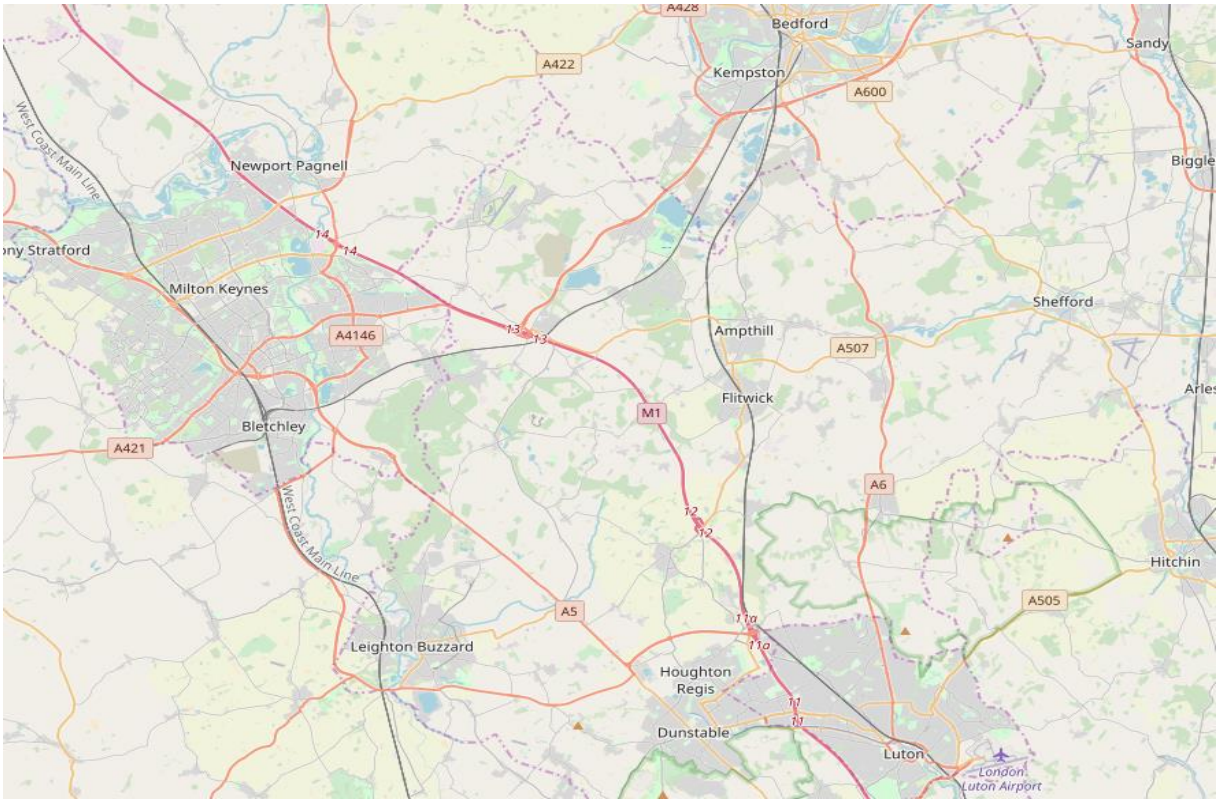


Figure 2 – Bedfordshire location plan

Although a settlement in its own right, its expansion and that of Bedford have merged into a small conurbation. Despite this Kempston retains its own identity, in part helped by the railway line which has only a few crossing points and runs on the boundary of the two settlements to the East of Kempston. Meanwhile to its north Kempston is separated from Bedford by the River Great Ouse. The southern and western boundaries of the town are typical urban fringe and merge into open farmland. In recent years this edge has been pushed out through new housing developments. Given the housing pressures in the area and absence of any other immediate settlements, it is likely that the southern and western boundaries of Kempston will continue to press outwards as more housing is built.

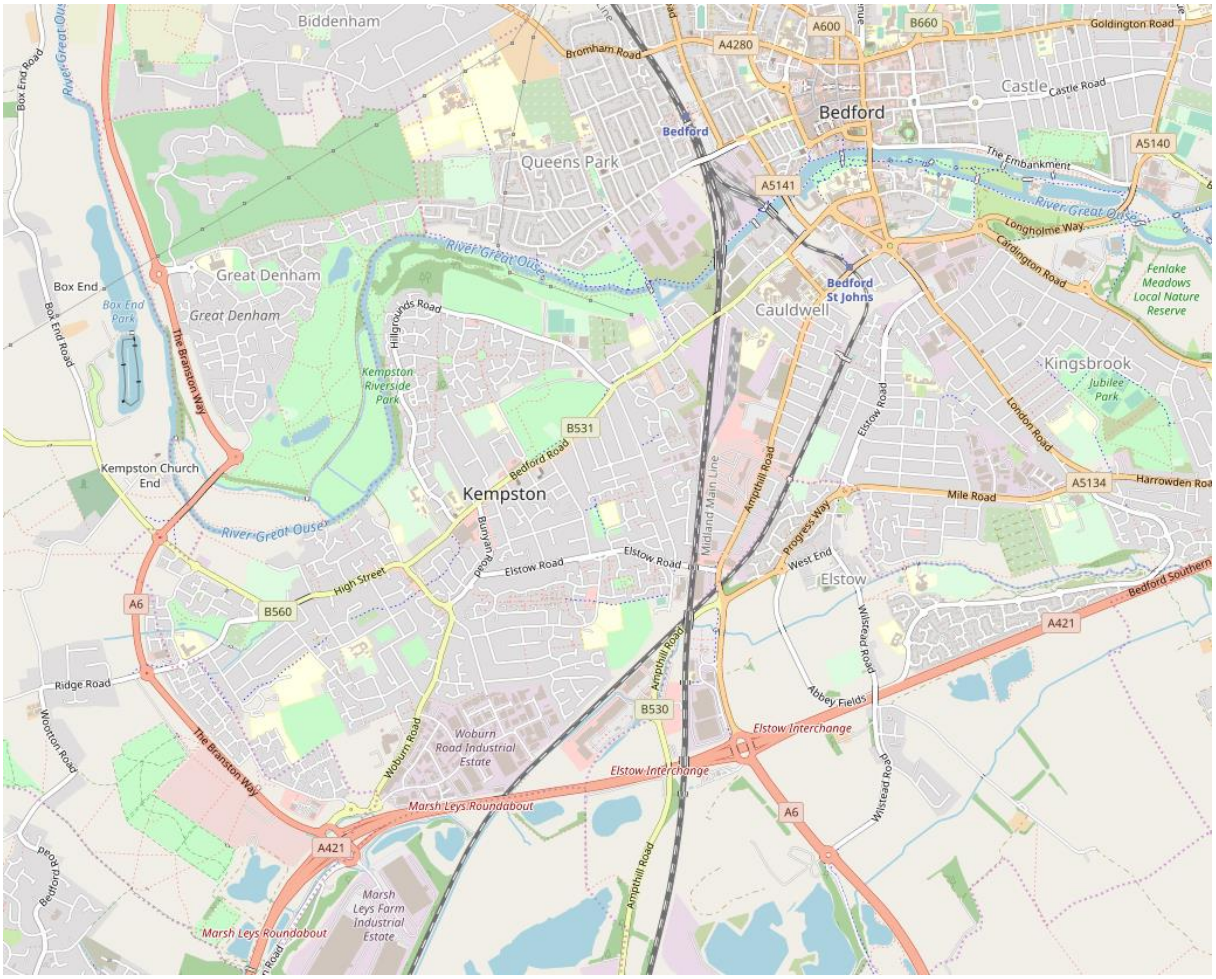


Figure 3 – Kempston location plan

Kempston is comprised of the following Wards: Kempston North; Kempston Central and East; Kempston South; and Kempston West. The population is around 22,000 residents although more from the surrounding rural areas make use of the shops and services within the town. Over the coming years it is likely that this number will increase by around 7,000 additional residents as a result of new housing. Most of this expansion will be in Kempston South and Kempston West wards.

Figure 4 - Kempston Wards

2.2.2 Key urban characteristics

The main arterial route through Kempston is Bedford Road, on which the majority of shops and services are situated. The town has a 'high street' arrangement rather than a defined urban core with shops and services spread along the road. However, the Saxon Centre complex, which includes a Sainsbury's, is regarded by most residents as the town's centre despite it having few other services other than a large underground car park.

As urban development continues in the south and west of the town, its epicentre will start to follow and migrate. However, the lack of any retail properties at the western end of Bedford Road will curtail this effect by in large.

Bedford Road acts as a collector for most of the town's traffic. Most roads lead onto Bedford Road and as a result a large number of bus routes pass along it and it can become congested with private traffic during peak times. Bus lanes help to keep public transport flowing.

2.3 Equality and Diversity

The proposal will support the advancement of equality and diversity through significant improvements to the physical estate. Two of the three current buildings are unable to accommodate patients with impaired mobility throughout the building, who are limited to the ground floor only. In addition, the buildings have restricted internal corridors and communal areas.

Access has been improved to align with legislation and the Public Sector Equality Duties, however it is often through retrofit, rather than implicit within the design. Development of a new MCCC will enable barriers to access to be designed out and the building supported by a lift allowing access to all areas of the building for health workers and patients.

2.4 Healthcare activity demand and capacity projections

2.4.1 Population change

Bedford Borough is home to around 171,625 people, a figure that has grown significantly in recent years due to large scale housing development. This picture is being replicated throughout the Cambridge – Milton Keynes – Oxford Corridor.

Despite the current geopolitical uncertainty, housing demand is likely to persist and this can be seen in the new housing sites that are coming on line and the maintenance of housing land value.

Much of the population change will come from new housing development, as unlike some other locations, there are few sites which could be converted into residential. In addition, there are only a few small brownfield sites within Bedford. The combined effect of this will be to push housing development to the peripheral locations of Bedford. This includes Kempston which sit to the south of Bedford. Although the two settlements abut on the northern and eastern flanks, Kempston has farmland to the south and west which are identified for development.

In addition, the settlements to the south, such as Wootton and Stewartby are likely to expand. Their current size is insufficient to support many services of their own and whilst this might change over time, initially residents of these settlements will use Kempston and Bedford for retail, employment and accessing services.

The Caritas Medical PCN has a patient list size of 43,972. Of the surgeries in Kempston, they have a combined list size of 22,743 patients. This is anticipated to increase significantly as new housing comes on line in the contractual catchment areas of the PCN.

2.4.1.1 Projected housing change

Planning permission has been sought or granted for a number of new major housing developments planned within the existing catchment areas of the three Kempston GP surgeries:

- Up to 2023 **1481 new homes**
- Up to 2027 **2040 new homes**
- Up to 2035 **3040 new homes.**

The 3040 new homes that will be built within the Kempston Surgery catchment area are expected to increase the population by 7298 individuals based on Bedford Borough Council's standard of 2.4 residents per home.

A breakdown of the sites identified have been included in Figure 5.

Whilst other development sites are active across Bedfordshire, they have been excluded as they fall beyond the contractual catchment area of the three existing GP surgeries in Kempston and those populations will be serviced by other primary care services within Bedford CCG.

However, there are two large areas of land that are expected to be identified for housing with a combined estimated area of 14 acres over the next 2-3 years. Housing densities typically exceed 30 properties per acre for urban areas. If this is developed it would bring an additional 1,000 residents to Kempston. As this is speculative and has not received planning this has not been included in this report.

2.4.2 Demographic change

As with the majority of the UK, the population in Bedford and Kempston expected to live longer whilst birth rates will remain relatively static. By 2041 the number of patients over 75 years old will have increased by 50% and the number of patients over 85 will have virtually doubled. In Table 4 the current population is shown with the bars with the predicted population shown in the lines. Whilst the number of pre-retirement aged patients is expected to remain unchanged.

Under the age of 60, the 2016 and 2041 populations are very similar, confirming that birth rates will remain constant. After the age of 60 the trends diverge with significantly more over 60 year olds in the population by 2041.

A larger number of older people in the community will create different demands on the health services. One factor will be an increased demand on managing health conditions associated with older age, namely mobility and cognitive function. Many of these conditions can be effectively treated in the community if support is available.

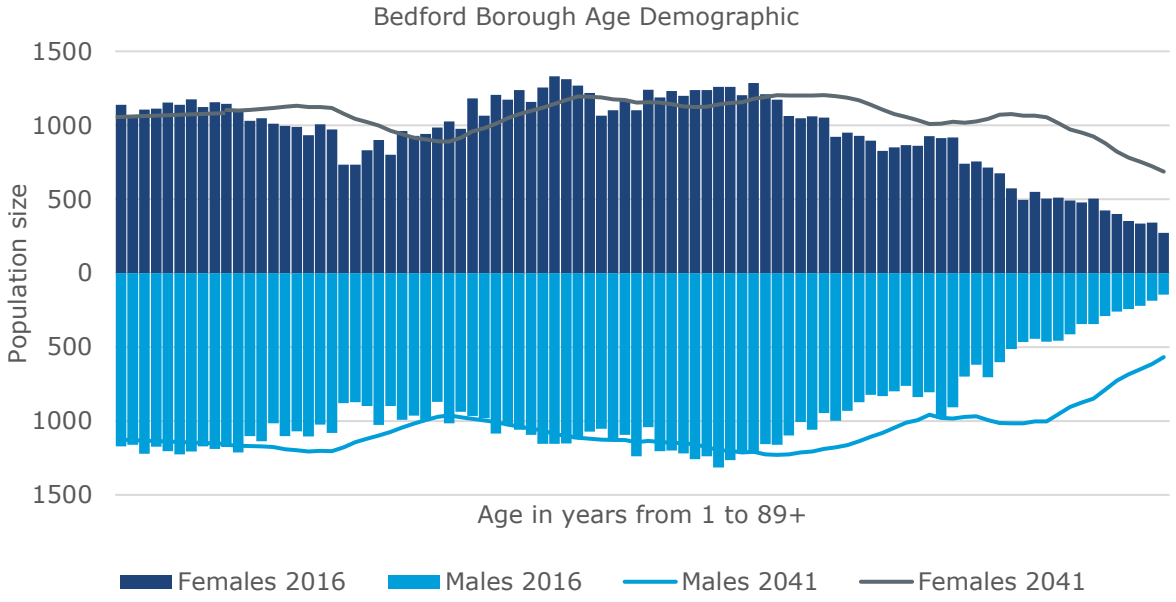


Table 4 – Bedford Borough projected age demographic

As identified in the services to be provided form the MCCC, the new building provides a significant amount of space for services that are able to assist in the management of long-term health issues at a community level.

2.4.3 Capacity

The size of the three Kempston surgeries is set out in the table below. It provides the net internal area of each surgery and excludes ancillary space such as training room and pharmacies. Exclusions of these facilities aligns the space calculation with the NHS England Space Maxima Schedule to allow a standardised comparison of the three surgeries against the expected clinical space the NHS sets as being needed to treat the patient list size.

Surgery	Patient list	NIA (excl ancillary space)	Patients/sqm[1]
Cater Street	4,029	139	29
King Street	12,287	345	36
St Johns	6,247	164	38

Table 5 – Existing surgery space standards

The Maxima schedule considers any surgery with a patient/sqm ratio of more than 29 patients/sqm to be constrained.

As can be seen, none of the surgeries have room for expansion of their patient list. St Johns has closed its list to new patients due to the lack of clinical space it has available. King Street remains oversubscribed how due to a lack of alternatives it is required to keep accepting new patients. Further increases in population will exasperate the situation.

Over the next 15 years it is expected that 583 additional people will register with the Kempston surgeries. This figure has been jointly agreed by the Project Team which includes representatives from the CCG and Local Authority who have verified these figures on behalf of the project. Using the Maxima estimator, this would need an additional 32sqm of clinical space to meet demand. However, this would be in addition to the current shortfall of 762sqm already missing from Kempston.

2.5 Space requirements

2.5.1 Department for Health Guidance

The Premises Maxima Size Schedule recommends 16 patients per sqm and has been robustly tested nationally, forming the basis for sizing GP surgeries for a number of years. The following equation sets out how the maxima can be calculated and uses the example of Cater Street from Table 5 above.

$$\frac{Patient\ list\ size\ of\ practice}{Net\ Internal\ Area\ of\ practice} = \frac{Patients}{sqm} \quad eg. \quad Cater\ Street\ = \frac{4{,}029}{139} = 29$$

Through PCNs and the expansion of primary care services there is some concern that moving forward this space allocation would be insufficient to house the additional services.

BCCG adopt the same space guidance when calculating GP rent reimbursement for GP surgeries of 16 patients per sqm. However, HBN guidance is generally silent around how space for PCN's should be calculated.

[1] Patients/sqm is based on the BCCG's calculation for surgery and the NHS England Space Maxima Schedule of 16 patients per sqm.

2.5.2 Engagement feedback on capacity requirements

As part of the preparation of this SOC, meetings were held with each GP practice. The availability of space was discussed and in general reported as insufficient for the needs of each surgery.

Part of these discussions including the list of PCN services that are currently undertaken at the surgery. Further discussions were held directly with PCN partners who highlighted that provision of their services within a GP surgery environment would help provide a more integrated approach to care and improve patient treatment.

Both GP and healthcare partners detailed the services that are currently provided within the PCN and the number of hours per week that are needed to deliver these services. This allowed the project to build up a specification for how much space would be needed to consolidate PCN services within the proposed building.

Room sizes were led by guidance from HNB11.01.

The total space allocation was then verified by the Project Team.

2.5.3 Agreed size and scope

In total, the Project Team and its stakeholders developed and agreed the following requirement as being sufficient to meet the combined needs of the three practices and a proportion of the PCN services. It was noted that this proposal covers 3 of 6 surgeries within the Caritas PCN, it is expected that some PCN services would continue to be provided at the other surgeries not included in this study.

Key requirements:

- Total expected patient list **23,326**
- Anticipated total annual contacts **121,344**
- Consultation rooms required **18**
- Treatment rooms required **4**
- Multifunction rooms used by PCN stakeholders **13**
- Car parking spaces **105.**

Notably, the recommended number of consultation rooms has remained the same and the number of treatment rooms has been reduced. However, those rooms intended to be used by the PCN is proposed to be increased from 3 to 18, indicating the significant strain that implementation of the PCN will have on the existing estate should investment not take place. Those rooms intended to be used for PCN services are envisaged to be of a less specialised fit out than consultation or treatment rooms. This is possible and many of the PCN services support mental health, and preventative services that do not need to be provided in a clinical environment.

From discussions with GPs, they are currently facilitating PCN services by using existing GP consultation rooms. This, however, prevents the space from being used by GP to undertake consultations. The proposed mix of consultation, treatment and PCN space reflects an up-to-date special requirement for Kempston where rooms are used in the most efficient purpose and

2.6 Rationale and Objectives

2.6.1 Rationale for Scheme

The proposed MCCC will improve access and the quality of primary health by expanding the areas capacity and joining up a number of primary care providers currently working in a range of un-coordinated locations around the Kempston area. The following table provides a number of specific objectives the MCCC will need to fulfil and how these could be assessed through the OBC, FBC and following completion.

Specific objective	Measurable	Achievable	Relevant	Time-bound
To provide the estate with capacity and improved capabilities	Increasing the number of available appointments through expansion of the building and compliance with the HBN guidance on space	Delivery of a new MCCC would enable the delivery of this objective.	The MCCC will significantly improve access to primary care services in line with the STP's and NHS's objectives of providing more care in the community and reducing attendance at hospital	Delivery of the MCCC is possible in year 2023/24, having allowed for completion of the OBC and FBC, land assembly and development of the proposed building.
To develop and implement a mutually-supportive network of GP practices	Number of PCN surgeries accessing out of hospital services.	Delivery of the MCCC would co-locate a large number of healthcare practitioners, facilitating informal interactions and increasing referral.	Referral to out of hospital services addresses illness and the cause of illness at an early stage preventing it from developing into conditions that require hospital and inpatient services.	1 year following completion of MCCC.
Illness prevention and health promotion	Reduction in the need to attend hospital of in-patient services	Giving people the knowledge and ability, individually and through local communities, to manage their own health effectively.	Preventing ill health and promoting good health by	1 year following completion of MCCC.
Primary, community and social care	Reduction in A&E attendance	Delivering high quality and resilient primary, community and social care	Treating ailments in a primary care setting is more cost effective than in hospitals and prevents	1 year following completion of MCCC.

Specific objective	Measurable	Achievable	Relevant	Time-bound
		services across Bedfordshire	conditions developing to the point where in hospital treatment is required.	
Secondary Care	Reduction in inappropriate A&E attendance	Providing a larger primary care base allow more patients with a wider range of ailments receive treatment in their community without needing to attend hospital	Treating ailments in a primary care setting is more cost effective than in hospitals and prevents conditions developing to the point where in hospital treatment is required.	1 year following completion of MCCC.

Table 6 – SMART objectives

2.6.2 Stakeholder Engagement

2.6.2.1 Defining Stakeholders

Ensuring a robust engagement process is imperative in ensuring that the SOC mirrors the needs of the local community and its health practitioners. Stakeholder engagement must be timed and coordinated with the progress of the project to ensure that it can provide meaningful input and help guide the process. A full list of stakeholders has been included in Appendix 2.

Stakeholders were initially identified by the Project Team, with a second round of stakeholder identification taking place following the GP meetings. Stakeholders were identified as individuals or organisations that would be central to the MCCC's ability to provide primary care services to the local community and meetings were held with each stakeholder.

The Project Team elected to exclude some organisations, such as charitable bodies as they were felt to be unable to provide any commitment at this stage in the process and their service provisions, whilst desirable, were not essential, with many able to provide their services through the hiring of multifunctional space.

Future OBC and FBC should endeavour to include voluntary organisations as well as reconfirming the requirements of those stakeholders consulted in the production of the SOC.

2.6.2.2 Stakeholder consultation details: GPs

GPs play a pivotal role in coordination patient's use of primary care services. For this reason, they were the first group of stakeholders to be consulted. Consultation took the form of interviews held over three days in August 2019. The interviews used a set agenda, previously approved by the Project Team to identify the current physical condition of the surgery building, its operations, future aspirations of both, together with identifying how a future hub could improve the operations of the practice.

Following the interviews, notes from the meeting, approved by those present, were circulated to the Project Team and have been included in Appendix 3 for reference.

In parallel, meetings were also held with the PCN representative for the Caritas PCN of which all the surgeries are part of. The PCN representative was involved in the site selection process in which the preferred site was identified.

Additionally, GPs and the PCN were consulted on the services that would be delivered from the new facility and the expanded PCN services envisaged for the future.

Key findings from these discussions identified that the estate was a major restriction on the provision of health services and the robustness of primary care in the area. The inability to expand any of the surgeries in the area limits the extent to which the number of an appointments can be expanded to meet the needs of the growing population. In addition, it also prevents new services being delivered as part of the expansion of primary care and out of hospital services envisaged for the PCNs.

The constraints of the estate also deter new GPs from joining the PCN at all levels. This increases the risk around the legacy planning for the surgeries. Whilst this issue is not unique to Kempston, the culmination of the other factors significantly increases the impact of this risk and limit the PCN's ability to implement mitigations.

The GPs will continue to play a central role in the development of the future OBC and FBC.

2.6.2.3 Stakeholder consultation details: other organisations

A range of other healthcare services and providers have been consulted as part of the preparation of this SOC. Those consulted includes:

- East London Foundation Trust (ELFT)
- Circle Integrated Care
- East of England Ambulance Service
- Bedfordshire Hospitals
- Bedfordshire Rural Communities Charity Children Services
- Cambridgeshire Community services
- Bedfordshire Police.

Through these consultations, around 25 different services were identified that could be located from the MCCC in Kempston. An overarching theme to the consultation was the pre-existence of each organisation's own estate strategy. As a result, no organisation expressed an interest in basing staff from the MCCC on a permanent basis. Organisations tended to operate with well-established mobile working policies and practises. However, many required space from which their services could be provided and reach service users. Common requirements were for multi-functional rooms from which individual or group work sessions could be held.

More specific requirements included multi-function rooms with an external door to enable their services users to enter/exit directly without having to go into the surgery. Also, facilities for making teas and coffees was useful. The option to store materials was also beneficial.

Over the course of the interviews none of the organisations expressed an interest in relocating static equipment into the MCCC, citing relocation cost as the primary deterrent.

As part of the building model the likely number of hours these services would use the building for were calculated. However, in the OBC it will be beneficial to timetable these out to ensure utilisation of the rooms remains efficient.

2.6.2.4 Stakeholder consultation details: Local Authority

BBC were able to commission this report after securing OPE funding for its authorship on behalf of their partnership with BCCG. BBC fully understand the importance of developing a robust network of primary care services to support the existing and expanding population of Kempston.

Within BBC, this project has been over seen by the Senior Officer and Policy Advisor for Health.

Senior and Elected individuals support

Additionally, the Chief Executive of the Council and the elected mayor have both been regularly updated throughout the development of this report and fully support its findings.

Both individuals were consulted following the initial identification of the potential sites. They reviewed all 15 potential sites and fully supported the Project Team in their evaluation of this list of sites to arrive at the preferred option. Following the identification of the preferred site the Chief Executive and the Mayor reviewed the financial model and supported the overall findings of the report.

Local councillors from each of the 3 Wards that make up Kempston have also been directly involved throughout the process. They have personally reviewed the findings of the report as they have been developed and support its overall findings. The local Councillors recognise the importance of improving the robustness of the Primary Care Network in Kempston by ensuring that patients have access to an appropriate number of GP appointments and that overall health and wellbeing of the community is enhanced through additional services that will be provided in the new facility.

Other Local Authority Departments

A number of other Local Authority departments have been involved in the preparation of this SOC. Notably these include Property Services and Public Health. Property Service's role has been in supporting the development of the estate proposal, and identifying surplus land within the public sector.

Public Health have been consulted as stakeholders with an interest in providing service from the completed building. Whilst their own workplace strategy is centred on mobile working, they consider the new MCCC to be a central hub for the delivery of their services to the Kempston community. As a result, their requirements have been included in the space calculation.

Both departments should continue to be involved throughout the subsequent OBC and FBC. This will allow them to continue to inform on property requirements within the MCCC.

2.6.2.5 Stakeholder Engagement Summary

Overall, all stakeholders were keen to be involved in the project as it continues to develop and would like to operate services from the facility. As stakeholders currently have existing back-of-house estate strategies in place, none were seeking office accommodation. Additionally, the nature of the work and the manner in which it is procured meant none were interested in take a lease of space within the MCCC, but would like to have access to space within the building to run surgeries/clinics, rent/booking space as required.

As a result, it is recommended that all stakeholders continue to be engaged throughout the development of the OBC and FBC.

2.7 Risk

The emerging nature of the PCN initiative and the infancy of this proposal present a number of generic risks that would be expected at a SOC stage. These are:

- National and local strategic priorities continue to develop and change
- How PCNs will operate is only now beginning to be tested and there are few examples of best practice
- HBN Guidance documents which have guided the primary healthcare estate have not been updated to respond to the new estate requirements of PCNs and their extended range of out of hospital services
- Stakeholders, whilst consulted as part of the SOC, have not made any firm commitments
- Funding initiatives needed to deliver this project are not yet announced at the time of writing
- Viability of the overall scheme may change due to economic forces as the future Outline and Full Business Cases are written.

The production of the OBC and FBC will go some way to removing a number of these generic risks as well the project specific risks identified in the next section.

A risk register of the associated risks of the project has been included in Appendix 4.

2.7.1 Conclusion

The expected outcomes and benefits, as well as the mains risks, key project constraints and dependencies from this scheme have been identified, developed and agreed by the Project Team during the development of this SOC. They have been assessed against national, regional and local healthcare policies to ensure they align with current key objectives.

These have been combined with following Economic Case to set out the details of how a solution can be provided for health care challenges currently faced in Kempston within the wider framework of the STP and NHS.

3 Economic Case

3.1 Introduction

The purpose of the economic case is to identify and appraise the options for the delivery of the MCCC and to recommend the option that is most likely to offer best value for money. The first stage of the economic case explores the preferred way forward by undertaking the following actions:

- Reviewing population changes and confirming need
- Develop and evaluate the long list of options
- Recommend a preferred way forward in the form of a shortlist of options.

The economic case explains how this is achieved by, identifying and appraising a wide range of realistic and achievable options, known as the "long list and assessing each site against key criteria to identify those sites that are deliverable and economically viable.

The shortlist was evaluated by undertaking both a qualitative analysis using the benefit criteria derived from the SIO and a quantitative analysis which involved applying a Discounted Cash-Flow (DCF) technique. The qualitative analysis involved participation by the Project Team to ensure objectivity in the process.

The quantitative analysis of the shortlisted options was undertaken on the basis of the HMT's "Appraisal and Evaluation in Central Government" rules and supplementary guidance which are mandatory for investment appraisal in the public sector. It should be noted that affordability is considered separately in the Financial Case of this Business Case.

3.2 Locations

3.2.1 Potential location

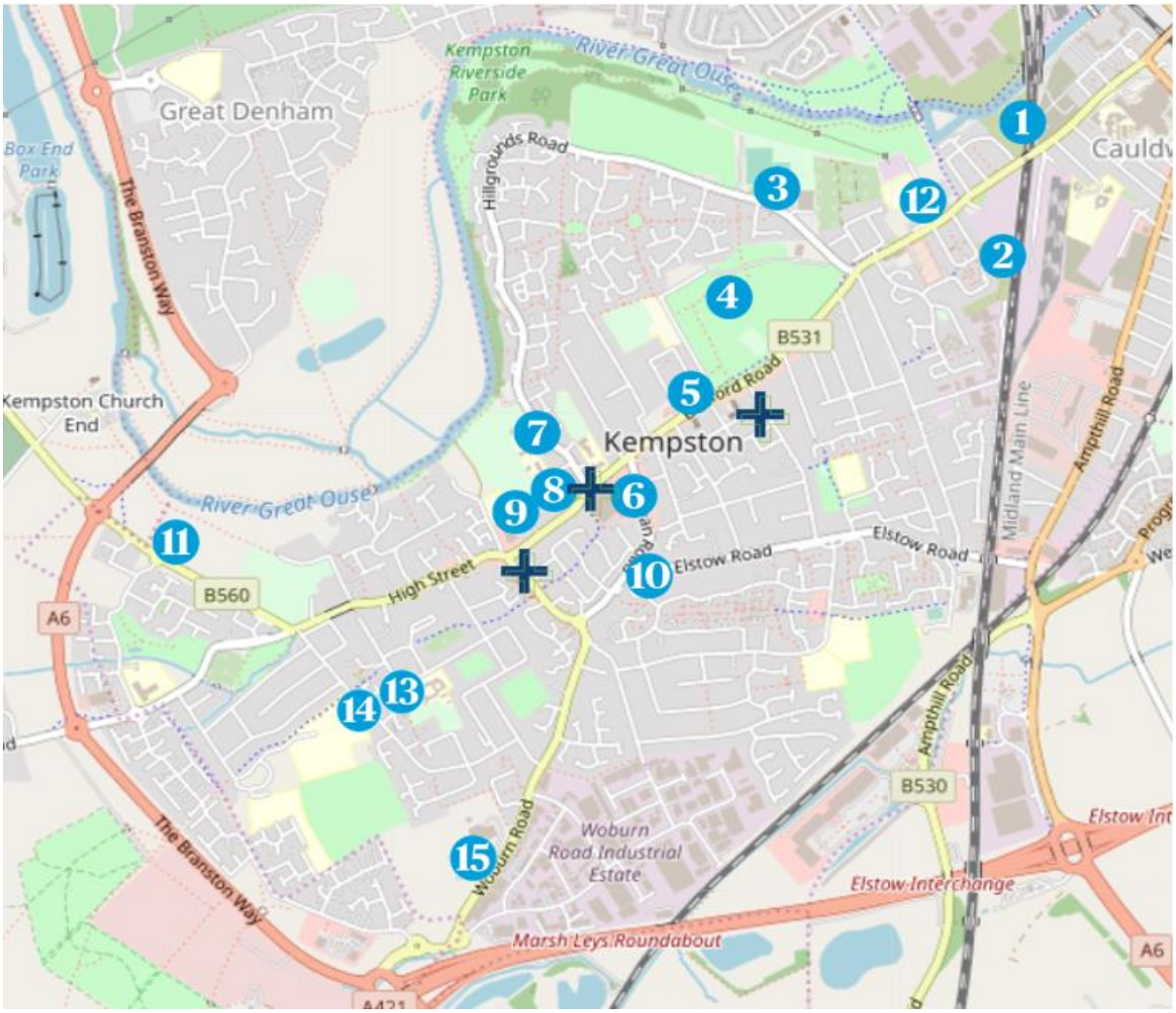
An initial search of the area revealed 15 undeveloped sites within Kempston. Peripheral sites on undeveloped land beyond the edge of the urban area were not considered as they were felt to be too remote, lack public transport and would be detrimental to the environment.

All vacant sites within the 4 Kempston wards were included on the site. As the MCCC is evolved and refined through the SOC to FBC, the building may increase or decrease. Highlighting all potential sites will assist the OBC and FBC in validating the site selected still remains the most appropriate. In addition, it will provide future Project Teams with a full rationale of why certain sites where not favoured during the SOC.

Other key factors that were used to identify potential sites included:

- **Size** – is the site foreseeably able to accommodate a building and car park
- **Surplus to requirements –** is the site vacant, undeveloped, due to be vacated in the foreseeable future?
- **Certainty of acquisition** – is it foreseeable that the site could be acquired from the existing owner, or is the existing owner already associated with the project (e.g., local authority or public sector body)?
- **Location and access** – is the site in or around Kempston and is it foreseeable that the site could be accessed by car and/or on foot?

The 15 shortlisted sites are shown in Figure 5 together with the existing locations of the three Kempston GP surgeries.



Site 1	Moorings	Site 10	80 Bunyan Road
Site 2	Beatrice Street	Site 8 & 9	Land adj BT Offices and Offices
Site 3	Land adj. Kempston Pool	Site 11	Land next to pumping station
Site 4	Addison Howard Park	Site 12	Kempston Ambulance Station
Site 5	Kempston Police Station	Site 13	Land next to Baliol Primary School
Site 6	Saxon Centre	Site 14	Land next to Challenger Academy
Site 7	Robert Bruce School	Site 15	Bedfordshire Police HQ

Figure 5 – Map of all identified development sites in Kempston

3.2.2 Site Selection - the process

The process to select a preferred site was agreed by the Project Team and focused on a qualitative assessment of all potential sites in Kempston. A total of 15 sites were identified.

An assessment criterion was developed with the Project Team to assess each site. It focused on four key themes: Access, Impact, Functionality and Deliverability. These four themes comprised 22 points of measures.

Each of the 22 measures were individually weighted based on how important the Project Team believed them to be in ensuring the overall deliverability of the scheme. Those measures which were felt to be essential to deliverability were awarded a higher weighting. The weighted maximum score was 390 points. Evaluation of each site was based on a scale of 1 to 5:

- 5 – Meets or fulfils expectations, going substantially beyond expectations
- 3 - Meets or fulfils expectations
- 1 - Falls substantially short of expectations, objective still achievable, but with notable compromises.

A full explanation of the marking criteria is given in Appendix 5.

A score of 0 was also available should a site fail to meet a basic level of the measure. The Project Team agreed that any site scoring 0 for any measure would be removed from further consideration. Of the 15 identified sites, 8 received a 0 on one or more measures and were discounted from further consideration. Commonly this was for measures such as being unable to form a junction with the highway or the site being too small for the proposed building and associated car park.

The remaining sites scored between 74% and 39%.

Ranking	Score	Site	
1	74%	Site 5	Kempston Police Station
2	47%	Site 7	Robert Bruce School
3	44%	Site 3	Land adjacent Kempston Pool
4	42%	Site 2	Beatrice Street
5	41%	Site 14	Land next to Challenger Academy
6	39%	Site 1	Moorings
7	0%	Site 12	Kempston Ambulance Station
8	0%	Site 10	80 Bunyan Road
9	0%	Site 4	Addison Howard Park
10	0%	Site 6	Saxon Centre
11	0%	Site 8&9	Land adjacent BT Offices and Offices
12	0%	Site 11	Land next to pumping station
13	0%	Site 13	Land next to Baliol Primary School
14	0%	Site 15	Bedfordshire Police HQ

Table 7 – Site selection results

Kempston Police Station scored the best during the assessment process and has been selected as the preferred location for the new MCCC.

The Robert Bruce site, whilst suitable for the development, would need to be brought forward as part of a masterplan for the site and adopted by the current site owner. Whilst this remains possible, there are a number of substantial obstacles in the delivery process that would need to be overcome. Primarily the scheme would need to be adopted by the Challenger Multi Academy Trust, which for which the provision of health services would sit outside its organisational mandate. Inclusion of obligations towards the whole landed needed for the MCCC at a planning stage would be excessive given the size of the Trust's masterplan proposal.

3.2.2.1 Discounted sites – Existing

The project first assessed the existing sites and the ability to be restructured through management and procedure changes to meet the demand. Through interviews held with each surgery and numerical assessments on the space needed to support the Kempston population it was identified that the estate was already being used very heavily and that additional clinical space was required, as shown in Table 5 on page 22.

Internal reorganisation, where possible, had already been undertaken with the surgeries converting back office space into clinical rooms and utilising hot-desking and working from home some years ago.

Even after maximising the amount of clinical space, the surgeries were unable to provide enough clinical space.

Expanded the existing surgeries was then reviewed as a means of meeting the clinical space deficit. However, this had by in large been undertaken with all surgeries having been expanded in the last 20 years through the use of permanent or temporary buildings. These extensions now filled the curtilage of each site, significantly compromising parking provisions and leaving no future room for expansion.

Further expansion beyond the curtilage of each surgery was not possible at a level needed to meet the space requirements of the MCCC as each location would have required the purchase of multiple adjacent plots of land with the high probability that each landowner would hold their site in ransom, thus exposing the project to a significant risk of pay substantially more than the market rate for the land and ultimately undermining the economic viability of delivery.

All existing sites where therefore discounted.

3.2.2.2 Discounted sites – Newly identified

In identifying new sites, the Project Team used a number of guiding principles to help in the identification process:

- The site should be in its respective settlement of Kempston or Wootton to avoid increasing travel requirements of patients.
- Whilst BBC or public body ownership of the site is preferable, it is not essential.
- Empty sites are preferable, although developed sites with a use that could foreseeably be relocated are considered.
- The buildings will be subject to the normal planning and legal constraints and scrutiny. Therefore, public parks or protected open space has not been considered.

- The size of the building is still being considered; however, it will need to be substantially bigger than the existing facilities in Kempston.

Although the criteria for assessing the sites were weighted to reflect each criteria's importance, all assessment criteria were deemed to be important. Therefore, any site where the Project Team felt they could not award any marks for the site, was discounted.

In total six sites had significant failings these were:

1 Addison Howard Park
2 Saxon Centre
3 Land adjacent to BT Offices and Offices
4 Land next to pumping station
5 Land next to Baliol Primary School
6 Bedfordshire Police HQ.

Common reasons for the site being discounted was an inability to acquire ownership or establish access to the public highway or public transport. Full details of can be found in the appended report.

3.2.2.3 Potential sites

The remaining sites where then assessed based on the agreed criteria. Of these, the following sites were identified as the most suitable:

- Kempston Police Station
- Kempston Ambulance Station
- 80 Bunyan Road
- Robert Bruce School (formerly).

Key features that made these sites preferable was their proximity to the centre of Kempston and public transport, public or third sector ownership and certainty of acquisition. Of the shortlisted four sites above, Kempston Police Station was identified as the preferred option. Key features in identifying this as the preferred option were:

- **Size** – The site is able to accommodate the building and associated car park
- **Surplus to requirements –** Although the building is still operational, Bedfordshire Police force has already identified the site as outside of their estate requirements and has begun a project to decommission the site. Consultation with the police estates department identifies that they intend to release the site in Q1 2022. Given the time needed to progress this proposal through OBC and FBC, it is felt that the projects would align.
- **Certainty of acquisition** – Under the One Public Estate, the Police are required to offer the site up to other public bodies before it can be disposed on the open market. As a result of the timescales mentioned previously, this project would be sufficiently mature that by 2022 it could acquire the site for the MCCC.
- **Location and access** – the site already has connections with the highway and is in close proximity to the public transport and the existing surgeries.

Whilst the remaining sites were all potentially viable, the Project Team unanimously agreed that the preferred site was more deliverable and had a smaller impact on the patients and residents of Kempston that the other shortlisted sites.

3.3 Evaluation Criteria

The Project Team jointly developed the following criteria to be used in identifying the most appropriate site. Evaluation criteria were grouped in to four categories; Access, Impact, Functionality and Deliverability. A weighting of between 1-5 was applied to each evaluation criteria by the Project Team prior to undertaking the evaluation of the sites.

Item	Criteria	Weighting
Access		
1.1	Is the site next to multiple bus routes	5
1.2	Is the site next to a bus routes	5
1.3	Is the site in a suitable area	5
1.4	Can a junction be formed with the main highway or is there an existing junction	5
Impact		
2.1	Does the site avoid estate roads which may become congested with additional traffic	5
2.2	Is the site centrally located to existing GP surgeries	2
2.3	Can surrounding parking be utilised	5
2.4	Will there be an ecological impact to the development	3
2.5	Does the site have restrictions on development (protected open space)	3
Functionality		
3.1	Is the location suitable for 24/7 working	5
3.2	Is the site suitable for 24 hour working	4
3.3	Is there sufficient onsite parking	5
3.4	What is the flood risk rating	2
3.5	Are there any complimentary services in the vicinity	3
Deliverability		
4.1	Can the site accommodate what is required?	5
4.2	Is there room for future expansion	1
4.3	Is the site in public body ownership	3

Item	Criteria	Weighting
4.4	Is the site vacant	2
4.5	Does the site align with the project's timescales	4
4.6	Is there certainty of acquisition	2
4.7	Are there any identifiable planning issues	2
4.8	Are there any development controls in place	2

Table 8 – Site evaluation criteria

3.3.1 Results

The site evaluation process was conducted in one session with the Project Team all in attendance.

The following table summarises the results of the evaluation process. A breakdown of the scoring is included in Appendix 6.

Ranking	Score	Site	
1	**74%**	**Site 5**	**Kempston Police Station**
2	47%	Site 7	Robert Bruce School
3	44%	Site 3	Land adj Kempston Pool
4	42%	Site 2	Beatrice Street
5	41%	Site 14	Land next to Challenger Academy
6	39%	Site 1	Moorings
7	0%	Site 12	Kempston Ambulance Station
8	0%	Site 10	80 Bunyan Road
9	0%	Site 4	Addison Howard Park
10	0%	Site 6	Saxon Centre
11	0%	Site 8&9	Land adj BT Offices and Offices
12	0%	Site 11	Land next to pumping station
13	0%	Site 13	Land next to Baliol Primary School
14	0%	Site 15	Bedfordshire Police HQ

Table 9 – Site scores

3.3.2 Engagement feedback on location

As part of the development of this proposal a number of external stakeholders have received updates on the project. This has included the Mayor or Bedfordshire and the Local Councillors who represent Kempston and Wootton together with partners from each of the GP surgeries.

All parties were most recently updated between December 2019 – February 2020 and broadly supported the proposed location. A copy of the presentation presented during December has been included in Appendix 7.

All parties agreed that the central location in Kempston and the opportunity to reuse a site already within public ownership and which the Police had confirmed they were already implementing an exit strategy supported the delivery of the project.

3.3.3 Social vitality and mobility

In comparison to the wider Bedfordshire area, Kempston has a lower level of economic vitality that the surrounding areas. However, deprivation within Kempston is not a major factor in the provision of primary care within the four Wards. Although Kempston North is the most deprived amongst the Kempston Wards, it is limited to small pockets affecting some of the population.

This is confirmed through analysis of those indicators, such as car ownership which shows that Kempston is generally in line or above the national average for car ownership.

3.3.4 Access

3.3.4.1 Walking

One of the foundations of Primary Care is its provision within the community. As a result, it should be as accessible as possible. Whilst not all patients will be able to walk to the surgery, irrespective of distance, maximising opportunities for walking is highly beneficial in measuring how accessible a location is.

The three existing surgeries account for 22,743 patients. Of these, NHS Shape data confirms that 93% of patients are within a 15min walk of the surgery[2]. In Figure 6 the yellow shaded area illustrated a 15min walking time to the nearest surgery in Kempston. The green perimeter line is used to estimate the number of resident's base on Middle Super Output Areas.

[2] Assumes that patients register with their closest surgery

Figure 6 – 15min walk time to existing GP surgeries in Kempston

As the three GP surgeries will be brought together on a single site, their spread through the town will be unavoidably reduced. Following the move to the Kempston Police Station site it is expected that 86% of patients will still be within a 15min walk of the MCCC (Figure 7). Whilst it is less than the current provision it is substantially above the BLMK STP average of 76% of patients and the NHS's target of 69% of 15mins by foot or public transport.

Figure 7 - 15min walk time to proposed MCCC in Kempston

The BLMK STP and NHS statistic combines walking and public transport in its 15min journey times. In the next section estimates of patient accessibility by public transport and on foot will be analysed

3.3.4.2 Public transport

The provision of public transport for key services is essential in ensuring that they are universally accessible and environmentally sustainable.

The following plan illustrates areas of Kempston that are within 15mins by public transport of one of the three GP surgeries. As can be seen (Figure 8, this covers the majority of Kempston, Gibraltar and Wootton to the south and central Bedford.

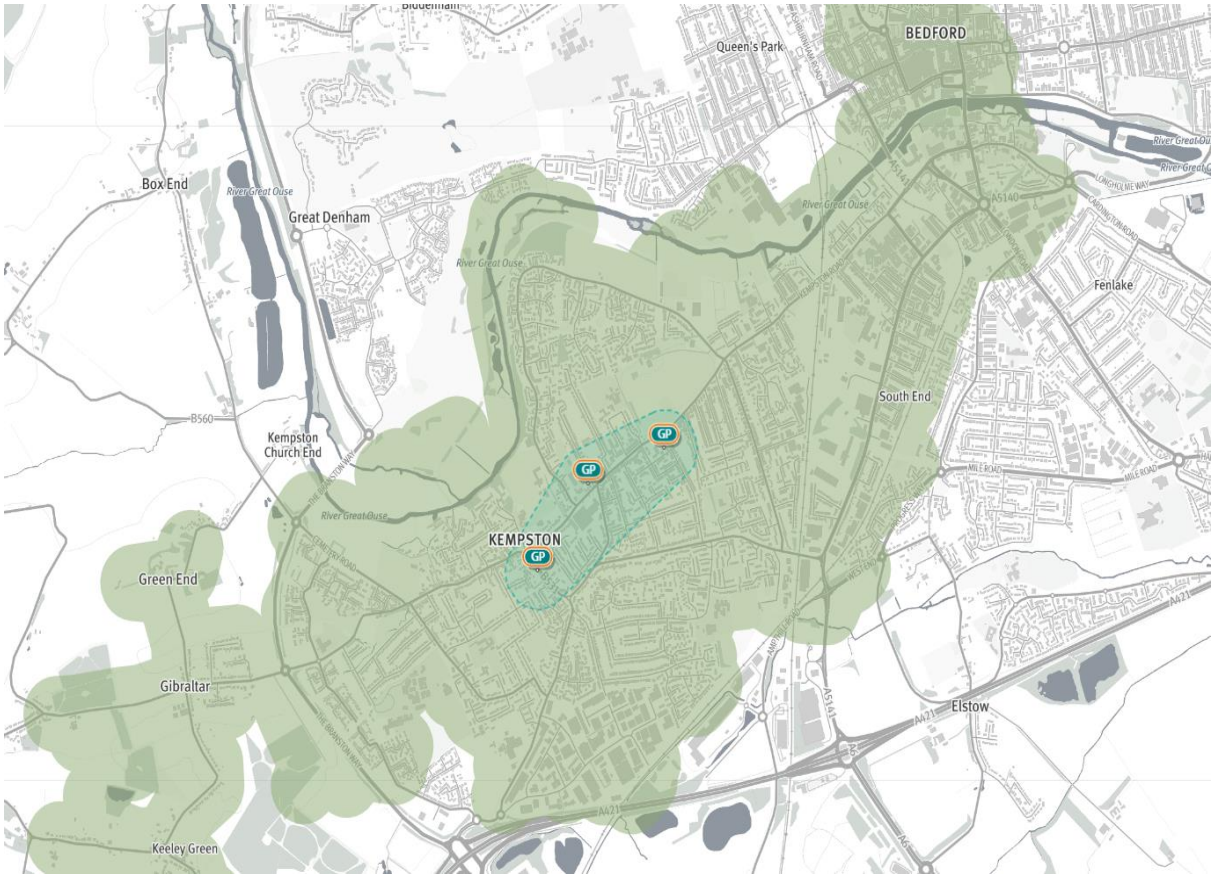


Figure 8 – Areas within 15mins by public transport of a GP surgery

Relocation of the three GP surgeries to the proposed site, as evidenced in Figure 9, illustrates no impact on the residents of Kempston in their ability to access the proposed location by public transport. Impact to any resident further-a-field is minimal as residents of Wootton, Stewartby and Bedford town will continue to enjoy the same travel times as they currently experience when accessing their surgery by public transport.

This outcome is expected as the proposed site sits within the cluster of the existing surgeries and is located on the same bus routes. Bedford Road, which passes through the centre of Kempston and is the main atrial transport route for the town.

The proposed location is within 200m of its nearest bus stop from which seven services depart through the day. The majority of these routes come from the surrounding areas, through Kempston and terminate in Bedford town centre. There are a few local services which travel around Kempston before returning to Bedford, these also pass the proposed site.

Figure 9 - Areas within 15mins by public transport of proposed site

3.3.4.3 Private transport

Providing an integral part of the transport network, private transport is widely used throughout the Borough with most wards in Kempston outperforming the national average of 26% of households having no access to a car.

- Kempston North **25%**
- Kempston Central and East **23%**
- Kempston South **16%**
- Kempston West **28% of households with no access to a car.**

Despite the dependency upon private transport, limiting its requirement is desirable as it reduces congestion, air pollution, noise and the chance of road traffic accidents. For this reason, key services, such as Primary Care can help to reduce the use of private transport by locating centrally, shortening the travel distance for the majority of people and encouraging access by walking or public transport.

Where private transport is needed, BBC planning requirements stipulate a provision of 5 parking spaces per consultation room or on merit in consideration of the travel plan[3]. A travel plan will need to be included as part of the planning application, in which it will calculate the mode of

[3] Non-Residential Parking Standards, Parking standards for sustainable communities.

transport people will likely use in accessing the MCCC. Given the central location of the MCCC in Kempston, it is unlikely that 5 spaces per medical room will be required or desired. Over provision of parking can discourage people from choosing other means of transport and result in large empty carparks in the town centre, which is not only wasteful, but also unsightly and detracts from the cohesion of the urban environment.

As there is already significant parking provisions in Kempston town centre (Saxon Centre), an abundance of bus routes and 76% of patients within 15min walk, it has been anticipated that the total number of parking spaces can be reduced to 3 bays per clinical room and a circa 100 space carpark would be sufficient for the needs of the MCCC. Whilst this will need to be tested as part of the Transport Assessment, it has been used for the purposes of developing cost estimates.

There is no notable impact on patient travel times who access the existing surgeries by car. The existing surgeries and the proposed location have the same catchment within the 10min drive time of 116,334 residents.

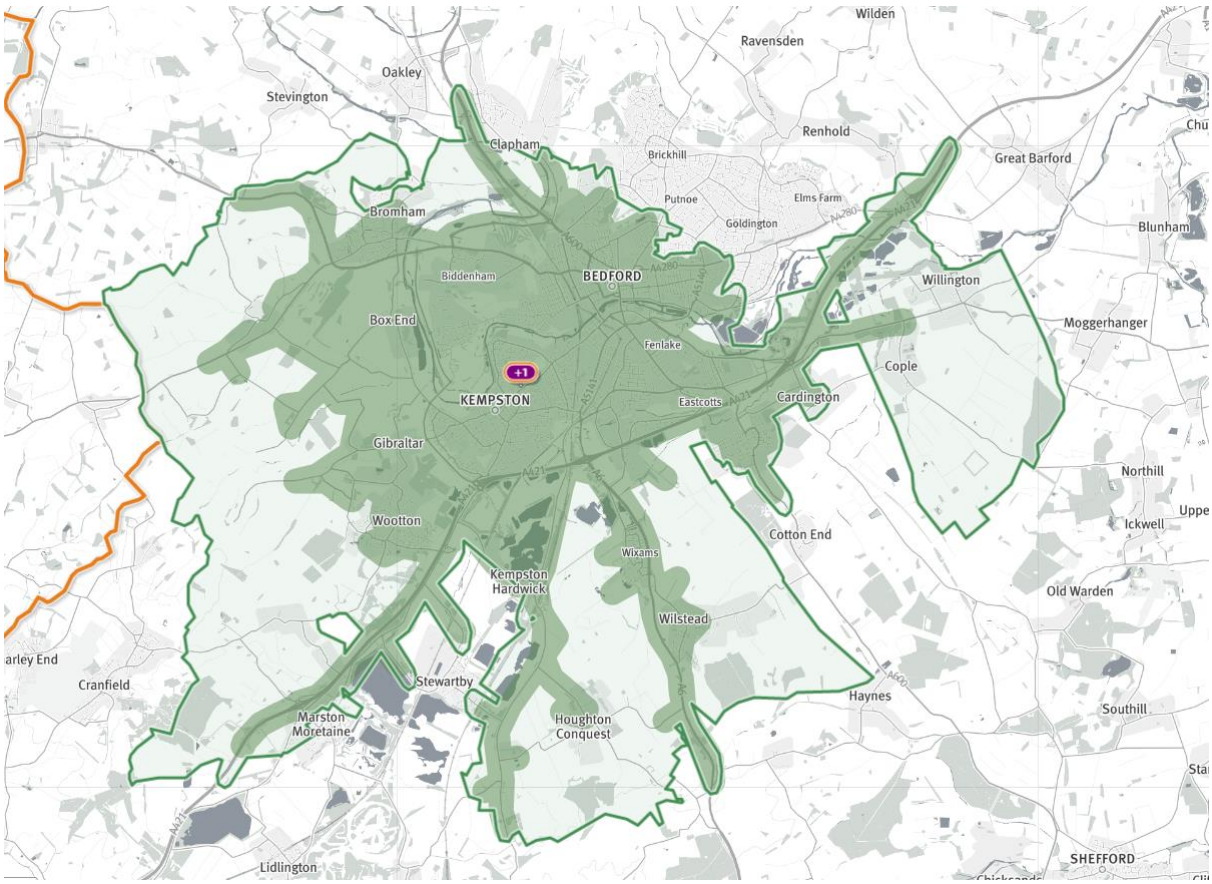


Figure 10 – Area within 15 min drive of proposed site

3.3.4.4 Summary of Mapping

Location plays an important factor in ensuring that patients can access the primary care services they require. Location and site accessibility played an import part in the assessment criteria for the site.

When transitioning from three site to a single central location, it is unavoidable that there will be changes to journey times. However, by including criteria such as bus routes and distances from the

existing surgeries the Project Team have remained mindful of this factor and identified a location that seeks to minimise travel times.

The preferred site of Kempston Police Station is located centrally between the existing GP surgeries and, like the existing surgeries, is located on the main road through Kempston. As is expected, the impact to the majority of patients has been minimised. Those most impacted will be patients on the outskirts of Kempston who walk to the surgery. However, even walking time increases will be minimal with increased journey times around 5-10mins. Those travelling by car or public transport will have a negligibly longer journey time increase.

3.4 Options Appraisal

3.4.1 Assumptions

3.4.1.1 Income

BCCG has stated that the expected rental level for GMS space in Bedfordshire is £225/sqm, however few comparable exist for newly built primary care facilities which could command a higher rent. This would be applied to the lettable area, and is assumed to include all clinical space and areas of the building that directly support this space. It excludes the areas associated with Planning and Engineering allowance, but does include circulation space as this is essential to accessing the clinical space.

The presence of PCN services and the substantial amount of space they require will require further exploration in the OBC. Whereas in health centres built over the last decade have had a small amount of space set aside for out of hospital services, the Kempston MCCC responds to the challenge of providing an increased range of out of hospital services and the building has to increase by around 40% to accommodate these services. It will therefore be unviable for the practices to accommodate these services without recharging for the space if they are unable to claim it as part of their GMS contract. The current specification of contracts issued under the PCN will need to be reviewed and aligned to either include a rental amount, specified location or back to back agreement with the commissioning body and the management of the MCCC to ensure non-GMS services do not need to be subsidised by the GMS contract rent reimbursement payments.

For the scheme to be finically viable at present, a rental income of £353/sqm will need to be obtained across the building. Work associated with the OBC will clarify and potentially reduce the amount of rent needed to make the scheme viable, through the reduction of risk, optimism bias and effective architectural design solutions to reduce circulation and engineering space.

In addition, a small pharmacy is planned to replicate the existing provision at Kings Street surgery. This will also be charged the market rent of £353/sqm.

Annual income from the car parking has been include at £235/bay.

Additional rent reimbursement and associated costs payable to the GP Practice under Primary Care Premises Costs Directions will need agreement and approval by NHS England at OBC stage.

3.4.1.2 Cost of site assembly

Purchase of the site has been assumed at £1.1m/acre as advised by BBC valuation department who have recently undertaken the disposal of a similar site in Kempston. Although the police station site is expected to occupy a 1.2 acres site the police station is 1.3 acres and it is expected that the whole site would need to be purchased. By comparison the Robert Bruce sites is significantly larger and it is assumed that a 1.2 acre site can be carved from the larger title. As a result, the purchase the police station site is expected to cost more because it is slightly bigger.

The existing police station building is assumed to impair the value of the site by the cost of clearance as no party, including Bedfordshire Police, would be able to use the buildings in its current form. It is estimated to cost £583,560 (exc. VAT) to clear the site.

3.4.1.3 Allowance for abnormals

No specific allowance for abnormals has been made, beyond those included in demolition of the site. A desk top survey of the history of the site has identified that prior to circa 1910 the site was used for open space/farming. Around this time the main police station building at the front of the site was built around this time. Subsequent buildings were added over the proceeding 100 years, all associated with the police use of the site.

One of the buildings is used for servicing of blue light vehicles. Although this is a modern construction it is possible that the ground may have become contaminated by hydrocarbons in the course of its use. As this is underneath the existing building, it is expected that intrusive ground contamination survey would be beneficial in ascertaining if contamination has occurred.

It is expected that the OBC and FBC will be responsible for commissioning intrusive condition surveys of the building and ground as this is not normally undertake as part of a SOC. The outcome of these surveys will need to be costed and included in the overall appraisal.

3.4.2 "Do nothing"/ "Business as" usual Option

Developing a viable business as usual option has proven challenging. All three existing sites are landlocked with very limited space for expansion. The surgeries have a combined clinical space deficit of 763sqm against best practice recommended to meet their existing requirements under their GMS contracts.

St Johns surgery, already utilises temporary buildings to provide additional accommodation. These have exceeded their life expectancy and it is no longer economical to maintain/repair.

At the King Street surgery, it has leased adjacent land to enable a wheel chair user access and welfare facilities to be built in addition to a number of clinical rooms. Over the course of the project the landlord terminated the agreement. Cater Street is similarly constrained from developing.

In consultation with the CCG each surgery is able to close its List for a period of time to help distribute new patients across the PCN, however this does not offer a long-term solution, particularly in light of the ongoing housing development in the area.

To address the needs of patients and meet the aspirations of the collaborative working under PCNs a threefold increase in the amount of clinical space is need.

As a result, whilst a 'do nothing' option whilst able to maintain the aging estate, it will be insufficient to address the existing shortfall in clinical space, a problem what will worsen year on year as new housing already under construction, becomes occupied.

3.4.3 Criteria for identifying options

The SOC has identified that substantial increase in the clinical floor space is needed in Kempston to enable it to serve the local population and achieve the goals of PCNs with out of hospital services.

3.4.3.1 Expansion of existing sites

All sites are landlocked and whilst one has been able to lease adjacent land, the landlord has already terminated the agreement in order to secure a higher rent. As the King Street surgery is

dependent on the leased land for is accessible welfare facilities, entrance and a significant number of clinical rooms, there is a significant risk the landlord, could if they chose to, exact increasingly higher rental amounts from the surgery because of this dependence.

Even with additional space leased on the adjoining plot, it there is currently insufficient space in the surgery to meet the needs of patients.

3.4.3.2 Preferred option

The preferred option is to develop a new facility in Kempston that is able to accommodate all practices and provide sufficient clinical space for the out of hospital services to be provided in the same building allowing healthcare professionals greater oversight into a patient's wellbeing.

3.4.3.3 Variant option

Whilst it is preferable to develop a new building capable of accommodating the three practices and a range of out of hospital services, relocating two of the surgeries is possible, however not deemed at this time to be practical. This is due to the size and scales of the three surgeries, two of which are substantially smaller than the third.

To obtain the increases in clinical that is needed by relocating only two surgeries, the most cost-effective solution would be to relocate the two smallest surgeries into a larger building, thus creating two medium sized buildings.

Whilst King Street, operates at scale, with a number of partners, GPs, trainees and range of supporting clinical and non-clinical staff, the Cater Street and St Johns surgeries have only 1 and 2 partners respectively. As a result, their structural capacity to significantly expand does not yet exist. Both surgeries would need to significantly increase their capacity through the recruitment of new GPs and support staff. Such rapid growth would inevitably require any business to take on a substantial amount of debt with which to forward finance the expansion putting stain and risk on the continued operation of the practices.

For the reason of ensuring stable and gradual growth of the three practices in Kempston it is strongly recommended that the largest of the surgeries be involved the new facility.

A further variant would to be relocate all three practices into a new smaller building, whilst keeping the King Street surgery operational. This option is also not desirable. It would require King Street to split its workforce over two sites, resulting in new management challenges and a disjointed primary care provision. Alternately it could create a branch surgery in the MCCC, however the practice has no experience of this type of operation and leading it as a result of an estates solution brings with it substantial risk and potential for error in the long-term maximisation of investment.

3.5 Development Appraisals

A development appraisal has been completed for the Police Station site. A full breakdown is shown in Appendix 8 and Appendix 9. Estimated income for both sites are the same, irrespective of the site chosen.

Total costs follow the same principal, in that each site would cost the same to develop, however the police station is slightly bigger and has an existing building. The cost of demolishing the existing building does not impact appraisal as it is netted off by a reduced purchase price. However, as the site is slightly bigger (but considered too small to carve off from the main title) the police station is more expensive to develop.

Site	Police Station	Robert Bruce
Estimated Annual Income	£666,555	£666,555
Estimated Total Costs	£14,546,800	£14,055,949
NPV at 3%	£0	£490,851

Table 10 – Summary of Development Appraisals

3.6 Risks

The development appraisal has a 10% Risk Allowance and 10% Optimism Bias included. Collectively this increases the build costs by circa £2.2m.

As the project progresses through OBC and elements of the project are de-risked or confirmed, these sums can be released. The released sums can be used to further enhance the proposal, improve the rate of return or reduce the amount of funding needed.

3.7 NPV, Optimism bias and sensitivity analysis

The Robert Bruce site returns a higher NPV primarily due to the absence of remediation needed on the school's playing fields where this site would be located.

Both NPV's assume a 3% yield and rental income of £353.15/sqm (building total rental of £666,555pa). Other operational costs have assumed to be on nil effect on the viability of the scheme and should be developed further in the OBC.

The NPV only illustrates which site has a better financial return and done not consider the overall viability of delivering that site or the fulfilment of the objectives of the MCCC.

3.8 Cost Benefit Ratio

The Project Team agreed to weight scoring or the quality and cost elements of each site on a 40:60 (quality:cost) basis.

The Police Station and Robert Bruce sites scored 74% and 47% respectively. Overall the Police Station is expected to cost an additional £490,851 over the Robert Bruce Site to deliver. As a result, the Robert Bruce site, as the lowest scoring site, received 100% for cost. By comparison the Police Station site received 97% as it is 3% more expensive to deliver.

Site	Site	Cost	Site	Cost	Total
	Unweighted		40%	60%	
Police Station	0.74	0.97	30%	58%	88%
School	0.47	1.00	19%	60%	79%

Table 11 – Cost to benefit ratio

Following the application of a cost benefit ratio the Police Station and Robert Bruce sites score 88% and 79% respectively. The recommended site to be taken forward to OBC is therefore the Police Station site.

3.9 Summary

Cost and quality analysis of each the two preferred sites has identified that the Police Station site in Kempston is the most suitable location for the proposed MCCC. Although slightly more expensive to deliver, its propensity to be delivered, central location and existing use led the Project Team to conclude it has substantial non-fiscal benefits over the site of the former Robert Bruce Middle school.

4 Commercial Case

The commercial case focuses on identifying the procurement route best suited to ensuring delivery of the "preferred option". It includes the planning and management of the procurement of the "preferred option" and is in accordance with European Union (EU) and Word Trade Organisation (WTO) rules and the current regulations for the public sector procurements.

It also specifies the service requirements for the proposed investment in the MCCC, together with the anticipated charging regime and the allocation of risk in the each of the design, build, funding and operational phases.

Finally, it includes the contractual arrangements and specifies the accountancy treatment to be used for the proposed service.

4.1 Procurement Strategy

4.1.1 Procurement options

This section explains potential procurement options available for use within the project, and includes:

- Procure 21+ / Procure 22
- Traditional Tender
- Design and Build
- Private Finance Initiative (PFI)
- Express LIFT
- LIFT Partner: Management of Design and Construction Elements Only
- 3rd Part Development (3PD)
- Social Enterprise
- Joint Venture (JV)

The key issues relating to each of the procurement options are summarised below:

4.1.1.1 Procure 21+/22

ProCure 22 (P22) is a framework of contractors originally set up by NHS Estates (subsequently managed by DH Estates and Facilities) for schemes being procured with public capital. The contractors on the framework have been selected through the OJEU procedure and therefore are not required to go through this procedure again, thus saving time.

A shortlist of contractors can very quickly be selected, interviewed and a preferred contractor selected. The contractor is selected on the basis of their methodology, proposed programme, team and interview. The PSCP would then work with the Project Team to prepare the design and agree a guaranteed maximum price (GMP) before starting on site. This procurement route requires the scheme to be funded through Treasury capital (or through internally generated funds in the case of Foundation Trusts).

Advantages	Disadvantages
▪ Single point contact and responsibility ▪ Inherent buildability ▪ Early Guaranteed Maximum Price (GMP) ▪ Reduced total project time ▪ Partnering approach to problem solving ▪ Early stakeholder engagement ▪ Early design/cost certainty	▪ Sometimes difficult for clients to prepare adequate employer's requirements at an early stage ▪ Client driven changes can be expensive post GMP

Advantages	Disadvantages
▪ Existing relationships and project history ▪ Known up-front charges for project front-end development ▪ Sub-contractor work packages tendered competitively ▪ Open-book accounting ▪ Satisfactory public accountability ▪ Private Sector Competitiveness Project (PSCP) Incentivised ▪ Compliance with the "Common Minimum Standards" OGC, 2006	▪ Not flexible in the event a GMP is not agreed ▪ Is time consuming in the event a GMP is not readily agreed ▪ Potential for design quality to suffer due to the PSCP contractor being possibly cost-driven ▪ Possibility to over-price in order to increase contractor share of savings

4.1.1.2 Traditional Tender

As with ProCure 22, these procurement routes are for schemes being funded by public capital. Both methods require NHS organisations to procure a contractor through the OJEU procedure.

Under this procurement arrangement, the responsibility for construction is in a single contract, separate from the design, utilising either Bills of Quantities or Specifications and Drawings. Bills of Quantities should only be prepared once design has been fully completed. Such a document provides measured quantities that allow competing contractors to price all material, plant and labour used on the project to arrive at a "lump sum" tender for the project.

Advantages	Disadvantages
▪ Open, competitive tendering ▪ Procedures well known ▪ Client has potential cost certainty before start of construction ▪ Sub-contractors are under the main contractors control	▪ Slow to start on site (no parallel working) ▪ Contractor not involved in design or planning (no buildability, unless a two stage process is used) ▪ Heavily reliant on the quality and completeness of tender documents ▪ Adversarial ▪ Can be subject to costly "claims" if design information is issued late or incomplete ▪ Variations can cause delay and claims ▪ Not supported by OGC "Common Minimum Standards" 2006 ▪ Does not deliver the project front-end engagement process to deliver VFM ▪ Nationally, problems historically with programme, cost, quality and final accounts ▪ Required to procure a contractor through the OJEU procedure. ▪ Due to requirement to procure a contractor through OJEU, procurement could take 6-9 months

4.1.1.3 Design & Build

As with ProCure 22, these procurement routes are for schemes being funded by public capital. Both methods require NHS/Public organisations to procure a contractor through the OJEU procedure.

The 'Design & Build' method involves the Project Team or lead partner working up the design to a certain stage and procuring a contractor on the basis of its proposals to complete the design and construct the building. The Project Team or lead partner could then either novate their own design team to the contractor or allow the contractor to bring their own design team.

Advantages	Disadvantages
▪ Competitive tendering ensures VFM ▪ Satisfactory public accountability ▪ Procedures well known ▪ Possible single point contact and responsibility ▪ Inherent buildability ▪ Early firm price possible ▪ Reduced total project time ▪ Significant risk transfer ▪ Sub-contractors and design team under the main contractor's control	▪ Client needs to commit before design is complete ▪ No design overview unless client retains design team or appoints due diligence consultant – extra expense. ▪ Client driven changes can be expensive ▪ Potential for design quality to suffer due to the contractor being primarily cost-driven ▪ Potentially adversarial

4.1.1.4 Private Finance Initiative (PFI)

PFI is a form of Public Private Partnerships (PPP) that has successfully delivered public infrastructure buildings for over 10 years. The contract is a concession contract for 25-30 years for the partner to design, build, finance and maintain the facility for the concession period.

A key aspect of PFI is that the partnership or lead organisation would only pay for the building or elements of the building if they are 'available' for use. Should the building fall below minimum standards or areas of the building be 'unavailable' for use, the partnership or lead partner organisation would be entitled to deduct money from the Unitary Payment.

Variations to requirements during the construction phase can be costly and therefore it is imperative that the building be designed to be flexible and easily adaptable. Procurement times can be lengthy if not managed correctly or if poor quality or insufficient information is provided at the tender stage. HM Treasury guidance indicates that PFI is unlikely to be a cost effective procurement route for capital schemes whose capital value is less than £25m.

4.1.1.5 Local Investment Finance Trust (LIFT) / Express LIFT

LIFT, operated by the Community Health Partnership (CHP), was developed an alternative form of PPP with a number of advantages over PFI. LIFT was introduced to give flexibility to Primary Care Trust's working with a partner to build primary care resource centres within the local community of a fixed geographical area. The LIFT partner constructed premises on behalf of the PCT and offered them to the NHS partner on a Lease plus Agreement (LPA). The LPA obligates the LIFT partner to maintain the building and, in some instances, provide soft services on behalf of the NHS organisation for the duration of the LPA (25-30 years). At the end of the concession the NHS organisation could either renew the lease or walk away with the LIFT Partner taking the benefit of the asset to find an alternative use for the land and/or building.

Express LIFT represents a short form of the full LIFT contract for smaller projects where a full LIFT approach is not appropriate. It is designed to be quicker to implement.

LIFT projects are, however, becoming increasingly unpopular procurement solution due for similar reasons as PFI and is not currently advocated by the Strategic Estates Advisor supporting this SOC.

4.1.1.6 Third Party Development (3PD)

A 'Third Party Developer' is a developer who funds and builds a new facility in return for a lease payment from the NHS/Public Sector Partnership and, potentially, other tenants. Under the 3PD approach, the development company forward funds the project and receives a share of development profits. The Project Team or lead partner organisation would normally enter into a 15 year FRI or TIR lease with the developer with agreed rental levels and rent reviews every 3 years, these can be based upon open market rent, set increases or a cap/collar.

Bedfordshire CCG is currently developing a scheme elsewhere in the region with a 3PD. The skills and experience developed on that project could be brought forward to support the delivery of Kempston MCCC.

4.1.1.7 Joint Venture (JV)

JVs offer public sector organisations (PSOs) the opportunity to share the risk albeit with a lower share of the return. Partners in JVs typically bring capacity, expertise and investment, enabling a more commercial approach, but they need to be chosen with care. There is an emerging breed of JVs within the public sector in which councils or health organisations partner with commercial companies that are themselves wholly-owned by the council or health organisation. Their commerciality combined with public sector ethos makes them a viable option compared to the more traditional public-private partnerships (PPP). Research into JV's provided the following learning:

- **Be clear on your objectives for setting up a JV such as income growth, cost savings and value to the community** - if all you want to do is deliver savings, outsourcing may be better.
- **Take time in the procurement process** - you need to be confident that the procurement process is capable of delivering the right JV partner who shares your values but also has the capacity to deliver.
- **Create a culture of trust and strong working relationships** - there should be a 'one team' ethos between the council/health organisation and the JV, and an understanding of the importance of communication across all stakeholders.
- **Share profits and risk** - it should not be possible for one party to benefit at the loss of the other partner.
- **Anticipate the changing environment in which the JV will operate throughout its lifetime, both operationally and politically** - put in place mechanisms to address future tensions, not just formal dispute processes but also regular meetings and guiding principles for how to expect to manage the relationship which will allow it to evolve and eventually exit.
- **Allow the JV to operate independently** - the JV must be able to operate outside of the council/health organisation focusing on income growth alongside improved service delivery and cost-reduction. The temptation to make the JV another corporate directorate that acts in the same way as others needs to be resisted.

This route may be difficult to follow as the land is normally the PSOs contribution to the scheme and in Kempston both land and building need to be procured.

4.1.1.8 Procurement strategy

Key considerations when selecting which procurement route to choose are:

- Time
- Certainty of time
- Certainty of cost
- Price competition
- Flexibility
- Complexity
- Quality
- Responsibility
- Risk
- Value for Money

These considerations can be developed by the OBC into criteria for selection of the appropriate procurement route for the MCCC.

4.1.2 Delivery

4.1.2.1 Site Acquisition

Either site must be acquired, or certainty of acquisition obtained for the project to progress. The Police Station site has the easiest path to acquisition as it is already held by a public body and there are no restrictions on the title or use of the land. Discussions with the Bedfordshire Police have confirmed their intention to dispose of the site, with some of the persistent uses of the site being transferred to sites owned by other public bodies, highlighting the willingness of the Police to work in partnership with other public bodies.

Acquisition of the former Robert Bruce site will be significantly more challenging as the land is intended for educational use. A proposal to construct a new school on the site for children with complex needs has been submitted, but awaits Ministerial approval to progress. A masterplan for the site has been developed and the site for the MCCC would need to be carved from the parcel intended or housing. Adding a further party into an already complex development proposal introduce a significant amount of acquisition risk that is not present on the Police Station site.

Discussions with the Police have confirmed they anticipate decommissioning the site by March 2022. The proposed programme within the document sets out how this would align with the delivery of the MCCC.

No discussions have been held with the Police around likely values. However, it is anticipated that they will be required to demonstrate best value in disposing of the site. Comparable valuation in formation has identified that that could be as much as £1.1m per acre.

The less favourable Robert Bruce site is in ownership of the Challenger Multi Academy Trust. The Trust are bring forward plans to redevelop the site. It is anticipated that the site would need to be purchased from the Trust in order to allow the MCCC to be built. The Trust is also obliged to seek best value from any disposal. As a result, both sites are expected to have headline values at the same level.

A key difference between the two sites is the need to demolish the police station, where as the school site offers a remediated site on which to build. However, the demolition cost is expected to come off the sale value. The police station is a purpose-built building, for which no other owner is likely to have a use for, including the police who site its obsolescence as its main reason for

disposal. It is therefore reasonable to assume that the presence of the building devalues the site as any new owner would need to first clear the site before they could make use of it.

Consequently, site assembly and preparation are is anticipated to be broadly the same for each of the two sites.

As a result, the key factor in determining which site to develop focuses on ability to deliver each site.

4.1.2.2 Delivery Partners

Below we have summarised the possible delivery partners who could deliver the new MCCC:

- **Local Authority –** through the course of the SOC development BBC has indicated that it may consider being a development partner for the scheme, provided it offered a financial return that in line with the Council's investment objectives of non-core investments. BBC has the existing skills and in-house expertise to deliver the scheme, however at present the scheme's rate of return are potentially too low. The Local Authority has indicated that they would require a return on investment (ROI) of circa 7.5% to ensure the cost of borrowing is covered. This should be reviewed at OBC once greater financial certainty is achieved and an updated position on the cost of borrowing is known.
- **Third Party Developer (3PD)** – there are a range of third-party developers who operate in the health sector, either as dedicated health sector providers or through an arm of their wider business. Companies such as Assura, Montpellier Estate and Primary Healthcare Properties PLC are dedicated investment company who specialise in primary care sector capital projects. Assura and organisation like it in the market place have a detailed understanding of delivering capital projects and are therefore able to manage their exposure to risk more efficiently that other developers or the Local Authority. As a result, these companies are willing to undertake riskier and more marginal projects that those unfamiliar with the market are unwilling to invest in. As a corporate entity they often have access to capital funding.
- **Community Health Partnership (CHP)** – works with commissioners and local parties within England to develop investment opportunities within the health sector. As with the other parties they are able to deliver projects and retain the expertise needed to manage.
- **NHS Property Services** – a dedicated organisation supporting the NHS on all property matters. They are able to develop new properties and retain the expertise to manage them. Although similar to those mentioned previously, it is more reliant on funding initiatives due to its ties to the Public Sector and therefore is not always able to generate capital as easily as a 3PD.

Whilst each option offers a potentially deliverable route, the OBC will need to consider each option in turn as part of its overall consideration of procurement to identify which route will optimise the delivery of the MCCC.

4.1.2.3 Rent

The passing rent needs to be £353.15/sqm for the new build MCCC to be financially viable given the current level of cost and a 3% return on investment. This has been calculated on a discounted cash flow basis and included in Appendix 8 and Appendix 9. It is estimated that if the optimism bias and risk can be released form the project this rental requirement can be reduced to around £300/sqm and still return a 3% Return on Investment (ROI) without the need for gap funding.

This is more than the current rent passing in the area, however substantially below other parts of the country where land values are substantially lower. BCCG will need to work with the District Valuer's Office to review prime rents in Bedford and potentially bring them in line with the rent being attracted to other similar new build properties elsewhere in the country by highlighting the MCCC's improved quality, facilities and overall value for money.

4.1.2.4 Team

BCCG is currently developing new primary care facilities with a national contractor. Due to the tight margins and the benefits of using an experienced contractor in supporting the design and delivery, it could be beneficial to bring a contractor on to the project at OBC stage. Whilst it is not essential, a contractor partner is able to reduce build risk and support the architect to improve the buildability and efficiency of the construction, helping to reduce the cost of the overall project.

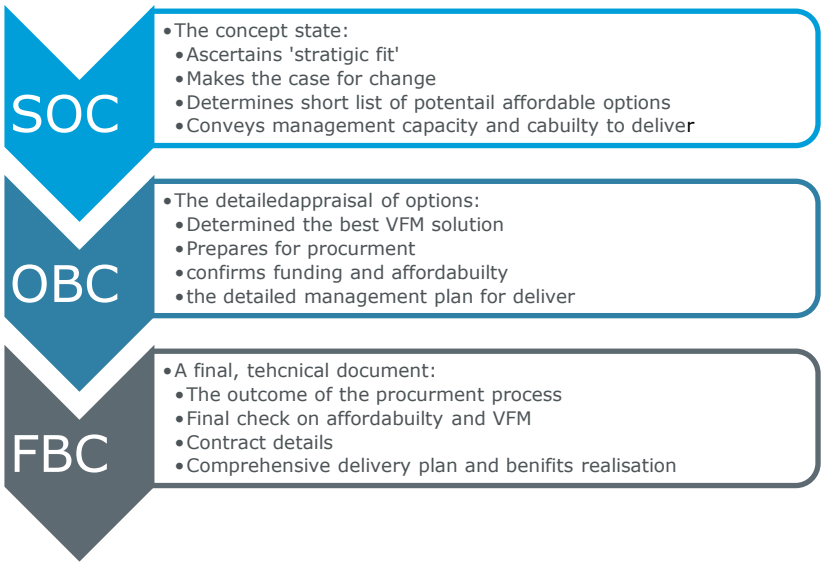
The OBC and FBC will also require the following services:

- Architect
- Structural, Civil and Mechanical & Electrical engineer
- OBC and FBC author
- Healthcare planner
- Cost manager
- Project manager
- Geo and Topographical surveys.

4.2 SOC to FBC Process

The SOC has set out the strategic case and need for change whilst developing, at a high level a deliverable concept, by understanding the size, function and location requirements of a new MCCC in Kempston.

The OBC will explore in further detail those requirements identified in the SOC by developing a design and using this detailed space assessment to refine and de-risk some of the costs of the project. The following diagram illustrates the key activities for each business case stage:



At each of the three stages (SOC, OBC and FBC) the business case needs to consider each of the five cases. The emphasis is different for each case at the respective stages. The priorities for each section are illustrated in the table below, these reflect the core purpose of the document at the various stages of the business case lifecycle:

Five Cases	Strategic	Economic	Commercial	Financial	Management
SOC	**Key step 1:** Ascertain the strategic fit **Key step 2:** Make the case for change	**Key step 3:** Develop a long list of options and agree a shortlist	Outline the procurement options	Estimate costs and revenue for shortlisted options	Proposed management arrangements
OBC	Review any significant changes and implications	**Key step 4:** Determine value for money	**Key step 5:** Prepare for the potential deal	**Key step 6:** Confirm funding and affordability	**Key Step 7:** Plan for successful delivery
FBC	Review and minor changes and implications	Confirm value for money	**Key step 8:** Procure the solution **Key step 9:** Contracting for the deal	Confirm financial implications and financing	**Key Step 10:** Ensure successful delivery

Figure 11 – Key features of the Business Case Model

4.3 Attractiveness to the market

Assuming site acquisition can be achieved, the similar costs of each scheme mean that either is likely to be attractive to the market, provided rental figures can be agreed with the Valuation Office Agency (VOA). Both schemes return around 3% yield. Whilst this is low, GP surgeries make for very safe forms of capital investment as they are ultimately backed by the NHS through the through rent. Companies such as Assura and Wilmot Dixon who specialise or have arms of the business that operate in this area are likely to be interested in this project.

High level discussions with the market have identified that a number are active in the wider area and looking for investment opportunities.

Discussions with the surgeries has identified that they are unlikely to be interested in forming a development company to deliver the building. Similarly, the Local Authority has indicated it may consider investing in the site however, as provision of health services and buildings fall out with the remit of Local Authorities, they would likely seek a higher return than specialist provider to need to limit exposure to risk when partaking in non-core investments. As a result, a 3PD would potentially offer the same level of service but with a lower financial cost to the project.

4.4 Timetable for procurement

The following table sets out a high level procurement route for production of the OBC and FBC. A number of months have been allowed to secure approvals as there will be an increasing number of organisations involved in the OBC and FBC.

Stage	Start	End
SOC Approval	March 2020	June 2020
OBC Tender	July 2020	October 2020
Write OBC	October 2020	April 2021
OBC Approvals	April 2021	October 2021
FBC Tender	October 2021	December 2021
Write FBC	January 2022	April 2022
FBC Approval	April 2022	October 2022

Table 12 – Indicative timetable

The schedule does not include for any pauses to the programme that might take place as a result of changes to government policy or periods when funding initiatives may not be active.

5 Financial Case

The purpose of this section is to set out the financial implications and considerations of the MCCC. The total project costs is expected to reduce over the lifetime of SOC to FBC as items held as risk are committed or released and design work is commissioned during the OBC stage.

5.1 Capital Costs

5.1.1 Site Acquisition

The preferred site of Kempston Police Station is currently under the ownership of Bedfordshire Police who hold its freehold. As a public body, Bedfordshire Police will be obligated to obtain best value for its disposal.

In estimating the value of the sites, recent comparable information provides the most appropriate method estimating the value of the site. Bedford Borough Council has recently sold land at Baliol Road at **£1.1m per acre**. The site is with vacant possession and with no significant abnormal costs to consider.

As the Police Station is 1.3 acres it suggests a vacant possession value of **£1.1m.**

It is assumed that the police would not undertake the demolition of the building and that the structures are of no use to any other future purchaser of the site. They are therefore treated as an impairment to the site and the cost of their demolition would be deducted from the open market value of a comparable site that had no structures upon it.

Clearance of the site is estimated at: **£583,560**

The estimated value of the site is therefore: **£846,440**

Allowing for Stamp Duty Land Tax and likely surveyor and legal fees the estimated cost to acquire the freehold title of the site is **£895,191.**

As no surveys of the building or ground to have been conducted these costs are estimates based on the available limited information and should be further tested in the OBC and FBC.

5.1.2 Building

The cost to construct the building, once the site has been assembled and cleared remain that same for each option. The building is estimated to cost around £9m to deliver at a cost of **£3,953/sqm**. However, there are other associated in addition to the previously mentioned land assembly and preparation such as externals works, these would add a further £1m to the cost of the overall building.

Details of cost for comparable schemes have been included in Appendix 10 for reference. These costs have been standardised and adjusted for time and geography to ensure they are directly comparable.

5.1.3 Other costs

At this early stage of the project there are also further costs needed to get the project to site. These include production of the OBC and subsequent FBC, together with ground surveys.

As these have not yet been undertaken the development appraisal retains around £2m of risk/contingency in the form of Risk Allowance and Optimism Bias. A decision of whether to convert

these contingencies into costed items or release them can be made from the OBC stage onwards once the initial design is completed and site survey information beings to infirm the design.

5.1.4 Total Project Cost

The estimated **total project costs of the preferred Kempston MCCC is £14,546,800** and includes all costs identified previously (Land, Build and Other costs) a full break down in included in Appendix 8. Some of these are enabling costs and may be secured from external funding sources, reducing the overall cost of the project, such as One Public Estate, under which funding this SOC was procured.

In addition, prior to the completion of the OBC elements of design and investigation will be commissioned. The effect of this expenditure through the OBC will be to reduce the total project costs when next reported in the OBC submission.

5.2 Rent Reimbursement

The primary source of funding for the scheme will be through capitalisation of the Rent Reimbursement as no grant funding is available and Section 106 is not considered likely.

The market rent for new build health centre is relatively untested as there has been limited development in the area. A rental amount of £225/sqm would likely require around £5m of grant funding to be viable. The project has been illustrated to be viable with a rental income of circa £353/sqm however with the reduction of risk and optimism bias, the capital funding requirement of the project could be reduced by up to £2.2 million and therefore could be sustained by a lower rental income of around £300-315/sqm.

Other options include funding from schemes like Estate & Technology Transformation Fund (ETTF). Although due to conclude in 2021, it is anticipated that a replacement fund will come on line to take its place and a new round of bids will be sought from CCGs

Sustainability and Transformation Partnership (STP) or Integrated Care System (ICS) capital funding could also be considered. Presently the Bedford Luton and Milton Keynes STP is currently developing. Once establish it is likely that it will identify schemes form across the BLMK area for capital funding.

Although not active at present, it is anticipated that the government will soon announce a new tranche of funding aimed at improving access to GP services.

5.3 Other building Costs

5.3.1 Facilities management costs

Costs to manage the building have not been developed in detail and will evolve from works to the design, selection of materials and specification of plant and machinery. The procurement route will also have an impact on the running cost, and who has to pay them, with many healthcare building developers retaining the obligation to maintain the building and charging the tenant for that service. It is expected that the building will cost in the region of £50/sqm to operate. Whilst rapidly evolving green technology can reduce install cost and energy demands, labour costs continue to increase.

Modern Methods of Construction and off-site construction can help to reduce upfront costs, although they invariably have shorter life expectancies and higher maintenance costs towards the end of the life cycle.

5.4 VAT Treatment

Further advice on the treatment of VAT will be required at OBC/FBC stage. This advice will be sought and presented at that time.

5.5 Revenue affordability

The rent currently paid to the existing surgeries in Kempston is around £120-150/sqm. This low level reflects the age and quality of the buildings. Due to the increased quality and size of clinical space proposed the gross rental payment will need to increase from around £125,000pa to £666,555pa (£353/sqm).

Such a large increase will bring significant budgetary and affordability challenges to the CCG who ultimately will be required to pay the rent. The CCG will need to review its budgetary commitments over the coming years to be able to support this scheme.

Detailed expenditure of the individual surgeries will also increase significantly. Some of the practices undertake their own repairs, snow clearance and landscape works. Directly undertaking the work artificially lowers the existing operating costs as it often done at nil cost. Relocating to a new managed building will generate new costs beyond increases for scale.

5.6 CCG Rent Reimbursements

BCCG has committed to reimbursing the rent, rates, water and clinical waste costs of the new building. The rental amount will need to be approved by the District Valuer. Although no District Valuer has been appointed for this scheme, other comparable schemes in the Bedfordshire area have been valued at £225/sqm. Without grant funding the Kempston MCCC s estimate to need between £300-350/sqm to be financially viable.

As the combined patient list is currently 22,743 patient with an expected additional 583 patients expected to register in the coming years the total list size has been calculated at 23,326 patients.

The CCG will reimburse rent on the GP consultation and treatment space; administration and circulation space within the NIA; stores and essential welfare facilities. Plant and circulation space beyond the NIA would not be reimbursed. Guidance on these elements form the Premises Directive does state that local variance is possible depending on the structure of the occupation agreement.

5.7 Sensitivity analysis

Due to the early stage of the project, a sensitivity analysis has been undertaken to stress test the assumptions. The project's infancy means that there is a considerable amount of 'risk' contained within all costed assumptions should any unforeseen cost emerge. As the project matures, items held as risk are converted to costed items or released. Releasing risk and contingency sums once it has been demonstrated that the funds are no longer required reduces the project budget and improves its financial viability.

5.7.1 Risk and Contingency sums

There are a number of areas where risk is currently included in assumptions in lieu of having completed detailed designs and surveys of the site, and include:

- Planning Allowance – 10% of the building size in accordance with HNB11.01 guidance
- Risk Allowance – 10% of the project cost totalling £1,128,000
- Optimism bias – 10% of the project cost totalling £1,241,000

As a detailed design is developed in the OBC the Planning Allowance can be converted to a fixed dimension. Risk and Optimism can be reduced once the design and surveys are completed, but it is likely that an amount for risk will be held until practical completion to account for any unforeseen events during construction e.g. contingency funds.

5.7.2 Grant Funding

As no grant funding has yet been secured for the project, none has been shown in the cost calculations used in this SOC. However, the increasing importance of primary care within the health service and historic funding initiatives, suggest that the project may be able to apply and obtain funding in the future. Available funding should be reviewed during the OBC stage.

Grant funding will offset some of the capital costs, improving the overall viability of the scheme.

5.7.3 Reduced Costs

Although inflation typically means costs increase over time, technological advances or process changes can mean that inflation is offset by a cheaper way of delivering the same project. Modern Methods of Construction (MMC) and modular builds are still emerging throughout the construction industry. As they become more established the cost of these options is likely to reduce and may reduce the overall build cost through reduced material requirements, utilisation of cheaper materials, or shorter construction periods (from which savings on prelims can be obtained).

5.7.4 Yield

Yield is a return measure for an investment over a set period of time, expressed as a percentage, and tend to be market led and whilst they can be forecast, the final amount will vary depending on how the market views the proposal at the time. Yields of 3-3.5% are typical reflecting that a property investment has more risk and a Government bond, but ultimately incomes are still Government backed (through the CCG, NHS and ultimately central Government). However, a developer can apply a lower yield if they feel the long term return of the project are particularly good. Alternatively, in a competitive situation a developer can outbid a competitor with a lower yield to secure their investment in the project.

5.7.5 Sensitivity analysis

In undertaking the sensitivity analysis, the following assumptions used in this proposal have been kept constant:

- Total project cost -£14,546,800
- Rental Growth 2.5% pa upwards only adjusted every 5 years
- Period 25 years.

By varying the project cost/grant funding and the yield the revenue needed to support the project can be analysed.

This SOC has assumed a 3% yield with no grant funding (see rental figure highlighted in red). By increasing the grant, the rental income needed to support the scheme is reduced. Similarly by increasing the yield (return for the investor) the rent needed to make the project viable has to increase.

Grant funding or reduced cost		Yield						
		0.0%	2.5%	3.0%	3.5%	5.0%	7.5%	10.0%
£	-	£237.26	£331.87	£353.24	£375.41	£446.64	£580.13	£729.85
£	500,000	£229.10	£320.46	£341.09	£362.51	£431.29	£560.19	£704.77
£	1,000,000	£220.95	£309.05	£328.95	£349.60	£415.94	£540.25	£679.68
£	2,000,000	£204.64	£286.24	£304.67	£323.80	£385.23	£500.37	£629.51

All values are £/sqm

Table 13 – Sensitivity Analysis

From Table 13 it is possible to identify that if the OBC is able to release the £1m of the optimism bias the rent needed to achieve a 3% yield could be reduced by £25/sqm. Similarly if a developer will only commit to with a 3.5% yield the project will need an additional £25/sqm, unless it can be offset by grant funding or cost savings.

5.8 Summary of Financial Case

Financial expenditure by the CCG will need to increase in order to meet the costs of delivering and operating the proposed primary care estate, which is both substantially bigger and of enhanced quality.

The building is expected to cost between £14-14.5m to build and budgetary allowance will need to be sought by the CCG during the OBC period should the building come on line within the proposed timescale of 2022/23.

6 Management Case

The Management Case demonstrates that the preferred way forward/option is deliverable and explains how the project will be managed and governed, how the expected benefits will be realised, how risks will be mitigated, how change will be managed and the anticipated timescales for delivery.

6.1 Approvals and Support

6.1.1 Approval of this document

The formal approval of this document will need to be made by the BBC as the commissioning body having accessed OPE funding. However, as the CCG is an integral stakeholder, and best placed to take this SOC forward, will also need to be seek internal approval before taking it to NHSI/NHSE at national level. Any proposed developments will need to become part of the STP's key estate priorities, which will need direct involvement from the CCG to achieve this.

6.2 Project Management

Where a project involves multiple stakeholders, as with the MCCC in Kempston, it is important to identify a "lead organisation" to manage the planning and implementation processes. It is not unusual for the "lead organisation" to change as the project progresses. BBC has led the development of the SOC through its access to OPE funding. However, as the scheme develops the CCG will be best placed to lead the development of the OBC and onto FBC of the OBC.

The development of the SOC for the Kempston MCCC has been led by BBC in conjunction with BCCG. Whilst it is appropriate for this partnership approach to continue, it is expected that a single lead organisation will be identified for development of the OBC. It is likely that BCCG would need to be the sponsoring body for the OBC, although this could be a different role from that of "lead organisation". Whichever organisation takes the lead, the involvement of and alignment with the wider BLMK ICS Out of Hospital Services Programme, will reinforce the integrated approach that has been adopted to date.

To complete the OBC, a business case author and healthcare planner supported by a design team will need to be appointed. Detailed involvement of the three GP practise will also be required to ensure the design reflects the needs of the local community.

It is recognised that a more robust governance structure is needed to take the scheme forward that will require formal commitment from all parties included.

The diagram overleaf outlines a proposed governance arrangement to get to the end of an OBC to support both the development and delivery of the preferred option.

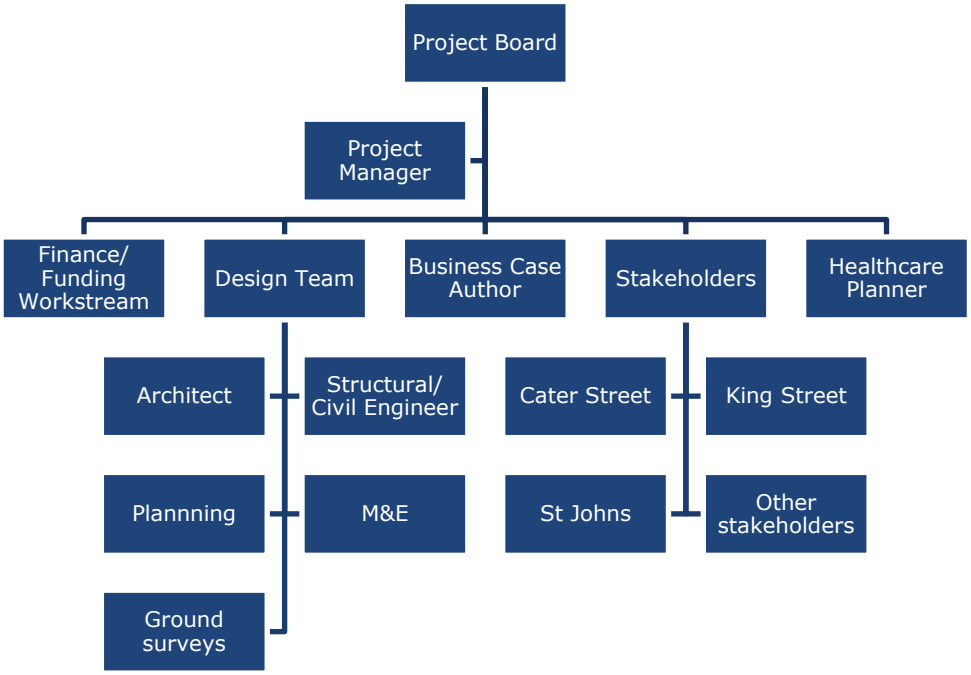


Figure 12 – Project Team structure for OBC

- **Project Board** – Responsible for setting the key objectives, success factors and direction of the project at OBC and FBC. They will also need to approve the final proposal and should therefore have representation from the CCG.
- **Project Manager** – Will be tasked with coordination of the various consultants on behalf of the Project Board.
- **Finance and Funding workstream** – Working with the Design Team, this workstream will need to investigate those funding streams identified previously, identifying which route are the most appropriate. They will also need to hold an ongoing dialogue with the VOA to ensure they final assessment aligns with revenue assumptions.
- **Design Team** – Commonly headed by the architect, OBC author or project manager, the design team will be responsible for developing a deliverable building that takes into considerations the requirements of the healthcare planner.
- **Business Case Author** – Will be responsible for production of the OBC document
- **Stakeholders** – At minimum this should include representatives from the three GPs, or if agreed by the surgeries, representation of the GPs by the PCN. Other stakeholder will include services commissioned under the PCN. This group should be bound to the project through a memorandum of understanding.
- **Healthcare Planner** – Specialist able to provide planning and development advice for healthcare services and facilities. Working with stakeholders and the design team, they will ensure the OBC responds to the specific requirements of patients in Kempston and the wider PCN.

6.3 Governance Arrangements

As the project moves forward, it is expected that the Council will remain a stakeholder, however the project will be led by BCCG under their remit of providing primary care health services.

The change to the lead organisation is not unusual and reflects the needs of the project and the position of the CCG to fulfil them. Primarily the CCG as project lead will be best place to access NHS funding needed to take the project through OBC and FBC. The Council is expected to remain involved in the project as a stakeholder.

6.3.1 ICS Estates Governance

Formal approval of the SOC will be sought form BBC, BCCG and in turn NHSI/NHSE. It will also need to be adopted by BLMK ICS which has commenced its formation and will continue to consolidate its care strategy for the area over the coming years.

6.4 Operation of the buildings

There are a range of active solutions where multiple stakeholders have come together to work in and operate a building. This section will look firstly at how the three GP surgeries can operate together before moving on to discuss the other stakeholder organisations.

6.4.1 GP Merger

Merging the three GP practise into a single entity offers the most efficient solution for operating an MCCC. By coming together as a single organisation, the new combined practice is able to make use of economics of scale within back-office and administrative functions.

A single organisation also simplifies the legal occupation of the building with a single tenant paying a landlord without the need for subleases and licences. However, mergers of GP practices are complex and can take a number of years to complete.

6.4.2 Co-location

If the GP practices wish to retain their individual legal structures and enter the building the can do so as individual tenants or as subtenants of one of the practices. The first option provides for all practices to be on an equal footing and have a direct relationship with the landlord. This option is dependent on a willing landlord and some may be unwilling to lease to multi tenants due to an increase in risk and management costs.

Should this pose a problem, one surgery, acting as head tenant could be used to resolve the issue. The head tenant would take on responsibility for the building from the landlord, taking a lease for the whole building then subletting it to the other surgeries. The risk is therefore held by the head tenant should one of the other practices fail to pay their rent or share of the service charge. It also places additional administrative burden on the head tenant as their need to issue rental invoices and manage repair/maintenance responsibilities for the building.

As PCNs become more established and the practise within each PCN work ever closer together services and resources will be increasingly shared. It is therefore possible that what started as a co-location could overtime turn into a merger and whatever occupational arrangement is undertaken at the start would not prevent this from happening.

6.5 Organisational Changes

6.5.1 MCCC Structure

A range of organisational structures can be employed to ensure the robust operation of the MCCC. Whilst this will require further and more detailed analysis and commitment from stakeholders in the OBC and outline of potential options has been considered in the following section. Each option has a number of pro's and con's which should be considered in detail by each surgery. Surgeries may also wish to seek professional legal counsel in considering these options.

6.5.1.1 Co-location

Of the potential options, co-locating within the same building is the fastest and simplest to achieve. Each surgery retains its own pre-existing legal and staffing structure and moves into the new MCCC.

As there are no legal changes to the organisations, save for their address, implementation can be done quickly and with minimal risk. In addition, each surgery is able to retain its own identity and established working practices – an important consideration in any small business.

However, this brings a number of inefficiencies. Invariably back office and support services have to be duplicated and the surgeries miss out on economics of scale that might help to reduce the number of non-medical staff. In primary health care hubs where this has happened is it not unusual to find each surgery having its own receptionist, facilities contracts store rooms et al.

Co-location inevitably makes for a more complicated leasing structure as each requires a legal agreement to occupy space in the building. Two solutions can be employed, but this is subject to the building's freeholder or landlord.

If the landlord is willing to contract with each surgery, it can issue separate leases for occupation. However, it can be difficult to determine the responsibility for communal elements of the building and landlords in general prefer to contract with as few parties as possible.

The main benefit to the surgeries is include equal legal footing within the building.

NHS Property Services remains the most likely landlords to offer leases to multiple surgeries. Private landlords will be significantly less inclined.

The alternative solution would be for a head tenant to contract directly with the landlord and take the other surgeries as subtenants. This option would be preferable to the majority of landlords as it simplifies the management of the building and resolved the uncertainty around the communal elements.

However, it requires a surgery that is willing to take on this additional responsibility and for the remaining surgeries to take secondary positions within the legal structure of the building. Whilst in principal this may work, the parties involved may, for their own reasons, be unwilling to contract in this format.

Each option has an implication on the rentable space. The amount of space allocated for rental and its makeup is contained in Table 15 and Table 18.

6.5.1.2 Merger

It is noted that the three surgeries are not perusing any intention to merge at this time. Whilst it is not the remit of this document to comment on the intention of the three surgeries to merge, if the

practices were to come together through merger, they would create a single entity which would be more efficient, both operationally and in taking a single lease of the whole building.

The merging of GP practices is a complex and lengthy process. Whilst the development of a new MCCC should not force GPs to merge, should they wish to explore this, the following key actions and decisions have been provided as a guide.

Activity	Description
Due Diligence	A due diligence questionnaire will be completed by each of the partners (GPs) to provide a schedule of assets and liabilities in order that everything transferring is correctly documented and would focus in particular upon requirements for third party consents (e.g. to transfer/re-grant of GMS Contracts, key IT contracts, etc.).
Employment Terms	A review of the employment terms is taking place in order that advice can be provided on TUPE consultation and harmonisation. The terms for the retirement of any exiting partners will also need to be concluded.
Partnership Agreement	A new partnership agreement is being prepared between the partners of the merged practices to deal with a range of issues including: ▪ Profits split and opening capital contributions ▪ Ability to appoint non-medical partners and deal with conflicts ▪ Decision making/meetings ▪ Restrictions on competition ▪ Entitlement to personal income ▪ Rights to absence/leave ▪ Duties and responsibilities ▪ Entitlements on departure.
Heads of Terms	Prepared to reflect the partners' agreed in principle position and avoid scope for further debate as the Transaction proceeds.
Legal Arrangements	Suitable legal arrangements will need to be put in place to govern the rights and responsibilities of the shareholders/members in that company.
Property Documents	Depending upon the "vehicle" used, freehold titles or leases are will need to be submitted.

Table 14 – Key tasks for merger of GP surgery

6.5.2 Assumptions that have been taken forward

It is assumed in this SOC that the three practices would remain separate entities, although would seek to gain efficiencies through their association in the PCN. It is also assumed that all three practices would dispose of their existing buildings and move to the new MCCC.

6.5.3 Areas where further work is required

The OBC will provide the opportunity to investigate in more detailed the preferred legal structure of the three practices. This may also be influenced by the building's provider/developer and their preference for managing the completed development.

A commitment will also need to be sought from the three practices to move into the completed development. This will be subject to their ability to terminate agreements for occupation at their existing premises and/or disposing of any surplus buildings. Cater Street, as the smallest of the practices, should it decide not to move to the MCCC, will have only a marginal impact on the proposal set out in this SOC. The two other practices, which have more patients, have a greater influence on the size and function of the MCCC should they decline to progress with the scheme. Commitments will need to be sought during the OBC and any adjustments made accordingly.

7 Conclusion

The Project Team assembled for the development of this SOC has represented a joined up approach to primary healthcare between the CCG, GPs and the local authority.

The SOC has reconfirmed that the existing primary care health estate is not able to provide the residents of Kempston with a sufficient space to fulfil GP obligations and will be ill equipped to respond to the emerging commitments of Primary Care Networks and out of hospital services.

Kempston is already heavily developed and all of the surgeries within the town are aging and incapable of being expanded to meet present day or future requirements. They are already unable to accommodate a full range of out of hospital services.

Despite the density of development in Kempston, two potential sites have been identified. Of these two sites, the Kempston Police Station has been identified and is highly suitable as a future MCCC. Initial discussions with Bedfordshire Police have confirmed that they are already preparing to vacate and dispose of the site. The Police Force are expected to dispose of the site in line with the expected timescales of the OCB and FBC process. Finding new public sector uses for existing sites is one of the Governments objectives and helps to keep public sector money in the system. It may also promote a more collaborative approach to the exchange of the sites.

Initial assessments of the Police Station site have identified the police hold a clean and unrestricted title of the site. Its existing 24-hour use is likely to be beneficial during the planning processes. The site already has a number of existing junctions with the public highway, close proximity to public transport and a central location within the town centre, all of which minimise the transport and accessibility impact of consolidating all three Kempston GP surgeries in a single MCCC.

7.1 Summary of recommendations

Our recommendations are:

1. **A new MCCC is needed to address the significant shortfall primary estate and respond to new special requirements of the PCN demands as the three current sites are unable to meet the needs of the local population in their current or a modified form.**
2. **Two suitable sites have been identified in this study, although the Police Station site has been identified as the preferred site and there should be an ongoing dialogue with the police to ensure that the site is not lost.**
3. **An initial accommodation schedule has been developed and a large number of stakeholders have expressed an interest in using the MCCC as their primary location for working with patients. The revenue costs will need to be developed in the OBC and commitments made by the stakeholders to ensure the completed building provides an appropriate amount of space.**
4. **Any expansion to the existing PCN will increase the rental obligations of GPs and the CCG. A rent of £353/sqm is needed to deliver this proposal. However, as this scheme is at SOC stage a significant amount of risk and therefore cost are present in the appraisal. As the MCCC concept is developed and de-risked, it is expected that contingent sums can be reduced and the revenue needed for this proposal reduced.**
5. **BBC and BCCG should recommend that this proposal is progressed to OBC stage, and that the resources are identified to support this.**

7.2 Next Steps

The following are suggested next steps for the project:

a The SOC will need to be reviewed by the procuring organisations, namely the BBC and BCCG with feedback included prior to moving to approval by each organisation's governing body.

b If the SOC is approved, formal agreement to proceed to OBC will need to be made by the CCG.

c The CCG, as the main health providing body within this project will need to identify appropriate sources of funding for the delivery of the overall scheme and necessary funding for the production of the OBC. This may be internal funding or government led. Whilst at the time of writing no funds have been announced, it is widely expected that a call for proposal will be launched later in 2020.

d Continue to work with stakeholders and move towards developing a Memorandum of Understanding with interested parties. This will set out the objectives of each stakeholder and the extent to which they are willing/able to commit to the project. This will play a significant role in crystallising the requirements of the OBC.

e The OBC will need to developed to confirm the following:

- Review and confirm the Case for Change and Critical Success Factors
- Review and confirm the options
- Develop the short-listed options to RIBA Stage 2
- Develop a cost plan per option
- Re-determine the best value for money solution
- Re-determine the Procurement Strategy
- Confirm funding and affordability
- Confirm the management plan for delivery
- Support and approval to progress to FBC.

Appendix 1. Other National Policies

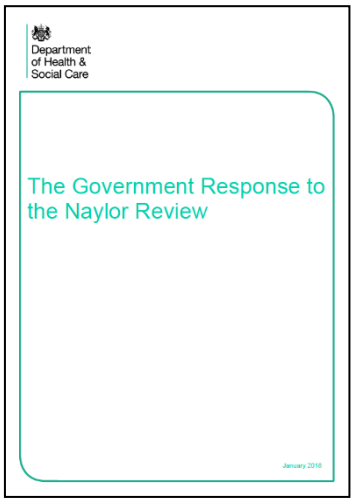
Government Estate Strategy, July 2018

This Cabinet Office produced strategy develops on from the previously developed estate strategy of 2014 and therefore builds on plans rather than laying the foundations. For example it highlights in its forward (page 02), "policies have already provided an estate that is cheaper and easier to run and allows more houses to be built on surplus government land. Creating a network of Government Hubs has also helped make it easier for public servants to work across the UK, within workplaces that promote Smarter Working and collaboration across traditional departmental boundaries".

The strategy aims to ensure that the government estate "deliver an estate that can adapt and respond"…"one that is leaner and more agile, and equipped with better ways of working, mobile technology and workplace design."

The strategy in its introduction (page 08) goes on to highlight, "Improving efficiency is key to a smarter state, and using property differently has a major part to play. For example, central and local government are working together on the One Public Estate (OPE) programme to bring frontline services under one roof, such as Jobcentre Plus offices and local authority benefits services." Key to this business case is highlighted in page 16, that the strategy aims to achieve (by the end of the Parliament), "**support major estate transformation programmes**, from digitising justice services to implementing the findings of the independent report by Sir Robert Naylor (Naylor review) **to transform the NHS England Estate**."

The Government response to the Naylor Review, January 2018



The document in its forward quickly highlights that improvements in the NHS estate are required, "…if we want to deliver world-class care, we need world-class buildings in which to deliver it. Many of the NHS's healthcare facilities – hospitals, health centres, GP surgeries – are excellent, but others could be better. They can be more efficient, more attractive, better maintained, and more effectively used to support clinical quality".

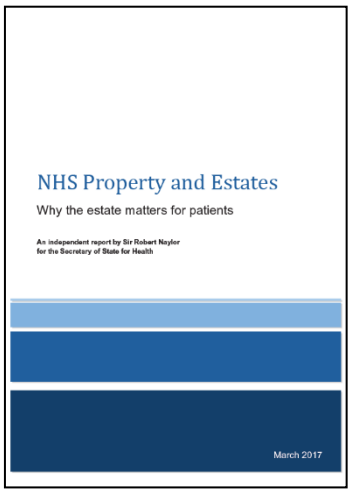
This document sets out "the actions the Government will take in response to the findings of the Naylor Review. We agree with his primary conclusion that the NHS must manage and use its estate more efficiently and strategically, whether by selling land and buildings that it no longer needs to deliver clinical services or using that land to develop new services in line with modern thinking or to provide housing for NHS staff."

Of particular importance to this business case, the document highlights on page 16, "All STPs should be continuing to develop

their estates strategies with the support of their Strategic Estates Advisers. For those bids which have already been supported and those which hope to be in the future, STPs will be expected to agree and submit an estates strategy prior to any funding being released – this will need to include disposals plans as set out in section 6. **STPs will also be expected to ensure that they maximise opportunities for self-funding of schemes using their own capital, receipts from land disposals and use of private finance where this provides value for money (eg LIFT)**." The response document goes on to highlight, "STPs should, as part of the capital planning process and with support from strategic estates advisers, NHSE, NHSI and the Department, **identify which projects could make effective use of private financing through LIFT, PF2 and public private partnerships (PPP)."**

On page 19, the document highlights "Organisations will only receive additional government funding through the STP capital programme if they can demonstrate that they are pursuing all value-for-money opportunities to generate capital within the STP footprint and are reducing running costs by improving estates utilisation and tackling backlog maintenance."

NHS Property and Estates, Why the estate matters for patients, March 2017



This review published in March 2017 considered "the options open to the NHS to achieve best value, from NHS property, in alignment with the delivery of the vision set out in the 5YFV, and to support a small number of high value property transactions in London". It found, "the general consensus is that the current NHS capital investment is insufficient to fund transformation and maintain the current estate. We estimate that STP capital requirements might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the 5YFV. This could be funded through property disposals, private capital (for primary care) and from HM Treasury. However, the NHS needs to develop a robust capital strategy to determine the final investment requirements through the STP plans.

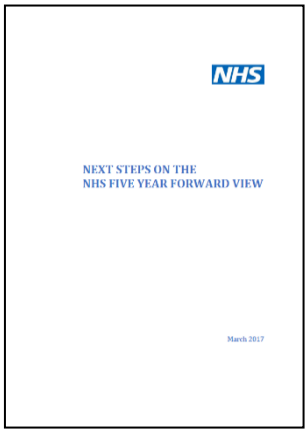
It highlighted 17 specific recommendations which fell into three main areas: "how we can improve our capability and capacity, support action at a local level and develop a robust and sustainable strategy that enables the estate to support transformation in the NHS".

Important for this business case is recommendation 11 which states "At a minimum, the Department of Health (DH) and HM Treasury (HMT) should provide robust assurances to STPs that any sale receipts from locally owned assets will not be recovered centrally provided the disposal is in agreement with STP plans. This report recommends that HMT should provide additional

funding to incentivise land disposals through a "2 for 1 offer" in which public funds match disposal receipts."

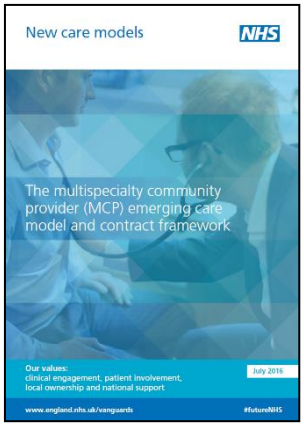
Also recommendation 17 applies to this scheme: "Substantial capital investment is needed to deliver service transformation in well evidenced STP plans. We envisage that the total capital required by these plans is likely to be around £10bn, in the medium term, which could be met by contributions from three sources; property disposals, private capital (for primary care) and from HMT."

Next steps on the NHS Five Year Forward View, March 2017



In March 2017 NHS England (NHSE) published an update on its Five Year Forward View. The documents highlights on page 4 that "some urgent care services are struggling to cope with rising demands. Up to 3 million A&E visits could have been better dealt with elsewhere." This therefore will rely on providing more community based infrastructure support the joined up care and support services. The documents goes on to highlight that "over the next two years the NHS will take practical action to take the strain off A&E. Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds. In addition, patients with less severe conditions will be offered more convenient alternatives, including a network of newly designated Urgent Treatment Centres, GP appointments, and more nurses, doctors and paramedics handling calls to NHS 111."

The multispecialty community provider (MCP) emerging care model and contract framework, July 2016



This document describes what being an MCP means, based on assembling the core features from the 14 MCP vanguards into a common framework. This document highlights in its introduction that "an MCP is about integration. As a patient or a clinician, you would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services. The boundaries make it harder to provide joined-up care that is preventative, high quality and efficient. The MCP model dissolves the divides. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model". The underlying logic of an MCP is that by focusing on prevention and redesigning care, it is possible to improve health and wellbeing, achieve better quality, reduce avoidable hospital admissions and elective activity, and unlock more efficient ways of delivering care. The document goes onto highlight:

"An MCP opens up new options for partners, clinicians and managers. Over time it should also help with managing demand for general practice, by building community networks, connecting

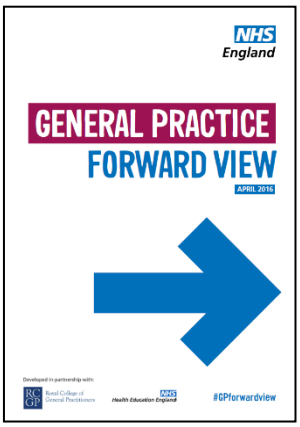
with the voluntary sector, and supporting patient activation and self-care."

"An MCP may start off as a loose coalition, but sooner or later it has to be established on a sound legal footing under contract."

"The fully integrated MCP contract will be a new streamlined hybrid of the NHS standard contract and a contract for primary medical services. It will set national and local service requirements and standards. Contract duration will be much longer than is usual for an NHS standard contract: 10 or 15 years. Payment to the MCP will comprise three parts: (i) a whole population budget for the range of services covered; (ii) a new performance element that replaces CQUIN and QOF; and (iii) a gain/risk share for acute activity."

"The contract could be held by entities such as a community interest company, a limited liability company or a partnership (e.g. building out from a GP federation or super-partnership), or by a statutory NHS provider. It opens up the prospect of new options for how GPs and other clinicians could relate to the MCP, but will not compel an existing practice to leave the security of its general medical services (GMS) contract in perpetuity."

GP Forward View, April 2016



The General Practice (GP) Forward View (April 2016) sets a new direction and opportunity to demonstrate what a strengthened model of general practice can provide to patients, those who work in the service, and for the sustainability of the wider NHS.

In the introduction on page 4, Simon Stevens clearly articulates the importance of GP's for the NHS, "GPs are by far the largest branch of British medicine. A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country's health system. As a recent British Medical Journal headline put it – "if general practice fails, the whole NHS fails". He went on to highlight in terms of investment in primary care, "…by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a 'turnaround' package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and red tape."

Five Year Forward View, October 2014

This five year forward view highlights in the Executive Summary: "This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local

service changes – will need explicit support from the next government

Interestingly for this business case, item 8 of the executive summary points out some of the new service models along with their progress, being adopted across the Country. "One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget. It goes on to highlight in Item 9, page 4; "A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** -combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too".

Appendix 2. Stakeholders

List of stakeholders and when meetings took place.

Date	Attendees	Organisation
29th August 2019	Ruth Bradley	East London NHS Foundation Trust
29th August 2019	Sarah Lister, Margaret Birtles, Jacqueline Gray	One Public Estate
11th September 2019	Mayor; Christopher Roe; Claire Colgan; Olivia Quinn	Mayor & Councillor Jackson
17th September 2019	Jacqueline Gray; Cllr Sue Oliver; Cllr James Valentine; Cllr Kay Burley;	Kempston Councillors Meeting
25th September 2019	Lorraine Chown; Margaret Birtles;	Police Estates
26th September 2019	Colin Foster; Ben Pearson;	Children's Services
26th September 2019	Kate Ellis; Jackie Golding;	Bedfordshire Rural Communities Charity
3rd October 2019	Michelle Bradley; Francis Barnacle;	ELFT Mental Health & Wellbeing services
8th October 2019	Robert Freake; Simon Harwin;	Cambridgeshire Community Services - Children Services
14th October 2019	Amanda Philips	Circle MSK
23rd October 2019	Nicky Wadely; Carrie Walker; Nikki Barnes;	BCCG
28th October 2019	Claudia Montgomery	Strategic Estates, NHS England

Appendix 3. GP Interviews

Meeting	Date	Document
King Street Surgery, Kempston	13th August 2019	Kempston MCCC_Wootton GP P
Cater Street, Kempston	13th August 2019	Kempston MCCC_Wootton GP P
St Johns, Kempston	13th August 2019	Kempston MCCC_Wootton GP P

Appendix 4. Risk Register

Category	Risk Title	Risk Description/ Narrative	Consequence	Prob.	Impact	Risk Rating	Mitigating Action
Commercial	Macro-economic risks	Market conditions, specifically the potential adverse impact that the political uncertainty of Brexit may cause on the project and or the sites identified.	Sites could become unviable.	3	3	9	Conducting sensitivity analysis and ensuring the SOC report is relevant
Stakeholders	Contradictory info. from stakeholders	Contradictory messages and requirements during discovery phase requiring ratification and clarification.	No clear outcome for the SOC	3	2	6	Robust governance and defined approval processes to be put in place
Site	Site lost	A preferred site is lost to another development due to time scales of approval for SOC/OBC/FBC.	SOC becomes obsolete	3	4	12	Ongoing dialogue with landowners of preferred sites to communicate time scales
Report	SOC Approval	Report not ratified by partner organisations	SOC becomes obsolete	2	4	8	Cross partner representation on the Project Team
Report	SOC Approval - NHS	Report is not approved by NHS	SOC becomes obsolete	2	4	8	Work with SEA and partnering bodies to ensure SOC meets requirements
Stakeholders	Change of needs	Stakeholders change their needs therefore changing the area required in the MCCC	The SOC calculated areas will be invalid.	3	1	3	Ensure their needs (and the potential for change) is understood
Stakeholders	Political Change	Change in Councillors/Mayor changing the needs	SOC becomes obsolete	2	2	4	Ensure buy in by Councillors
Programme	Programme	Stakeholders cannot be consulted in time for input into the SOC	Stakeholders' views are not represented in the SOC	1	3	3	Ensure stakeholders are contacted as early as possible
Programme	Delivery of SOC	SOC cannot be delivered in time	Sites may be lost; Wave 5 may be missed	2	1	2	Ensure programme is reviewed and NHS Christmas shutdown is taken into account.

Appendix 5. Site assessment criteria

Criteria		Points
1	**Access**	
1.1	Is the site next to multiple bus routes	5
1.2	Is the site next to a bus routes	5
1.3	Is the site in a suitable area	5
1.4	Can a junction be formed with the main highway or is there an existing junction	5
2	**Impact**	
2.1	Does the site avoid estate roads which may become congested with additional traffic	5
2.2	Is the site centrally located to existing GP surgeries	2
2.3	Can surrounding parking be utilised	5
2.4	Will there be an ecological impact to the development	3
2.5	Does the site have restrictions on development (protected open space)	3
3	**Functionality**	
3.1	Is the location suitable for 24/7 working	5
3.2	Is the site suitable for 24 hour working	4
3.3	Is there sufficient onsite parking	5
3.4	What is the flood risk rating	2
3.5	Are there any complimentary services in the vicinity	3
4	**Deliverability**	
4.1	Can the site accommodate what is required?	5
4.2	Is there room for future expansion	1
4.3	Is the site in public body ownership	3
4.4	Is the site vacant	2
4.5	Does the site align with the project's timescales	4
4.6	Is there certainty of acquisition	2
4.7	Are there any identifiable planning issues	2
4.8	Are there any development controls in place	2
5	**Total**	**390**

Appendix 6. Site Scores

	Maximum Points	Site 1 Moorings	Site 2 Beatrice Street	Site 3 Land adj Kempston Pool	Site 4 Addison Howard Park	Site 5 Kempston Police Station	Site 6 Saxon Centre	Site 7 Robert Bruce School	Site 8 + Site 9 Land adj BT Offices and Offices	Site 10 80 Bunyan Road	Site 11 Land next to pumping station	Site 12 Kempston Ambulance Station	Site 13 Land next to Balfol Primary School	Site 14 Land next to Challenger Academy	Site 15 Bedfordshire Police HQ
Access															
Is the site next to multiple bus routes	5	3	3	1		4		2		3		3		2	
Is the site next to a bus routes	5	3	3	3		4		2		3		3		3	0
Is the site in a suitable area	5	1	1	2		5		3		3		3		2	
Can a junction be formed with the main highway or is there an existing junction	5	1	3	3	0	5		3		1		5		1	
Impact															
Does the site avoid estate roads which may become congested with additional traffic	5	1	1	1		3		1		3		3		1	
Is the site centrally located to existing GP surgeries	2	1	1	1		4		3		3		2		2	
Can surrounding parking be utilised	5	1	1	1		3		2		1		1		1	
Will there be an ecological impact to the development	3	3	3	3		5		3		4		5		3	
Does the site have restrictions on development (protected open space)	3	1	3	3		3		2		3		3		2	
Functionality															
Is the location suitable for 24/7 working	5	1	1	3		5		3		3		5		2	
Is the site suitable for 24 hour working	4	1	1	3		5		3		3		4		2	
Is there sufficient onsite parking	5	3	2	1	0	3		3		2		3		2	
What is the flood risk rating	2	1	3	3		3		3		3	0	3		3	
Are there any complimentary services in the vicinity	3	1	1	3		3		2		2		1		1	
L4 Deliverability															
can the site accommodate what is required?	5	3	2	1		3	0	3	0	0		0	0	2	
Is there room for future expansion	1	4	1	1		3		2		2		3		1	
Is the site in public body ownership	3	4	3	3		2		1		3		3		3	
Is the site vacant	2	2	3	3		2		2		2		1		3	
Does the site align with the project's timescales	4	3	3	3		3		2		2		1		3	
Is there certainty of acquisition	2	3	3	3		3		1		3		2		3	
Are there any identifiable planning issues	2	1	2	3		4		2		3		4		3	
Are there any development controls in place	2	2	3	3		3		2		3		3		2	
Total	390	39%	42%	44%	-200%	74%	-100%	47%	-100%	-52%	-100%	-44%	-100%	41%	-100%
Black Mark Score		0	0	0	2	0	1	0	1	1	1	1	1	0	1

Appendix 7. Presentation to Mayor of Bedford

Meeting	Date	Document
Presentation of Key Findings to Mayor of Bedford	1st December 2019	 Summary of Findings Report - Briefing Pape

Appendix 8. Police Station Site Financial Appraisal

Income

GMS Contract					
Valuation	**Quantity**	**Units**	**Value**	**FI Factor**	**PA Rent**
Consultation/Treatment Space	352	sqm	£353.15	100%	£124,309
Associated Patient Waiting Space	181	sqm	£353.15	100%	£64,019
Associated Office/Administrative	288	sqm	£353.15	100%	£101,707
Meeting Rooms	73	sqm	£353.15	100%	£25,780
Pharmacy	24	sqm	£353.15	100%	£8,476
Planning Allowance @10%	91.828	sqm		100%	£0
Engineering Allowance @20%	183.656	sqm		100%	£0
Circulation Allowance @20%	183.656	sqm	£353.15	100%	£64,858
Parking	66	bays	£235.00	100%	£15,510
Total Annual Income from GMS	**1377**	**sqm**		**£404,659**	

PCN Contract					
Valuation	**Quantity**	**Units**	**Value**	**FI Factor**	**PA**
Multi-function Rooms	325	sqm	£353.15	100%	£114,774
Associated Patient Waiting Space	167	sqm	£353.15	100%	£59,108
Associated Office/Administrative	104	sqm	£353.15	100%	£36,728
Meeting Rooms	0	sqm	£353.15	100%	£0
Pharmacy	0	sqm	£353.15	100%	£0
Planning Allowance @10%	59.6375	sqm		100%	£0
Engineering Allowance @20%	119.275	sqm		100%	£0
Circulation Allowance @20%	119.275	sqm	£353.15	100%	£42,122
Parking	39	bays	£235.00	100%	£9,165
Total Annual Income from PCN	894.6	sqm		£261,897	
Total Annual Income for Building	**2272**	**sqm**		**£666,555**	

Table 15 – Estimated Income of Police Station site

Cost

Land Assembly							
1	Land Value	£1,100,000	@	1.3	acres	£1,430,000	
2	Risk Factor	£1,430,000	@	0%		£1,430,000	
3	Demolition/Remediation					£583,560	
4	Residual Land Value					£846,440	
5	Stamp Duty Land Tax					£31,822	
5	Vendors Agents Fees	£846,440	@	1%		£8,464	
6	Vendors Legal Fees	£846,440	@	1%		£8,464	
7	Total Land Cost					£895,191	
Construction Costs							
1	Demolition					£583,560	
2	Works to Existing					£0	
3	New Build	£1,075	@	2272		£2,442,400	
4	Fit out Allowance	£1,550		2272		£3,520,852	
5	Car Park					£232,000	
6	External Works					£890,400	
	Sub total	**£3,376**				**£7,669,212**	
7.1	Prelims	£7,669,212	@	13%		£997,000	
7.2	OH&P	£8,666,212	@	5%		£433,000	
	Total Construction Cost					**£9,099,212**	
8.1	Professional Fees	£9,099,212	@	13%		£1,183,000	
8.1.1	OBC/FBC	£9,099,212	@	3%		£273,000	
8.2	Trust Works	£9,099,212	@	2%		£182,000	
8.3	Non Works	£9,099,212	@	1%		£91,000	
8.4	Equipment / IT	£2,272	@	200		£454,397	
9.1	Risk Allowance	£11,282,609		10%		£1,128,000	
9.2	Optimism bias	£12,410,609		10%		£1,241,000	
	Total Build Cost	**£6,009**		**2272**		**£13,651,609**	
Total Cost						**£14,546,800**	

Table 16 – Development Appraisal of Police Station site

NPV over 25 years

NPV has been calculated with a target rate of return of 3% and a rental growth of 2.5% pa reviewed at 5 year intervals on an upwards only basis.

Periods	Future Income	Run. Cost	Balance	Dis.Factor	PV
0	-£14,546,800				-£14,546,800
1	£666,555		£666,555	1.03	£647,141
2	£666,555	£0.00	£666,555	1.06	£628,292
3	£666,555	£0.00	£666,555	1.09	£609,993
4	£666,555	£0.00	£666,555	1.13	£592,226
5	£666,555	£0.00	£666,555	1.16	£574,977
6	£754,146	£0.00	£754,146	1.19	£631,586
7	£754,146	£0.00	£754,146	1.23	£613,190
8	£754,146	£0.00	£754,146	1.27	£595,330
9	£754,146	£0.00	£754,146	1.30	£577,990
10	£754,146	£0.00	£754,146	1.34	£561,156
11	£853,247	£0.00	£853,247	1.38	£616,404
12	£853,247	£0.00	£853,247	1.43	£598,450
13	£853,247	£0.00	£853,247	1.47	£581,020
14	£853,247	£0.00	£853,247	1.51	£564,097
15	£853,247	£0.00	£853,247	1.56	£547,667
16	£965,371	£0.00	£965,371	1.60	£601,587
17	£965,371	£0.00	£965,371	1.65	£584,065
18	£965,371	£0.00	£965,371	1.70	£567,054
19	£965,371	£0.00	£965,371	1.75	£550,538
20	£965,371	£0.00	£965,371	1.81	£534,503
21	£1,092,229	£0.00	£1,092,229	1.86	£587,127
22	£1,092,229	£0.00	£1,092,229	1.92	£570,026
23	£1,092,229	£0.00	£1,092,229	1.97	£553,423
24	£1,092,229	£0.00	£1,092,229	2.03	£537,304
25	£1,092,229	£0.00	£1,092,229	2.09	£521,655
Total					£0.00

Table 17 – NPV of Police Station site

Appendix 9. Robert Bruce Financial Appraisal

Income

GMS Contract					
Valuation	Quantity	Units	Value	FI Factor	PA Rent
Consultation/Treatment Space	352	sqm	£353.15	100%	£124,309
Associated Patient Waiting Space	181	sqm	£353.15	100%	£64,019
Associated Office/Administrative	288	sqm	£353.15	100%	£101,707
Meeting Rooms	73	sqm	£353.15	100%	£25,780
Pharmacy	24	sqm	£353.15	100%	£8,476
Planning Allowance @10%	91.828	sqm		100%	£0
Engineering Allowance @20%	183.656	sqm		100%	£0
Circulation Allowance @20%	183.656	sqm	£353.15	100%	£64,858
Parking	66	bays	£235.00	100%	£15,510
Total Annual Income from GMS	1377	sqm		£404,659	

PCN Contract					
Valuation	Quantity	Units	Value	FI Factor	PA
Multi-function Rooms	325	sqm	£353.15	100%	£114,774
Associated Patient Waiting Space	167	sqm	£353.15	100%	£59,108
Associated Office/Administrative	104	sqm	£353.15	100%	£36,728
Meeting Rooms	0	sqm	£353.15	100%	£0
Pharmacy	0	sqm	£353.15	100%	£0
Planning Allowance @10%	59.6375	sqm		100%	£0
Engineering Allowance @20%	119.275	sqm		100%	£0
Circulation Allowance @20%	119.275	sqm	£353.15	100%	£42,122
Parking	39	bays	£235.00	100%	£9,165
Total Annual Income from PCN	894.6	sqm		£261,897	
Total Annual Income for Building	2272	sqm		£666,555	

Table 18 – estimated revenue of former Robert Bruce Middle school site

Cost

Land Assembly							
	Land Value	£1,100,000	@	1.2	acres	£1,320,000	
	Risk Factor	£1,320,000	@	0%		£1,320,000	
	Demolition/Remediation					£0	
	Residual Land Value					£1,320,000	
	Stamp Duty Land Tax					£55,500	
	Vendors Agents Fees	£1,320,000	@	1%		£13,200	
	Vendors Legal Fees	£1,320,000	@	1%		£13,200	
	Total Land Cost					£1,401,900	
Construction Costs							
1	Demolition						
2	Works to Existing					£0	
3	New Build	£1,075	@	2272		£2,442,400	
4	Fit out Allowance	£1,550		2272		£3,520,852	
5	Car Park					£232,000	
6	External Works					£890,400	
	Sub total	£3,119				£7,085,652	
7.1	Prelims	£7,085,652	@	13%		£921,000	
7.2	OH&P	£8,006,652	@	5%		£400,000	
	Total Construction Cost					**£8,406,652**	
8.1	Professional Fees	£8,406,652	@	13%		£1,093,000	
8.1.1	OBC/FBC	£8,406,652	@	3%		£252,000	
8.2	Trust Works	£8,406,652	@	2%		£168,000	
8.3	Non Works	£8,406,652	@	1%		£84,000	
8.4	Equipment / IT	£2,272	@	200		£454,397	
9.1	Risk Allowance	£10,458,049		10%		£1,046,000	
9.2	Optimism bias	£11,504,049		10%		£1,150,000	
	Total Build Cost	£5,570		2272		£12,654,049	
Total Cost						**£14,055,949**	

Table 19 – Development Appraisal of former Robert Bruce middle school site

NPV over 25 years

Periods	Future Income	Running Cost	Balance	Discount Factor	PV
0	-£14,546,800				-£14,055,949
1	£666,555		£666,555	1.03	£647,141
2	£666,555	£0.00	£666,555	1.06	£628,292
3	£666,555	£0.00	£666,555	1.09	£609,993
4	£666,555	£0.00	£666,555	1.13	£592,226
5	£666,555	£0.00	£666,555	1.16	£574,977
6	£754,146	£0.00	£754,146	1.19	£631,586
7	£754,146	£0.00	£754,146	1.23	£613,190
8	£754,146	£0.00	£754,146	1.27	£595,330
9	£754,146	£0.00	£754,146	1.30	£577,990
10	£754,146	£0.00	£754,146	1.34	£561,156
11	£853,247	£0.00	£853,247	1.38	£616,404
12	£853,247	£0.00	£853,247	1.43	£598,450
13	£853,247	£0.00	£853,247	1.47	£581,020
14	£853,247	£0.00	£853,247	1.51	£564,097
15	£853,247	£0.00	£853,247	1.56	£547,667
16	£965,371	£0.00	£965,371	1.60	£601,587
17	£965,371	£0.00	£965,371	1.65	£584,065
18	£965,371	£0.00	£965,371	1.70	£567,054
19	£965,371	£0.00	£965,371	1.75	£550,538
20	£965,371	£0.00	£965,371	1.81	£534,503
21	£1,092,229	£0.00	£1,092,229	1.86	£587,127
22	£1,092,229	£0.00	£1,092,229	1.92	£570,026
23	£1,092,229	£0.00	£1,092,229	1.97	£553,423
24	£1,092,229	£0.00	£1,092,229	2.03	£537,304
25	£1,092,229	£0.00	£1,092,229	2.09	£521,655
Total					**£490,851**

Table 20 – NPV of former Robert Bruce middle school

Appendix 10. Cost benchmarking

	Wootton Vale	Kempston Police Station	Selby Community Project	Buckinghamshire Health & Care Centre	Houghton le Spring Primary Care Centre	Pallion Health Centre, Sunderland	3PD led scheme appraisal
Photo	PID Project	SOC Project					Provided by BCCG
Size (sqm) (GIA)	672	2,272	3,175	2,018	5,256	3,352	1,288
Construction cost	£2,776,180	£8,981,649	£10,183,500	£8,347,826	£24,156,546	£15,543,882	£4,477,287
£/sqm	**£4,131**	**£3,953**	**£3,207**	**£4,137**	**£4,596**	**£4,637**	**£3,473**

The above provides a cost comparison of the proposed costs of Wootton and Kempston against completed projects elsewhere in the country. The costs have been adjusted for the Bedford location factor to allow them to be compared.

The construction costs have been extracted from the appraisals for each project with the following site specific costs or costs that are not included in the final cost excluded from the above figure to provide a like for like comparison:

- Land purchase
- Demolition
- External works
- OBC/FBC production costs
- Risk allowance
- Optimism bias
- Prelims and OH&P associated with these specific costs
- Finance

Kempston is bigger than Wootton so benefits from economies of scale. Both buildings also have a Planning Allowance which offsets risk at this early stage of the project and may be reduced at OBC, reducing the size of the building and overall cost of the project.