Full Business Case

for

a Care Village in Stirling

(A Health & Social Care Partnership Venture)

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Contents

1. Executive Summary

1.1. Introduction

Note: Elements in this Executive Summary and of the Financial Case of this Full Business Case, relating to the financial model and financing arrangements, have been edited to remove text. (Reference Freedom of Information Act (2002), Part 2 Exempt Information, Section 33 'Commercial interests and the economy'.)

This Full Business Case describes the supporting case for NHS Forth Valley, Stirling Council, Scottish Ambulance Service, Forth Valley College and the Clackmannanshire & Stirling Health & Social Care Partnership together with partners, including those in the Third Sector, to take forward an innovative and integrated care model that combines primary & community healthcare with older people's care to create a joined-up holistic approach to service delivery. The Full Business Case further develops the proposed integrated care model and the supporting infrastructure using the Care Village concept as identified as the preferred way forward in the Initial Agreement and the preferred option in the Outline Business Case. The Outline Business Case demonstrated that this option is most likely to maximise the non-financial benefits required from the project, provides best value for money and has an acceptable level of risk.

Stirling Care Village will bring together on one site, in the centre of Stirling, a range of health, local authority and potential partner organisation's services. These services include: a 116 bed integrated care hub which will support an integrated care model and which can flexibly meet the short stay health and social care needs of service users over coming years, including provision of rehabilitation, assessment for ongoing care needs, palliative care and dementia care; General Medical Services; Community Nursing; a Minor Injuries Unit; Diagnostics; GP Out of Hours Service and an Ambulance Station and Ambulance Vehicle Workshop. The project will be further enhanced by its location on the Stirling Community Hospital site, co-located with a wide range of existing outpatient and community services and health professionals.

The Full Business Case describes the proposals for delivering the preferred option which demonstrably provides value for money; emphasises sustainability; sets out the contractual solution; demonstrates its affordability; details the supporting procurement strategy and the management arrangements for the successful delivery of the project. The preferred option involves the development of over 11,000 sq.m of new build accommodation at a capital (construction) cost of circa £[redacted] million.

1.2. Structure of the Full Business Case

The Full Business Case has been prepared using the agreed standards and format for Business Cases, as set out in the Scottish Capital Investment Manual (SCIM) – Business Case Guide. The document follows the recommended format of the Five-Case Model for business cases which explores the project from five perspectives:

- **The Strategic Case** - explores the case for change – whether the proposed investment is necessary and whether it fits with the overall local and national strategy.
- **The Economic Case** - asks whether the solution being offered represents best value for money – it requires alternative solution options to be considered and evaluated.

- **The Commercial Case** - tests the likely attractiveness of the proposal to developers – whether it is likely that a commercially beneficial deal can be struck.

- **The Financial Case** - asks whether the financial implication of the proposed investment is affordable.

- **The Management Case** - highlights implementation issues and demonstrates that the partner organisations are capable of delivering the proposed solution

1.3. The Strategic Case

The Initial Agreement for this project, approved in September 2012, clearly demonstrated that there is a strong Strategic Case for investment in the proposed integrated approach to health & social care. This was reviewed and confirmed when developing the Outline Business Case in 2014. The proposals in this FBC are fully in line with national and local policies and the strategic direction of Stirling Council, NHS Forth Valley and the newly established Integration Joint Board. In particular, the proposals align with the following:

- The Scottish Government's 2020 Vision – by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, and that we will have a healthcare system where:

    - We have integrated health and social care
    - There is a focus on prevention, anticipation and supported self-management
    - Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
    - Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
    - There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

- The Clackmannanshire & Stirling Health & Social Care Partnership Strategic Plan, agreed in March 2016, which endorses the Care Village as one of its key strategic priorities.

- The recently published National Clinical Strategy, the NHS Forth Valley's Healthcare Strategy, which is currently being refreshed and aligns with the aims of the 20:20 Vision and Healthcare Quality Strategy for NHSScotland.

- Scottish Ambulance Service's 5 year strategy Towards 2020: Taking Care to the Patient

- The projected increase in the elderly population and restrictions on available resources across Stirling and the wider Forth Valley area.

- Stirling Council's and NHS Forth Valley's property and asset management strategies.

1.4. The Economic Case

The main focus for the Outline Business Case was the rigorous appraisal of the short list of options for delivering the preferred way forward that were identified in the Initial Agreement.

Each of the short listed options was evaluated in terms of its benefits, lifecycle costs and risks using SCIM and HM Treasury guidance. That appraisal clearly showed that the Reference Project was the option most likely to maximise the non-financial benefits required from the project and provide best value for money with an acceptable and manageable level of risk. This FBC has revisited the economic appraisal undertaken at the OBC stage and has further developed the preferred option with the supplier to optimise value for money through the most efficient and effective procurement route.

1.5. The Commercial Case

It is intended that the Care Village will be delivered via the hub initiative, in partnership with Hub East Central Scotland Ltd (hub).

The hub route has been established to provide a strategic long-term programme approach to the procurement of community-based development through joint local venture arrangements. SCIM guidance states that this route should be the default for community based new builds over £750,000. The Economic Analysis in this FBC demonstrates that, when compared with a capital solution, the hub delivery route compared favourably in terms of value for money.

1.6. The Financial Case

The Project will be delivered under a Design, Build, Finance and Maintain (DBFM) agreement over a 25 year term with NHS Forth Valley retaining all of the assets for no additional financial consideration at the end of the contract term. The partners (NHS FV, Stirling Council and Scottish Ambulance Service) will pay an annual unitary charge throughout the contract term.

The Scottish Government will commit (subject to the required conditions being met) to provide NHS Forth Valley, on behalf of all the partners, with approximately 81.6% of the unitary charge annually over the life of the contract. Exact funding requirements will be confirmed following financial close but the net impact on annual revenue for the partners is estimated to be:

- Estimated Annual Unitary Charge: £ [redacted] m per annum
- Scottish Government Support: £ [redacted] m per annum
- Revenue Funding from Stirling Council in Lieu of Capital Injections: £ [redacted] m
- Net Remaining Cost to Partners: £ [redacted] m per annum

1.7. The Management Case

Under the hub initiative, NHS Scotland has provided an exclusivity arrangement which requires all Health Boards to consider hub as the procurement option for all community based projects in excess of capital construction value of £750.000. Only if the project does not demonstrate value for money is there the option to consider other procurement options.

Template project agreements have been developed by the Scottish Futures Trust for Design, Build Finance and Maintain contracts. These template agreements are designed to be applicable for use by all of the public sector organisations as participants in the National Hub Programme as a basis for improved efficiency in contract procurement and delivery. As part of this project, the partners, working with the Scottish Futures Trust, have also produced a draft Interface Agreement for use by the public sector partners on DBFM based contracts procured through hub across Scotland.

The project structure for the Care Village has been designed to provide a high level of consistency and co-ordination with the service change programme and the operational management structure. These links are of key importance to ensure that:

- The refinement of the plans for the Care Village take account of the most recent clinical, management and organisational practices
- The project provides a tangible framework for service redesign(i.e. significant change needs to be implemented in accordance with the project timetable)
- The operational policy for the Care Village is totally consistent with NHS Forth Valley and Stirling Council's strategies for local and accessible services.

The table that follows sets out the anticipated milestones for the development of the Care Village from formal decision making to close out and bring into service.

Stage	Activity	Date
Stage 1	Commencement	24th May 2013
Stage 1	Report Submission	18th November 2013
Stage 2	Participant requests Hubco to make a Stage 2 submission	June 2014
Stage 2	Commence RIBA Stage D Scheme Design	June 2014
Stage 2	Full Planning Consent Determination	June 2015
Stage 2	Report Submission	March 2016
Stage 2	Participant Approval to Proceed to Financial Close	June 2016
Financial Close	Contract Finalisation	June 2016
Construction	Start on Site	July 2016
Construction	Completion/ Handover of Facility	March 2019

The Strategic Case

2. Strategic Context

2.1. Introduction

This Full Business Case (FBC) describes a project developed in partnership between NHS Forth Valley, Stirling Council, Scottish Ambulance Service, Forth Valley College and the newly established Health & Social Care Partnership to develop a care model, within the centre of Stirling, that combines primary & community healthcare with Older People's Care to create a joined-up holistic approach to service delivery across the organisations.

The care village model for Older People / Adult Frailty will enable the transformation and integration of traditional health and social care community models to a new model of short stay assessment and rehabilitation based care delivered at scale. The 116 bed Care Hub will replace, integrate and expand intermediate care models currently based in Stirling Community Hospital and two Stirling Council residential care homes. The Care Village will enable this transformation model, which has been planned for and implemented since 2011, to be fully realised.

The Care Home services currently provided by Stirling Council (see Appendix A for locations) are:

- Beech Gardens, a 10 bedded unit which now provides wholly short stay assessment services (no long term residents continue to live there)
- Allan Lodge, a 25 bedded unit which now provides 20 short stay assessment services, one respite bed, and continues to support 4 long term residents. A commitment has been given to continue to support the long term residents to live there for as long as they wish while their needs can be met in this unit

A further 31 bedded unit, Wellgreen Care Home, has been closed since January 2016 as part of this transforming care programme.

The Council intends to provide the short stay assessment service in the proposed Care Hub and commission long term care and respite care from the independent and voluntary sectors.

Through provision of a flexible, integrated care environment, service users will be more appropriately supported on a broad continuum of care; from provision of a focussed (but more complex) post-acute health care model, to a more enabling, social care based model for step down and step up rehabilitation, recovery and discharge home wherever possible.

To further enhance this model of service provision, General Medical Services delivered by local GP practices will become a key service partner co-located on the site. Four Stirling City primary care practices will co-locate with Out of Hours and urgent care services, aligning closely with retained community hospital outpatient and community services. This addresses long standing challenges for GP Practices in Stirling, with the provision of modern, fit for purposes premises with flexibility to improve and expand multidisciplinary working and support new models of primary care. These new models of primary care have already been piloted in GP Practices in Stirling and elsewhere in Forth Valley.

The Care Village concept also presents an opportunity for the development of commercial and social housing as part of the wider scheme which would not only enhance the financial viability of the project but also bring potential service users closer to service providers. Housing will not be provided as part of this project but will be developed separately and a Planning Brief developed by Stirling Council will ensure consistency with the Care Village in terms of content and physical connection.

The purpose of the Full Business Case is to make the case for the investment required to deliver the Care Village. This FBC has reviewed and confirmed the value for money of the preferred option that was identified in the OBC. It has also selected a preferred procurement route and confirmed the affordability and achievability of the project.

2.2. National and Local Policy

The 2020 Vision for NHS Scotland

The 2020 Vision for NHS Scotland provides the strategic context for taking forward this project. The 2020 Vision is that by the year 2020, everyone is able to live longer and healthier lives at home or in a homely setting. Scotland will have a healthcare system where there is integrated health and social care, a focus on prevention, anticipation and supported self-management, hospital treatment when care cannot be provide in the community and day surgery as the norm.

The Care Village model will support meeting the Vision to provide integrated services closer to home. With a focus on intermediate care services which aim to prevent unnecessary admission to hospital, while supporting timely discharge, the Care Village will provide greater opportunities for interdisciplinary services which realise individual personal outcomes.

National Clinical Strategy 2016

The National Clinical Strategy was published earlier this year. The Strategy further develops the 2020 Vision, and lays out a framework that takes account of the significant changes in Scotland, including the changing demographic composition of our population, the increased demand for health and social care and significant technological changes in healthcare.

Chief Medical Officer's Annual Report 2015 - Realistic Medicine

The Chief Medical Officer's (CMO) Annual Report 2015, describes the future model of care as one with an empowered patient in a shared decision-making partnership with the clinician. The requirement for there to be co-creation of care packages that include prevention and rapid access to services when required is highlighted. The growth of supported self management is noted as a key priority allowing patients to regain control of their own health. The CMO underlines that healthcare now needs to extend far beyond the classical settings of hospitals, GP practices, and hospices and reach more effectively into a person's own home and community. The ethos of the Stirling Care Village aligns well with these aspirations.

Independent Review of Primary Care Out of Hours Services - 2015

Professor Sir Lewis Ritchie led an independent review of the Primary Care Out of Hours Service in Scotland which was also published recently. Access to urgent primary medical services outwith normal GP surgery hours is a fundamental part of unscheduled care in Scotland. The main recommendations of the report have begun to lay the foundations for an approach that will provide consistent, urgent and emergency care that is sustainable throughout Scotland. A major focus is on the need for multi-disciplinary teams – including GPs, nurses, physiotherapists, community pharmacists, social care and other specialists – working together at urgent care resource hubs across Scotland. The Stirling Care Village is an ideal location for such an innovation.

Clackmannanshire & Stirling Health & Social Care Partnership Strategic Plan

The Integration Authority for Clackmannanshire & Stirling was formally established in April 2016. The Partnership has published a Strategic Plan which endorses the Care Village as one of the key priorities of the Integration Joint Board.

The Strategic Plan identifies a core set of local outcomes in support of the nine national health & social care outcomes. These local outcomes are:

- **Self-Management** - Individuals, their carers and families are enabled to manage their own health, care and wellbeing;
- **Community Focused Supports** – Supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community;
- **Safety** - Health and social care support systems help to keep people safe and live well for longer;
- **Decision Making** - Individuals, their carers and families are involved in and are supported to manage decisions about their care and wellbeing;
- **Experience** – Individuals will have a fair and positive experience of health and social care

To implement these outcomes, the Strategic Plan identifies the following key priorities for the Partnership:

- Further develop systems to enable front line staff to access and share information
- Support more co-location of staff from across professions and organisations
- Develop single care pathways
- Further develop anticipatory and planned care services
- Provide more single points of entry to services
- **Deliver the Stirling Care Village**
- Develop seven-day access to appropriate services

- Take further steps to reduce the number of unplanned admissions to hospital and acute services

While it is clear from these priorities that the Partnership has identified the development of the Care Village as a core priority in its own right, it is equally the case that the delivery of this project will significantly contribute to the delivery of other priorities. In co-locating health and social care employees in this service, there will be greater opportunities to share information, develop single care pathways, and utilise anticipatory care approaches. This service will also contribute to the avoidance of unnecessary or unplanned admissions to acute services with the development of pathways for people to step up directly into the Care Hub facility.

Reshaping Care for Older People: A Programme for Change 2011 - 2021

The principles of Reshaping Care for Older People, together with the Clackmannanshire & Stirling Joint Commissioning Plans, are now embedded in the new Integration Authority's Strategic Plan and local outcomes.

The current Commissioning Plan supports the delivery of other strategies for particular groups or issues including the Dementia Strategy, Carers Strategy, Self Directed Support Strategy and the new Strategic Framework for Action on Palliative and End of Life Care. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people. The delivery of Stirling Care Village will support ambitions to optimise independence, while seeking to ensure that older people live well within their communities. The development of Third Sector space within the front door of the Care Hub facility will add further value in providing a space with access to information and support for carers as well as service users, again contributing to the strategic aims of the Partnership.

Clackmannanshire and Stirling's Joint Commissioning Plan for Older Peoples services (2013) outlines how, in partnership, the new care model aligns with the improvement drivers associated with Shifting the Balance of Care and Reshaping Care for Older People by providing a more user-centred and flexible approach to the care of the elderly in Stirling. It begins by shifting care towards health promotion and ill health prevention followed by short term therapeutic intervention where necessary. Provision of alternatives to hospitalisation such as ambulatory care, hospital at home and short stay step up intermediate care models are proposed with the emphasis towards care at home with short term supports and where appropriate admission to a care home planned carefully at the right time in relation to individual choice and need. The wider Care Village brings services together, including the GP Practices, to provide an opportunity for better alignment of priorities with those of the Partnership and towards developing the locality approach which is an important strand of health and social care integration.

The development of a Care Village based on older adult frailty care will, therefore, support all of these strategic intentions whilst also responding to the projected increase in the elderly population and making better use of limited resources across Stirling and the wider Forth Valley area.

Single Outcome Agreement for Stirling

Scottish Government and the Convention of Scottish Local Authorities (COSLA) expect Community Planning Partnerships, through their Single Outcome Agreements, to mobilise public sector assets, activities and resources, together with those of third and private sectors, to deliver a shared, binding 'plan for place'. The Stirling Single Outcome Agreement (SOA), approved in June 2013, is based on an understanding of the needs and aspirations of Stirling communities. The Stirling Single Outcome Agreement has seven outcomes:

i. Improved outcomes in children's early years
ii. Improved support for disadvantaged and vulnerable families and individuals
iii. Communities are well served, better connected and safe
iv. Improved supply of social and affordable housing
v. Reduced risk factors that lead to health and other inequalities
vi. Improved opportunities for learning, training and work
vii. A diverse economy that delivers good quality local jobs

The Care Village will make a positive contribution to the majority of these outcomes over time but particularly the following:

ii. Improved primary care services will support vulnerable families and children to access modern healthcare facilities when required.
v. The delivery of the Care Hub will ensure that people disadvantaged by age or frailty will be provided with services that maximise opportunities to live well in their local communities.

vii. By working in partnership with Forth Valley College, this facility will ensure that there are improved opportunities for learning and development for the current and future workforce

Scottish Ambulance Service "Towards 2020: Taking Care to the Patient"

The Scottish Ambulance Service has recently launched its new five year strategic framework "Towards 2020: Taking Care to the Patient" which continues to reflect the aspirations of the SAS to act as a key enabler in shifting the balance of care away from acute hospitals into local communities and improving patients' experience of healthcare.

The SAS recognises that it has a significant contribution to make to the effective delivery of the 2020 Vision as a frontline service providing emergency, unscheduled and scheduled care 24/7. The strategic framework describes how the SAS plans to do that in a way that supports the national quality ambitions for safe, effective and person-centred care. By 2020 the SAS aims to:

- Improve access to healthcare;
- Improve outcomes for patients – specifically cardiac, trauma, stroke, mental health, respiratory, frailty and falls;
- Evidence a shift in the balance of care by taking more care to the patient;
- Enhance clinical skills as a key and integral partner working with primary and secondary care;

- Developing the Service as a key partner with newly formed Integration Boards;
- Build and strengthen community resilience;
- Expand diagnostic capability and use of technology to improve patient care, and;
- Develop a more flexible, responsive and integrated scheduled Patient Transport Service.

Key to the delivery of this strategy is the transition to the Service's new clinical model which underpins the strategy and the transition of the workforce to work within an increasingly integrated and complex landscape. The new clinical model will facilitate a reduction in the proportion of patients being taken to hospital to around 33%. The remaining patient demand will be appropriately dealt with at the scene by paramedics or other healthcare practitioners with enhanced skills ('See & Treat'), or through the provision of telephone advice, including referral on to planned healthcare services ('Hear & Treat'). Both of these options will have access to decision support from an appropriate senior clinician.

The relocation of the Service's ambulance station and workshop to the Stirling Care Village site supports the Service's new clinical model by enabling more collaborative working with NHS Forth Valley and other partners to support an increase in the number of patients being cared for in a community setting. It also provides an opportunity to develop and enhance the Service's Specialist Paramedic model within the Forth Valley region. The enhanced skills of Specialist Paramedics means they are able to work autonomously and are able to access alternative care pathways directly, thereby offering a greater range of treatment and interventions resulting in fewer A&E attendances.
In addition, the location of the new ambulance station within the Care Village will enable improvements to be made in the Service's response times for immediately life threatening and emergency incidents.

Forth Valley College

As a key partner, Forth Valley College will be able to offer a wide range of vocational training opportunities and enhanced learning experiences in state-of-the-art facilities. They will continue to develop and nurture their extensive range of partnership arrangements which will develop the skills required by employers. Their involvement will also inform the curriculum and associated resources and shape the Continual Professional Development (CPD) of staff. This will contribute to the success of the Forth Valley area and its' regional and national economic growth and social development.

The extensive portfolio of training and development opportunities available at Forth Valley College have been enhanced through the College's involvement in the innovative approach taken by Stirling Council and NHS Forth Valley in the development of a Care Village.

This nationally recognised and supported project will provide a range of services that will underpin a unique shift from more expensive, dependant and institutional care to more independent, community enabled and responsive support that will be anticipatory and preventative and therefore preserve the independence and dignity of older people to a far greater degree than available through previous approaches.

Tackling health and social inequalities are major government priorities, and this is entirely consistent with Forth Valley College corporate objectives. The students and their learning experiences and other outcomes are critical to the College's success but unless these are cemented firmly to economic and social conditions, the professional practices and innovations will not serve to enhance the College's role and reputation as a leading provider of education and skills for Scotland.

The needs of the Care Village community will be varied and complex and will be in accordance with the strategic priorities of the Ministerial Strategic Group for Health and Wellbeing. These priorities are already well represented in the learning experiences of the College's students as well as the professional expertise of the staff, and while they cannot be provided by the services of Forth Valley College alone, the College is excited at the full contribution it will make to this multidisciplinary partnership.

Being involved from the beginning in the planning, development and delivery of such an innovative community experience is a testimony to the confidence our partners have in Forth Valley College. And, whether it is training the students to become personal carers, benefits advisors, hairdressers, construction workers, catering providers or to make some other contribution to the life of the residents of this unique and innovative Care Village, Stirling Council and NHS Forth Valley partners know that the College will do so to the highest possible standards.

It is of note that, Forth Valley College as a strategic partner, are important to the long term delivery model rather than occupying physical space within the Care Village. Their role in the partnership will be key in developing and sustaining the future workforce model for the Care Hub.

3. Existing Arrangements

3.1 Existing Service Arrangements

3.1.1 Health and Social Care Services for Older People

Until 2010, Stirling Council and NHS Forth Valley had 161 long and short term beds between Bannockburn Hospital (84) and 4 Local Authority Residential Care Homes (77). Stirling Council changed the model of care delivered within their premises in 2011, reducing and shifting residential care to care at home and creating a new intermediate care model of short term assessment in two residential care homes. The aim was to achieve a system shift, moving from long term care to assessment, rehabilitation and respite. Following a capacity modelling exercise, the service projected a requirement to grow the provision of short stay assessment and rehabilitation beds and this is being delivered within the current care homes (Allan Lodge and Beech Gardens) until completion of the Care Village, which will then see an expansion in the number of short stay intermediate care beds from 25 to 64.

Until recently NHS Forth Valley had a further 84 community hospital beds within Bannockburn Hospital but these moved (in November 2012) to the former maternity building on the current Stirling Community Hospital (SCH) site, 64 of these beds are rehabilitation / medical elderly and 20 Old Age Psychiatry (now 18). The beds were moved in line with the

Board's Healthcare Strategy, including site rationalisation plans, which identified SCH as the location for the redevelopment of bed based services in the area. Bed usage in SCH is a flexible mix of rehabilitation, complex care / palliative care, Psychiatry for Older Adults and transition patients awaiting discharge.

There are currently 18 (previously 20) resourced old age psychiatry beds in SCH, which form part an area wide model of old age psychiatry community beds. An objective of this development would be to expand opportunities for third sector involvement in the Care Village.

Third Sector organisations provide support to services largely on a visiting or outreach basis with limited capacity to expand opportunities within the current accommodation. One Third Sector organisation operates the café within the current Stirling Community Hospital site, but this is not easily accessible to all patients or their carers, with its situation in a different building to the ward based services.

3.1.2 Community Health Services

Community Teams are currently based in separate locations, with Social Care teams based in Municipal Buildings, Rehabilitation and Community Mental Health teams based in Stirling Community Hospital and District Nursing in St Ninian's Health Centre and Orchard House Health Centre.

3.1.3 GP Practices

There are four GP practices, with a combined list size of c 24,500 patients, located in separate premises with the city of Stirling (two have branch surgeries at St Ninian's Health Centre which would also be incorporated into this scheme). Information on these Practices is follows:

Practice	*List Size*	*Activity* *Typical Number of Appointments per week*	*Geographical Boundary*
Viewfield Medical Practice	7,999	Doctors 550 Practice Nurse 200	Stirling, St.Ninians, Bannockburn, Cornton, Whins of Milton, Cambuskenneth and Cambusbarron Village. The boundaries are Easter Cornton Road to the railway crossing between Cornton Vale and Bridge of Allan and from the Alloa roundabout on the bypass and along Alloa Road to Causewayhead.
Park Avenue Medical Practice	7,950	Doctors 500 Practice Nurse 185 Visiting Clinicians 26	North of Stirling to Keir roundabout, South of Stirling to Pirnhall roundabout, East of Stirling to Eastern Distributor Road (Logie Kirk), West of Stirling to Gargunnock Village, Bridge of Allan, Bannockburn,

Practice	*List Size*	*Activity* *Typical Number of Appointments per week*	*Geographical Boundary*
			Cambusbarron, Gargunnock.
Park Terrace Medical Practice	6,631	Doctors 400 Practice Nurse 330 HSW 110 (2) Visiting Clinicians 15	Bannockburn, Blairlogie, Bridge of Allan, Fallin, Gargunnock, Plean and Stirling.
Wallace Medical Practice	1,894	Doctors 144 Practice Nurse 91 Visiting Clinicians 5	Stirling, Bridge of Allan, Fallin, Bannockburn, Cambusbarron

The Practices are currently located in either GP owned or leased premises within the city and these will be sold/vacated as the Care Village becomes operational. A full transport assessment has been carried out which shows no significant detriment to the Practices' patients and indeed concludes that, on average, more would be within walking distance.

3.1.4 Scottish Ambulance Service

The Scottish Ambulance Service currently operates from the Ambulance Station at Lovers Walk, Riverside, Stirling, on a 24/7 basis, this facility has been in use since October 1987 and most recently has become the location of their vehicle workshop since its transfer from Falkirk.

A plan showing the locations of the main services in question is included in Appendix A.

Further details of existing arrangements in association with each investment objective are outlined in the section describing the 'Business Need'.

3.2 Existing Property Arrangements

NHS Forth Valley and Stirling Council carried out a design quality assessment of their existing properties to articulate the shortcomings of accommodation currently used to provide their health and social care services affected by this project. A standard toolkit was used, namely Achieving Excellence Design Evaluation Tool (AEDET), which provides a questionnaire based assessment focussed on ten areas of property design. The intention of this assessment is to identify key design objectives that any new facility needs to achieve by setting a benchmark of current performance from which future design proposals and eventual replaced facilities can be assessed against.

The ten areas of property design used in the assessment are:

- Character and innovation in overall design.

- Appearance based on building form and materials.
- Quality of internal environment for staff and service users.
- Urban and social integration with neighbouring community.
- Physical performance of building.
- Quality and suitability of engineering systems.
- Ease of construction (not used at this stage of design consideration).
- Functionality of accommodation.
- Ease of access to accommodation.
- Sufficiency of available space

The following table provides an average AEDET score against each of these design areas from each partner organisation:

Design Area	Average AEDET Score (out of 6)		
	Stirling Council	**NHS Forth Valley**	**GP Premises**
A: Character & Innovation	2.55	2.30	2.43
B: Form and Materials	2.80	3.60	3.20
C: Staff and Patient Environment	2.80	3.60	2.53
D: Urban & Social Integration	2.55	2.50	3.80
E: Performance	3.20	3.80	3.60
F: Engineering	2.75	2.60	1.73
G: Construction	-	-	-
H: Use	1.40	3.70	2.23
I: Access	2.48	3.40	2.17
J: Space	3.05	3.70	2.13

The average AEDET score for all properties associated with this project is 2.84 out of a potential total of 6, which is less than 50% of that available. The main issues highlighted within the assessment for each property group are summarised below:

- Stirling Council accommodation:
    - Buildings will be unable to cope with projected increased throughput and are inflexible to change.
    - Building layouts will restrict implementation of new care model.
    - Buildings' design and age creates a detrimental impact, rather than an improvement, to their locality.
    - Engineering systems to buildings are old and outdated.

  - General access to buildings is poor.
  - Available space is inadequate for needs.

- NHS Forth Valley accommodation- former Maternity Block:
  - Designed for alternative use and remodelled to best fit current use which limits effectiveness of modern service delivery.
  - Old building is not particularly appealing or welcoming.
  - Most of engineering infrastructure is aged, in poor condition and in need of replacement.
  - Best use is made of available space but design and layout does affect functionality.
  - General access around site and to former Maternity Block is poor.
  - Space in some areas is compromised, mainly in the inpatient areas where there is also a significant lack of single rooms.

- GP accommodation:
  - Available space is inadequate for requirements which affects functionality of service provision.
  - Practices are full to capacity based on available space.
  - Engineering systems are old and outdated.
  - Some accommodation needs internal refurbishment.
  - Existing properties will struggle to support delivery of new service model and are inflexible to change.

NHS Forth Valley's Property & Asset Management Strategy (PAMS) identifies known condition and other issues with several of the existing NHS owned and GP owned and leased properties. The 2015 summary position for Stirling Community Hospital is as follows:

					% in Category A or B, or Fully Utilised			
Site	Floor Area (m^2)	Overall Backlog Cost	Cost per sq.m	Age - 50+ Years	Physical Condition	Functional Suitability	Space Utilisation	Quality
Stirling Community Hospital	27,330	£1,874,177	£69	NO*	68%	82%	98%	54%

In the most recent survey carried out on Primary Care Services, the Viewfield, Park Avenue and Park Terrace Medical Practices are identified as having improvement needs. The Wallace Practice, as noted, occupies leased premises in the centre of the City and whilst of reasonable condition and quality, it is on an upper floor, shared with offices and with restricted parking.

Practice Name	Ownership of Premises	Physical Condition	Functional Suitability	Space Utilisation	Quality
Park Avenue	GP owned	C	B	F	B
Park Terrace	GP owned	B	B	O	B
Viewfield	GP owned	C	C	F	B
Wallace	Private Landlord	B	B	F	B

3.2.1 Scottish Ambulance Service

The location of Scottish Ambulance Service at Lovers Walk, Stirling is not ideal in terms of good access and egress for emergency and non-emergency ambulance vehicles. Access to the Station is via Lovers Walk which has a partial one way system in place. This also creates operational resilience issues as the site can only be accessed via Lovers Walk. This issue was recently evidenced when a utility company attempted to close off the only access/egress route from the Ambulance station in December 2012. In addition to this, egress from the Station can be delayed due to traffic congestion at peak times. This has the potential to have a detrimental effect on Ambulance response times and ultimately patient care. In addition, Lovers Walk cannot be accessed from the customs roundabout which results in ambulance vehicles requiring to take a significant detour to access the Ambulance station.

The current Ambulance Station in Stirling is almost 26 years old and is in need of investment to ensure that it meets the various standards required e.g. Health & Safety, Healthcare Environment Inspectorate [HEI].

3.2.2 Forth Valley College

Forth Valley College enjoys significant campus presences in Stirling, Falkirk and Alloa. The recent and extensive capital expenditure and campus redevelopment will be more than sufficient to meet the needs of this project and will ensure access to sustainable and appropriate high quality learning across the Forth Valley region for many years to come. Training will therefore be delivered across existing sites, supported effectively and efficiently within planned Care Village facilities.

4. Organisational Overview

4.1 NHS Forth Valley

NHS Forth Valley controls an annual budget of around £550 million**,** and is responsible for providing health services and improving the health for a population of c300,000 covering a geographic area from Killin and Tyndrum in the North to Strathblane and Bo'ness in the South. Its services are provided through an integrated system comprising acute and community hospital services and community based services. The Public Bodies (Joint Working)(Scotland) Act 2014, saw the creation of two partnerships in Forth Valley through the integration of health and social care, one partnership in Falkirk and one joint partnership with Clackmannanshire and Stirling. The Integration Joint Boards that govern the

partnerships have been established and are responsible for delivery of the Partnership's Strategic Plan.

NHS Forth Valley employs around 8000 staff from a wide range of professional and support occupations in our acute hospital, four community hospitals, other community based sites and 56 health centres.

4.2 Stirling Council

Stirling lies in the heart of central Scotland with a population of 90,770 with projected growth to 104,300 by 2035.

Stirling Council controls an annual budget of around £214 million, of which the budget relating to social care is £47 million and covers a geographic area of over 800 square miles reaching from the shores of Loch Lomond in the west, to the village of Tyndrum on the edge of Rannoch Moor in the north, and the former mining villages of Fallin and Plean in the east.

Its services are wide ranging and essential to enhancing the quality of life of people living in or visiting the area, including support for those in need; education for young people and provision of cultural and sporting opportunities for all. From the city, with its stunning skyline dominated by the historic castle, to some of Scotland's finest countryside beyond, the area may be steeped in history, but it also has a modern vibe within the city centre.

The Council provides a wide spectrum of services and support and employs around 4,500 staff from a wide range of professional and support occupations.

4.3 Scottish Ambulance Service

The Scottish Ambulance Service is Scotland's national public Ambulance Service. As the frontline of the NHS in Scotland, it provides an emergency ambulance service to a population of over 5 million people serving all of the nation's mainland and island communities. The Service employs 4,300 highly skilled staff and responds to nearly 600,000 Accident and Emergency calls a year, around 450,000 of which are 999 emergency calls. The Patient Transport Service undertakes over 1.3 million journeys every year. It provides care for patients who need support to reach their healthcare appointments due to their medical and mobility needs.

East Central Division covers the geographical and Health Board areas of Tayside, Fife and Forth Valley with over 650 staff employed across 23 Ambulance locations covering an area of around 4,500 square miles and a population of around 1048000. Divisional Headquarters are located in Dundee. Forth Valley Sub-Division have 170 staff spread across the area at 8 locations covering a population of nearly 300,000. Stirling Ambulance Station has 65 staff who provide scheduled care [non-emergency] and unscheduled care [emergency] services to the people of Stirling and surrounding areas.

4.4 Forth Valley College

Forth Valley College is a leading provider of further and higher education offering a wide range of courses and training opportunities. They welcome approximately 14,500 students per academic session with 94% of learners progressing to further studies or employment upon completion of their course.

They are Scotland's first regional college with four state-of-the-art campuses across the central belt in Alloa, Falkirk, Raploch and Stirling. Their dynamic provision ranges from access to degree level and includes full-time and part-time courses, evening classes, flexible and on line learning, vocational qualifications and business training courses. They have eight teaching departments including Access and Progression; Applied Science, Maths and Mechanical Engineering; Business; Care, Health and Sport; Construction; Creative Industries; Electrical, Instrumentation and Chemical Engineering; and Hospitality and Salon Services.

The college works closely with a wide range of partners to ensure they are delivering opportunities which meet the needs of learners, employers, local industry and national skill agendas.

5. Business Strategy & Aims

NHS Forth Valley and Stirling Council are entering a new and exciting chapter through the integration of health and social care and the establishment of the Integration Joint Board. As described, the Stirling Care Village also provides the opportunity to work in partnership with the Scottish Ambulance Service and Forth Valley College. The Integration Joint Board Strategic Plan sets out the desired outcomes and priorities for the partnership with the delivery of Stirling Care Village a core part of the overall Plan. The focus is to fully embed new and integrated models of care across the range of care settings, from home to hospitals. The continued focus on partnership working towards greater integrated service provision with improved outcomes is at the heart of the vision.

NHS Forth Valley has also developed a Property & Asset Management Strategy (PAMS) to bring together a range of proposals that support and enable NHS Forth Valley to respond to the challenges and drivers for change and grasp the opportunities that these create for improving the quality, effectiveness and efficiency of its services and physical assets. Further work is planned with the newly formed partnerships to maximise opportunities and potential across the organisations in terms of asset management.

5.1 Performance Targets (SOAs, Local Delivery Plan - HEAT Standards)

The extant Scottish Government's National Performance Management Framework sets out the overall approach to deliver the Government's long term aspirational goals and purpose. The key aims are to:

- Identify and drive the contribution of NHSScotland to the overall strategic objectives of the Scottish Government through the National Performance Framework
- Demonstrate clear alignment between short term operational targets and the longer term strategic direction set out in this document
- Ensure close linkage with the accountability and performance arrangements that apply for local government and enables joint roles, responsibilities and actions to be agreed at local level through Community Planning arrangements

Integral to the National Performance Framework are NHS Local Delivery Plans (LDP's) and Single Outcome Agreements (SOAs). The Local Delivery Plan (LDP) remains the delivery

contract between Scottish Government and NHS Boards in Scotland. The LDP focuses on the priorities for the NHS in Scotland and supports delivery of the Scottish Government's national performance framework, the Health and Social care outcomes that have been developed in partnership, and the 2020 Vision for high quality, sustainable health and social care. SOAs set out how each community planning partnership will work towards improving the health and wellbeing of their local population in a way that reflects local need, circumstances and priorities consistent with national outcomes. As highlighted in the Section 2.2 the Stirling SOA has 7 outcomes, with this project making a positive contribution to these aims.

As previously noted, the Clackmannanshire and Stirling Strategic Plan 2016 – 2019 describes how the Partnership will make changes and improvements to develop health and social services for adults over the next three years with the Stirling Care Village a key priority.

As part of the overall picture of performance, the Scottish Government has also developed 9 National Health and Wellbeing Outcomes supported by a Core Indicator Set to provide a framework for integration partnerships to develop their performance management arrangements. It is worthy of note that the National Outcomes for Health and Wellbeing also directly relate to the Benefits Realisation against the Investment Objectives for this project.

It is important to note that Stirling Care Village may have an impact on relevant targets and indicators. By linking the Investment Objectives to realising core benefits such as co-location, minimising Length of Stay, focussing on rehabilitation and intermediate care, the real impact will be evident.

Key targets within the LDP that will be of relevance are:

Enable people to understand and adjust to a diagnosis, connect better and plan for future care.

- People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support

NHS Boards are expected to improve SAB infection rates during 2016/17. Research is underway to develop a new SAB standard for future years.

- Clostridium difficile infections per 1000 occupied bed days (0.32)
- SAB infections per 1000 acute occupied bed days (0.24)

Enabling people at risk of health inequalities to make better choices and positive steps toward better health

- Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients

- 48 hour access or advance booking to an appropriate member of the GP team (90%)

Sound financial planning and management are fundamental to effective delivery of services

- Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Over and above the LDP Standards, additional issues such as Delayed Discharges, Length of stay, patient experience, etc. all require consideration. A significant number of measures within the SOA are also of relevance to this project, many of which focus on improved experience and support for disadvantaged or vulnerable people.

Through the focus on Benefits Realisation, work has been undertaken to review the Investment Objectives and link these, where possible, to the 9 National Outcomes for Health and Social Care and the core suite of indicators developed by the Scottish Government, along with other relevant KPIs and targets noted above. This will develop over time as the project delivers.

6. Other Organisational Strategies

6.1 The 2020 Workforce Vision

NHS Forth Valley is fully engaged in the developing 2020 Workforce vision. Building on the current workforce framework "A Force for Improvement", the 2020 workforce vision is currently being developed. Integration of health and social care is a thread that runs through all of the 2020 workstreams which are underpinned by:

- Staff governance and engagement

- Leadership and capability

- Capacity and modernisation.

6.2 Telehealth and Telecare Strategy

Stirling has a well-developed telecare service. The role of telehealthcare in supporting the delivery of strategic initiatives such as Reshaping Care for Older People and Shifting the Balance of Care has been increasingly recognised within the Scottish Government and with Health and Social Care Partnerships.

The partnership have supported the implementation of telehealthcare under this plan, and continue to do so through grant funding from the Technology Enabled Care Programme – 'Delivering out Ambitions – A National Technology Enabled Care Improvement Programme Plan.' This includes opportunities to expand the use of technology enabled care, along with increasing access to video-conferencing for home health monitoring. The Care Village will support the assessment of appropriate technology to maximise independence and self-management.

7. Stakeholder Engagement

Service change has been assessed by the Project Team in accordance with the Chief Executive Letter (2010) 04 and in liaison with the Scottish Health Council. This assessment concluded that the project does not involve a major service change.

The process of engagement and consultation with stakeholders in developing the proposals in this FBC is described below and will be ongoing as implementation continues:

A Communications Plan is in place for the project and is reviewed at each stage to ensure that it remains robust and appropriate. This lists the various stakeholders, milestones and key activities to be carried out and in what way.

Further to that, the Care Village concept is an integral element of the Joint Commissioning Plan and the communication and engagement strategy thereof. Extensive consultation has taken place with older people, service users, carers and the third sector as well as health and social care service providers over the lifetime of Reshaping Care for Older People and the Joint Commissioning Plan and prior to that in the context of NHS Forth Valley's Integrated Healthcare Strategy. (Further information on the Joint Commissioning Plan and engagement can be found at http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/joint-commissioning-plan/)

Through the project governance structure, members of the Public Partnership Forum (PPF) participate in a number of workstreams and groups and the Scottish Health Council are part of the PPF and also participate there, as well as giving specific advice and assistance with engagement. Updates on the project are given regularly at PPF meetings.

Specific public engagement has taken place as part of the development of the masterplan for the Care Village site and the process for securing Planning Permission in Principle. This has taken the form of open events held in Stirling Community Hospital and attendance at Community Council meetings and other forums as well as information being available on the web and in press releases.

The NHS Board is facilitating the GP Practices' engagement with their patients, building on work undertaken previously with a similar, centralised proposal on another site. It is recognised that further assistance will be required for the Practices to fulfil their commitment to engagement and to continue to improve upon what has gone before and this will take place as appropriate as the project progresses

Briefings have taken place with local elected members and communication with the local MSP has occurred on a regular basis.

A Steering Group has been established as part of the project structure to keep Council elected members and Health Board Non-Executive Directors appraised of the development of the Care Village business case and the work undertaken to involve stakeholders and local communities including Community Councils.

8. Business Needs – Current and Future

This section identifies the 'business gap' in relation to existing arrangements. In other words, the difference between 'where we want to be' (as suggested by the Investment Objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, difficulties and inadequacies associated with the status quo. The following table shows the existing arrangements in respect of each Investment Objective and describes the problems with these existing arrangements in order to identify 'business need'. It then further describes what is needed to overcome these problems.

Note: the detailed information used to describe the existing arrangement will form the benchmark from which the future achievement of the Investment Objectives can be measured**.**

Investment Objective	**Increase integration & communication between health & social care services and delivery to service users**
Existing Arrangement The status quo	Service providers are currently split over multiple sites / locations across Stirling (see above). Each service provider generally works autonomously to deliver outcomes specific to that organisation / centre. Communication is often via remote channels or a joint meeting when circumstances demand. Although joint collaboration between organisations has improved more recently, the separation of services in discrete locations remains a significant challenge in implementing effective service delivery solutions.
Business Need Problems with the status quo	Current split site arrangements restrict opportunities for co-ordinated approach to service provision and the potential to improve service outcomes for users. This includes restricting effective development of Intermediate Care services and the benefits that would arise from that arrangement. It also restricts service continuity which can be difficult when patients are unable to access their 'own GP'. An approach towards preventative care is difficult without a holistic co-ordinated approach between health and social care professionals and Third Sector organisations. Communication between professionals is disjointed and has the potential to confuse service users and to not attain the best possible service.
Potential Scope What is needed to overcome these problems	Co-locate services to increase opportunities for integration and effective service delivery. Develop intermediate care services to provide rehabilitation and reablement services Provide holistic, co-ordinated approach towards preventative care Develop relationships with Third Sector organisations to offer preventative supports, which enable service users to live successfully in their own homes, reducing social isolation. Engender opportunities for joined-up working & improved communication between different service providers

Investment Objective	Improve user experience of local health & social care service provision
Existing Arrangement The status quo	Consultation with the Stirling community suggests that they want: • The opportunity to stay in their own home, with friends and family around them for as long as possible. • To have a service that can respond to changing need. • Prevention from having to stay in hospital longer than needed. Baseline planning information for this development indicated that: • The number of home care clients is 54.7 per 1000 population, which is lower than the Scottish average of 68.2. The latest data suggests some improvement. • Provision of intensive (10+ hours per week) care at home is 9.4 (per 1000 population) was significantly lower than the Scottish average. The latest data suggests some improvement. Whilst the number of residential Care Home places per 1000 population for Stirling was the same as the Scotland average, the 'Balance of Care Indicator' for Stirling was much lower than the Scotland average, thus confirming a greater reliance on institutional residential care. • There has been significant development of reablement / rehabilitative approaches over the last two years. Service users may need several transitions through the care journey to access the appropriate care (based on multiple locations for service delivery), which creates a fragmented approach to the delivery of health and social care services Service users access care via old, outdated accommodation that impacts on user perception of their overall experience (see AEDET review of existing accommodation)
Business Need Problems with the status quo	Outcomes for individuals, particularly at the key decision points such as following illness, bereavement or other traumatic life events, are at times adversely affected by the lack of appropriate levels of support at home or in a flexible intermediate care resource. The limited capacity in the current intermediate care model (25 beds v planned 64) results in increased likelihood of admission to hospital and to long term care and delays in discharge. The lack of support to older people to help them maintain independence or intermediate care reduces quality of life for those in need and also contributes to an increase in emergency hospital days. Service fragmentation has the potential to confuse service users, require unnecessary transitions through the care journey, and restricts attainment of the best possible service. User perception of old, tired accommodation is that this will impact on the quality of service provision.
Potential Scope What is needed to overcome these problems	Reduction in unnecessary hospitalisation through enhanced discharge pathways. Reduced delayed discharges. Increased number of people being supported to live at home Shorter lengths of stay in care home Increase in number of home care clients to, at least, Scotland average levels. Increase in provision of intensive care at home to, at least, Scotland average levels. Providing a greater proportion of care delivered at home, and thus ensuring that the 'Balance of Care Indicator is, at least, at Scotland average levels. Develop intermediate care services to provide rehabilitation and reablement services. Co-locate services to reduce the number of disjointed transitions through the care journey. Improve the condition of facilities used to provide services.

Investment Objective	Improve access to care
Existing Arrangement The status quo	There are multiple locations from which services are based and / or accessed; which includes separated accommodation for health care beds and social care residential beds, and 4 separate locations to access GP services. The AEDET review of existing premises suggests that they present difficulties regarding physical access to service delivery points. The 'Balance of Care Indicator' (as discussed above) for Stirling of 19% seems to suggest a greater reliance on institutional residential care than population needs.
Business Need Problems with the status quo	The variety of access points can lead to confusion over the most appropriate point of access and delays to care provision whilst transferring from one access point to another. Physical access to service providers can require several journeys which also increases the problems of accessibility to older properties. Access to the current model of care can lead to a more institutionalised placement when more user focussed intermediate care would be more suitable. There had been historical delays in accessing social care services for older people. Access to care through the current system is inflexible to user needs and, therefore, more flexible solutions are required.
Potential Scope What is needed to overcome these problems	Centralise services to reduce number of physical access points and create seamless link between health & social care beds. Improve accessibility of facilities used to provide services. Shift the focus from long term care in care homes to short stay intermediate care, maximising the potential for older people to be independent or cared for at home. Providing a greater proportion of care delivered at home, and thus ensuring that the 'Balance of Care Indicator is, at least, at Scotland average levels. Make effective use of resources to ensure that number of those waiting for social care assessment is reduced.

Investment Objective	Improve care pathways, capacity and flow management
Existing Arrangement The status quo	The baseline number of community hospital beds is 86 at Stirling Community Hospital, however, this can vary in year with the deployment of planned, additional winter capacity. At the baseline planning stage, there were three care homes operating across Stirling. (One has now closed and only one of the remaining care homes has long term care clients, currently 4 clients.) There are over 500 independent sector care home beds in Stirling with an average occupancy of 85% and a reducing length of stay as Stirling has redressed what was a slightly high balance of care indicating higher than average reliance on long term care The four separate GP practices across Stirling City have a combined list size of c24,500 patients. Population expectations for Stirling suggest an increase in over 65 year olds of 14% within a 5 year period (15,447 in 2010 to 17,639 in 2015); and a 17% increase for over 80s (4006 in 2010 to 4684 in 2015). More recent data suggests that over the ten years from 2016-2026, this population will increase further by 22.1% Stirling has generally met delayed discharge targets over a number of years but

Investment Objective	Improve care pathways, capacity and flow management
	with some pressures on packages of care, mainly in rural Stirlingshire.
Business Need Problems with the status quo	The current financial climate requires maximisation of all available capacity to minimise increased demand for beds. Current accommodation is unsuitable for modern service provision and patient expectations. It will therefore need to be replaced at some point in the near future. Flow of patients from Forth Valley Royal Hospital into available beds is compromised due to lack of availability of single rooms. Cumulative length of stay across the full hospital/ intermediate care stay requires to be reduced. Although average stays are between 6 and 10 weeks across the current models, lengths of stay at significantly higher levels are not uncommon for complex frail elderly individuals who often are discharged to long term care. Delays in discharge are generally low, however, meeting the two week target is extremely challenging and a lack of integration between models of care mean that more people than necessary are discharged to care homes rather than their own homes. Maintaining delayed discharge targets relies on minimising long term care demand through preventative models of care and adequate care home capacity and home care provision. Increased future demand for services, particularly for those over 65 years old will put increasing pressure on existing services to cope with that demand. The functional suitability difficulties associated with old, outdated accommodation restricts the effectiveness of care pathways and flow management. There is a critical need to further develop the effectiveness of health care in communities, especially in remote and rural areas, to ensure that they receive the best possible service. This will mean working in conjunction with all community partners, including the communities themselves, to understand needs and identify, design and implement solutions through collaborative working and sharing of resources.
Potential Scope What is needed to overcome these problems	Reduce reliance on institutional care and demand for health & social care beds to ensure capacity continues to meet demand. Provide more suitable and flexible bed provision so that use for health and social care purposes can be interchangeable. Provide an integrated approach to service delivery to improve flow of patients from health beds to social care or own homes, whilst also maintaining current low levels of delayed discharge. To achieve this, resources need to be increased to enable more care at home, and bed capacity needs to be more flexible to cope with changing demands. Provide pathways that enable people to 'step up' to beds and avoid the need for admission to acute hospital.

Investment Objective	Maximise flexible, responsive and preventative care - at home, with support for carers
Existing Arrangement The status quo	Baseline data in 2011 indicated that: • The number of home care was lower than the Scottish average. • Provision of intensive (10+ hours per week) care at home was significantly lower than the Scottish average. • Whilst the number of residential Care Home places per 1000 population for Stirling was the same as the Scottish average, the 'Balance of Care Indicator' for Stirling was much lower than the Scotland average, thus confirming a greater

Investment Objective	Maximise flexible, responsive and preventative care - at home, with support for carers
	reliance on institutional residential care. • Reablement and Rehabilitation are now core to community care services, but there continues to be limited effective delivery of step down care due to numerous sites and inconsistent pathways. The baseline data for the 'Balance of Care Indicator' (as discussed earlier) for Stirling suggested a greater reliance on institutional residential care than population needs.
Business Need Problems with the status quo	The model for Older People's Care does not fully meet Stirling community's needs and aspirations for them to be able to stay at home for as long as possible, to have a service that is flexible to their changing needs, and which prevents them from staying in hospital longer than they need. Any lack of support to older people to help them maintain independence or intermediate care reduces 'quality of life' for those in need and also can contribute to an increase in emergency hospital days.
Potential Scope What is needed to overcome these problems	Increase the number of home care clients. Increase provision of intensive care at home. Develop effective step up and step down Intermediate Care to provide rehabilitation and reablement services to avoid hospital and care home admission and expedite hospital discharge where appropriate. Provide a Third Sector interface which supports users and carers to maximise their potential, receiving effective sign-posting to community supports. Further scope to utilise Third Sector space to support people to continue to live well with long term conditions, through meeting and social spaces.

Investment Objective	Make best use of available resources
Existing Arrangement The status quo	The baseline data of the 'Balance of Care Indicator' (as discussed earlier) for Stirling suggested a greater reliance on institutional residential care than population needs. Population expectations for Stirling suggest an increase in over 65 year olds of 14% within a 5 year period (15,447 in 2010 to 17,639 in 2015); and a 17% increase for over 80s (4006 in 2010 to 4684 in 2015). More recent data suggests that over the ten years from 2016-2026, this population will increase further by 22.1%
Business Need Problems with the status quo	Current facilities are run at capacity. Meeting projected increased future demand for services will be unsustainable from current financial resources. More expensive interventions from both health & local authority provision are having to be utilised due to the lack of support for self-care and independent living at home
Potential Scope What is needed to overcome these problems	Introduce a new model of older people's care that: • Provides a greater proportion of care delivered at home. • Provides the flexibility to deliver better services and deliver all the investment objectives described herein. • Is able to cope with the projected increase in demand for services. • And, is affordable for all partner organisations.

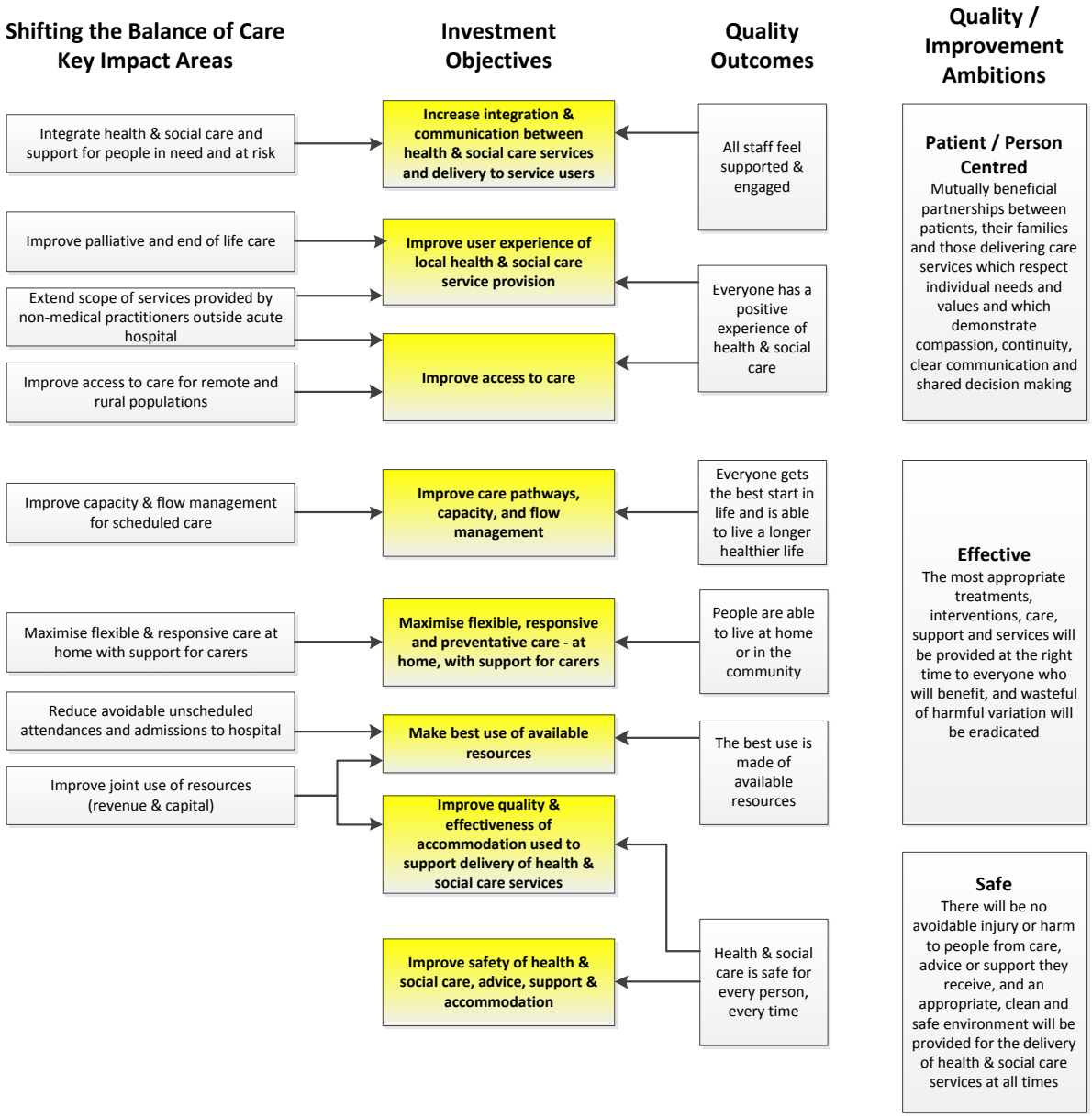
Investment Objective	Improve quality & effectiveness of accommodation used to support service delivery
Existing Arrangement The status quo	An AEDET assessment has been carried out on all properties associated with this project which produced an overall average score of 2.84
Business Need Problems with the status quo	The main issues and problems highlighted within these assessments are summarised within the 'Existing Property Arrangements' section of this Full Business Case
Potential Scope What is needed to overcome these problems	The design of any new or remodelled accommodation delivered as part of this project will need to overcome the existing accommodation deficiencies as described and, more specifically, will need to attain a minimum AEDET score of 5 for each Design Area, with an average overall score of 5.5. The sustainability objective will be to obtain a BREEAM "Excellent" rating for all new build accommodation.

Investment Objective:	Improve safety of health & social care, advice, support & accommodation
Existing Arrangement The status quo	There is a lack of single bedrooms in the existing NHS accommodation. The AEDET review of existing premises highlights the outdated accommodation which is not always maintained to modern statutory compliance and health & safety standards.
Business Need Problems with the status quo	There is an increased risk of HAI from multi-bed wards with a lack of flexibility towards isolation. These older properties increase the risk of harm from property related incidents due to: • Lower fire safety standards • Need for backlog maintenance • HAI concerns • Trips and falls
Potential Scope What is needed to overcome these problems	Increase number of single room use to reduce risk of infection transmission Improve AEDET score for facilities used in providing services Improve access to Third Sector supports for advice, support and involvement through having a presence within the Care Hub facility.

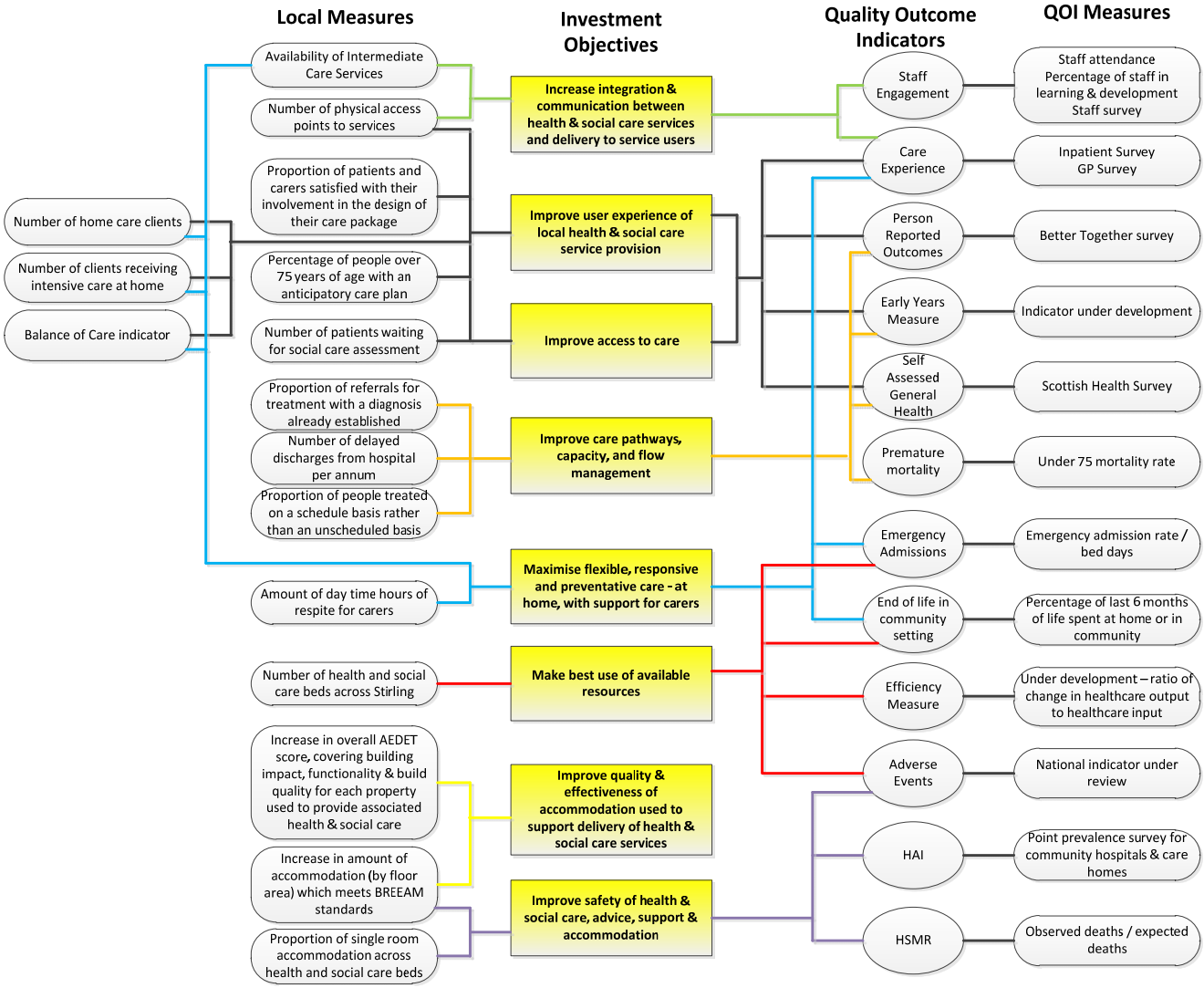
9. Investment Objectives

9.1 Investment Objectives

The investment objectives for this scheme have been developed to specifically fit with the key impact areas considered in the Shifting the Balance of Care Improvement Framework. It also aligns with the six quality outcomes identified in NHSScotland's Quality Strategy. The following diagram maps out how the Investment Objectives are aligned with both the Shifting the Balance of Care and Quality Strategy Policy initiatives. Although the investment objectives were agreed some time ago, they align well with the local outcomes within the Health & Social Care Partnership's Strategic Plan (as Section 2 above).



The measure of attainment of these Investment Objectives will be via a combination of the published Quality Outcome Indicators (QOI) and associated measures which are able to be specifically linked to this scheme, as well as a range of local measures developed specifically for this scheme. The QOI measures will be used to demonstrate the wider contribution this scheme will have on the improved health and well being of the Stirling community whilst the local measures will provide the local focus for improvement and achievement of the Investment Objectives related to this scheme. The following diagram maps the linkage between each Investment Objective and the range of Quality Outcome Measures and Local Measures:



9.2 Design Quality Objectives

The design quality objectives for the scheme have been set out in the attached Design Statement (Appendix B). The Design Statement has been prepared to ensure that implementation in terms of the design and construction of the physical premises meets the needs and objectives of stakeholders.

The Design Statement has been used as the initial tool with which to communicate the vision of the Care Village to designers and those "non-negotiables" which form a variety of

perspectives which the design must achieve. It has also been used to develop a more detailed design brief, again in consultation, which forms the basis of construction information used to develop the detailed proposals described in this Full Business Case.

Any new or remodelled accommodation used to provide the services described in this FBC will need to overcome the existing accommodation deficiencies as described in Section 3.2. In line with current guidance, the sustainability objective associated with this accommodation was to obtain a BREEAM "Excellent" rating for all new build accommodation. A BREEAM Assessor has been appointed for the project and initial assessments undertaken which at OBC stage indicated that “Excellent” was achievable, although with minimal tolerance. Detailed discussion has taken place during Stage 2/Full Business Case in relation to the ‘pragmatic’ approach to BREEAM and the output of the final pre-construction assessment proposed as follows:

Primary & Urgent Care and Care Hub – Very Good

Scottish Ambulance Service Workshop – Excellent

10. Desired Scope and Service Requirements

This section of the Full Business Case provides a detailed description of the business scope and the service outputs and requirements. It has been prepared following a revisit, review and further development of the potential business scope and high level service requirements developed in the Initial Agreement and Outline Business Case for the project.

The Initial Agreement assessed the scope and the service requirements for the project and the Preferred Way Forward that emerged from a detailed appraisal of a long list of options is for joint commissioning of a new care model for Older Peoples Services with a “care hub” located on Stirling Community Hospital site. Further work at the OBC and FBC stages confirmed that this model sits at the core of a much broader community based care model for older people across Stirlingshire. It is a model that provides a unique opportunity to develop an innovative and integrated form of care provision and one which inherently facilitates and promotes significant integration of current health and social care services.

The short stay model proposed for the Care Village will largely provide the capacity to support acute hospital discharge whilst avoiding premature admissions to care homes. It also provides an opportunity for community services to ‘step up’ into the Care Hub at the point of crisis or as an alternative to acute hospital when care at home is no longer possible for reasons of health, carer crisis or other. The Care Hub is central to reducing time spent in institutional care and breaking the historic cycle of delayed discharges, reducing the time spent unnecessarily in hospital and providing appropriate placement for long term assessment. The overlap between community hospital and SC short term assessment is evident as is the requirement to reduce overall lengths of stay and generate a more effective flow of care with better outcomes. Day of care audits conducted from 2014 onwards confirm the assumption that around 80% of patients in Stirling Community Hospital were suitable for non-medical models of care and could have their needs met outwith an inpatient environment with health support.

From the model of step up/down services currently being delivered within Stirling Council Care Homes, outcomes for service users are routinely analysed. The Health and Social Care Benchmarking Network carried out an appreciative inquiry into the outcomes of these services during December 2015, and found that 70% of service users returned home following a step up/down intervention, and remained at home 12 weeks after discharge. Service strengths identified in this inquiry included networked teams, and a high level of co-production between health and social care partners. Skill levels of staff were also found to be high, with increased autonomy resulting from this.

Personal outcomes are collected within service provision to support service change and improvement and these feed into national frameworks including a Community of Practice Website – Community Hospitals and Intermediate Care Networks: –

http://www.knowledge.scot.nhs.uk/chin/intermediate-care.aspx

Digital stories of service user experience of step up/down are held on this site along with other materials which support the model of service delivery.

Further outcomes from step up/down services are illustrated below:

Service User Experience	**Outcome**
Mr C was admitted to step up/down services following a number of falls at home. Personal outcomes of improving mobility, while being assessed on ability to manage daily living tasks were identified. Mr C was visually impaired, meaning that he had additional risks when carrying out some tasks, especially managing his medicines.	While Mr C worked at improving his balance and physical strength, the team worked with him to identify simple, low tech solutions to managing his medicines effectively. Mr C was reluctant to accept home carers as part of his discharge plan so it was found that through a simple method of colour coding his medicines, which his family could maintain, he could manage these independently. The service was able to seek solutions which were meaningful to Mr C, with him at the centre of decision making. This avoided overly complex or costly packages of care to return home, while supporting him to maximise his independence.
Mrs D was admitted to step up/down services following assessment of risks identified by her Reablement Carers. This avoided an admission to the Acute Hospital and allowed Mrs D to be assessed in a more homely environment. Mrs D had a diagnosis of Alzheimer's and had had a number of falls at home. She was also having difficulty in managing her own meal preparation, sometimes forgetting to eat at regular intervals. Mrs D had also activated the fire alarm within the housing complex where she lived, due to burning food that she was trying to prepare.	Following assessment and rehabilitation of her physical strength and mobility, Mrs D was identified as someone who would benefit from a range of technology enabled care solutions to support her to live at home. This included:- • A wrist worn fall detector • A light sensor connected to a bed exit monitor • An extreme temperature sensor • A dementia clock

Service User Experience	Outcome
	Further to this, links were made with a Third Sector organisation who were able to offer a be-friending service to Mrs D and support her with both her shopping and social networks. This gave Mrs D the confidence to be able to return to a historical society she attended locally as well as her library, enabling her to live well with her condition at home.

The desired scope for this new service model is a continuum of care from prevention through to short term therapeutic intervention, long term continuing care and to palliative and end of life care. Whilst the Older Peoples Services Care Hub will form the nucleus of the project on the Stirling Community Hospital site the project will also incorporate and co-locate a range of integrated health, social care and housing services for the Stirling area. Hence, in addition to creating an Older Peoples Services Care Hub the project proposes to co-locate General Medical Services, Primary Care Services (including Community Nursing, outpatient clinics, minor injuries, x-ray and GP out-of-hours services) on the site. The long term vision for this integrated health and social care model also includes the provision of housing designed with older people in mind, with the ability to introduce either formal or informal personal care services as required to enable the resident to remain at home for as long as they choose.

The vision extends to the provision of vocational training on the site through Forth Valley College. This is seen as a very important supporting service in terms of ensuring the future workforce through training, placement and volunteering opportunities.

The Stirling Care Village offers an exciting opportunity for the Scottish Ambulance Service to work together with partner organisations to improve the quality of care and service offered to the people of Forth Valley. In addition to enhanced facilities and learning opportunities for the SAS workforce, the move to the Care Village would allow greater integration and partnership working between Scottish Ambulance Service Paramedics and other clinical colleagues in the Minor Injury Unit [MiU] and the General Practitioner out of Hours Service [GP OOH]. The integration, partnership working opportunities and patient benefits that this initiative has the potential to create fits with the SAS Clinical Strategy which is intrinsically linked to the delivery of the Strategic Framework noted above. SAS aim to optimise their unique position to be able to work across boundaries in primary, secondary and tertiary care through a range of national clinical networks. This will be increasingly important in the current financial climate as SAS seeks to support its wider NHS partners to maintain high quality and cost effective care. Traditionally, the role of the Scottish Ambulance Service has been to take patients to hospital, whether for emergency, unscheduled or planned care. This role is changing as the healthcare needs of patients and the NHS in Scotland change. The Scottish Ambulance Service is committed to supporting the wider NHS to achieve a shift in the balance of care by extending the range of pre-hospital care, working in partnership with NHS Boards to agree and implement evidence based pathways of care that will see more patients being treated in their homes or local communities.

In addition to the relocation of the Ambulance Station to the Care Village the Scottish Ambulance Service has already relocated their vehicle workshop from its existing site in Falkirk to the Lovers Walk facility in Stirling. The current facility operates with two maintenance craftsmen and provides a vital service which ensures that the Scottish Ambulance Service vehicle fleet and associated equipment is serviced and maintained to a high standard to enable Ambulance crews to respond to and support the people of Forth Valley. The next move, to the Care Village site, will enable a better operational footprint for the workshops to access Ambulances requiring maintenance, better staff and workshop facilities and has the potential to develop further into collaborative working in the public sector should this be developed in future. It is this co-location of a range of services and facilities which will provide a continuum of care based on an integrated service model that has led to the partners adopting the term “Care Village” to describe the project. The concept is aimed at developing the flexibility of care provision that will be needed in the future whilst introducing economies of scale both that will enable the these services to be affordable and sustainable in the longer term.

Service Outputs

The services included within the scope of the project are intended to deliver a number of service outcomes.

The review of the Initial Agreement and the Outline Business Case has confirmed that this approach is essential for the sustainability of Older Peoples Services over the next decade and beyond. It is clear that during this period demographic trends and pressures on health and social care spending will require service providers to identify opportunities to deliver improvements in quality at lower cost. This is a challenge that has been recognised for some time by the partners in this project and a change programme has been underway for a number of years aimed at a new model of service delivery that optimises the effectiveness of services and the use of resources. Older Peoples Services are the essential “hub” of the proposed investment in modernising services and facilities that are proposed in this Full Business Case. Without this investment in the redesign of services and modernisation of facilities the improvements in service effectiveness and quality that arise from the new model will not be realised.

The design of the facilities will be flexible enough to allow either short or longer term variation in bed use. Current modelling indicates that, set against an expected rise in demand due to demographics, the overall social care transition from long term (Length of stay in years+) to short term care (length of stay 6-7 weeks) can support a reduction in overall resourced bed numbers from 161 in 2011 to 140 (116 care hub beds, resources for commissioning 14 respite beds outwith the Care hub and resources to reshape psychiatry activity).

New admissions of psychiatry patients to community beds in Stirling have remained low and care audits demonstrate that very few patients actually require specialist hospital care. There is a reducing number of patients who have long lengths of stay and who meet the criteria for NHS continuing care. At a recent review, supported by Stirling Social Services, it was proposed that 13 out of 15 patients in SCH could have their care needs met out with a hospital setting and that an intermediate care model could provide better outcomes for individuals.

The proposed strategy, in alignment with the recently published NHS Continuing Care Guidance (DL (2015) 11), highlights that there is a case for continuing an area wide specialist inpatient model and reshaping bed based resource to provide intermediate care focused provision alongside community psychiatry support to care homes and community teams, both health and social care, across Forth Valley.

The table below demonstrates combined bed model transition for older peoples care.

Local Authority and NHS Transition of beds for Older Peoples Care 2011 -2017

	2011		**Winter Peak 2014/15**		**2017**
Intermediate Care Beds	**94**	**Intermediate Care Beds**	**125**	**Care Village**	**116**
Bannockburn Elderly Medicine	62	SCH Elderly Med	68	Integrated Intermediate Care Model	116
Bannockburn Old Age Psych	22	SCH Old Age Psych	18	Release hosted Bed resource Psychiatry	10
		SCH Winter Contingency	14		
Stirling Council Int care	10	Stirling Council Int Care	25		
Residual Residential	67	Residual residential	23	Provision for Respite out with care village	14
TOTAL	161	Total	148	Total Re-provision	140

It should be noted that all long term care is now provided in the private sector in Stirling where supply is strong and lengths of stay are slowly but steadily reducing (see graph below). From regular point prevalence and day of care audits over many years it has been evidenced that the numbers of service users delayed in discharge has reduced, however the proportion of service users who are appropriate for non-medical intermediate care is over 80%. It is envisaged that there will be a reduced number of health specific beds, however an increase in flow from FVRH for those patients with more specific health needs. The majority of beds will be integrated based on a more social model of care with health input as individual needs require. Workforce for the health component of the Care Hub model is aligned with acute inpatient wards while the intermediate care workforce is social care based but with enhanced health input, (eg AHP workforce) to maximise the potential for rehabilitation.

Demand and Length of Stay Assumptions

At the outline planning stage for the Stirling Care Village Care Hub in 2011 the baseline capacity available was 84 beds in Bannockburn Community Hospital and 77 beds in Stirling Council Care Homes, therefore total bed capacity of 161 beds. However, at that time there were a number of beds which were “inactive” within Stirling Council care homes and were in the process of being closed. The table above explains the transition of beds from 2011. At that time, it was identified that there was an overlap in planning assumptions between Council intermediate care planning and community hospital planning for those patients who no longer required medical intervention and were in a process of rehabilitation and planning for discharge. Models of intermediate care in a social care setting were evidencing shorter lengths of stay and the care model was predicated on an assumption that patients would not

be in a community hospital bed for discharge planning, but would be transferred to a social care bed model with enhanced health input to maximise rehabilitation potential within a 6 week average length of stay. Subsequent audits of the needs of patients in Stirling Community Hospital confirm that the majority of patients do not require ongoing continuing health care and that their needs could be met in as intermediate care facility.

Assumptions & Key Differences from Baseline Model to Care Hub Model

A number of assumptions were made when assessing the capacity required for Stirling Care Village:

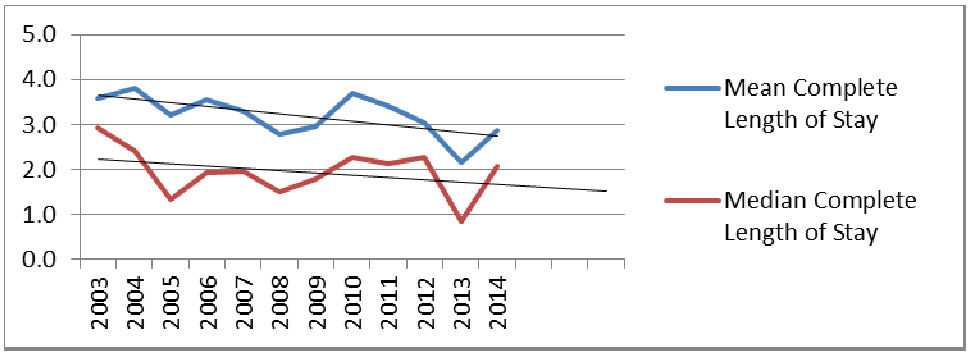
- Number of residential long term care placements has been reducing with internal Stirling Council care homes no longer utilised for long term care. This has resulted in the closure of Wellgreen Care Home, while other facilities, Beach Gardens and Allan Lodge have been developed to provide the intermediate care model of step up / step down beds.
- Average length of stay has been reducing within long term nursing care (care home), indicating that people are entering long term provision later than in the past, with better personal outcomes being cared for at home. We have assumed this trend will plateau or continue to decrease.
- There are established models of community supports including rehabilitation at home and reablement. The use of these services supports the overall delivery of intermediate care closer to home.
- There is evidence of a robust independent care home sector which meets the expectations of the capacity modelling. Beds in the independent sector are being utilised with length of stay reducing.
- Current models of intermediate short stay assessment (step up / step down beds), show that 70% of users return home either independently or with a package of care, while 30% of users require support in a care home.
- Stirling Care Village will deliver a reduced average length of stay of 6 weeks.
- Shorter LoS will help decrease the risk of loss of independence and maximise the ability of people to return home
- Ability to use bed resource flexibly between Health and Intermediate Care beds
- Ability to coordinate patient's pathway in a more streamlined way in a single unit with a flexible workforce.
- Enhanced health support for the intermediate care beds to maximise rehabilitation opportunities.

Current Capacity and Demand

The capacity assumptions for the Care Hub are based upon a co-located and integrated model whereby a reduction in average length of stay will be realised through more focussed intermediate care, reablement and rehabilitation. As highlighted previously, it is important to recognise the changing demographics indicating a 22.1% increase in the population over 65years of age by 2026 which will require additional capacity over time. Based on current utilisation of both health and social care facilities (2015) circa 42000 bed days were utilised running at 92% occupancy with a 7-8 week length of stay. Through the Care Village model,

calculations are based on an increased occupancy and shorter length of stay to between 6 and 7 weeks providing sufficient capacity for current demand and growth.

Stirling Council: Length of Stay in Independent / Charitable Sector Long Term Care



General Medical Services

The Primary Care facility provides a significant opportunity to improve the quality of GP premises and includes capacity for further development in Primary Care Services in the future.

The co-location of GPs within a single facility supports the implementation of new models in Primary Care Services linked to the new GP contract, including supporting workforce sustainability; multidisciplinary team development similar to those piloted in other areas of Forth Valley (Practice based Pharmacist, Advanced Nurse Practitioners, AHP's and Community Mental Health Nurses) and the introduction of new quality improvement clusters.

The co-location on site with other community services will enable improved and streamlined working across core members of the Primary Care Team including District Nurses, Health Visitors and AHP's.

The role of GP Practices in delivering the shift in focus from hospital based care to community based care, high on the strategic agenda, will be reflected in locality plans being developed through the Integration Joint Board.

Primary Care Hub, including Minor Injuries, X-ray and GP out-of-hours

As part of NHS Forth Valley's full implementation of its Healthcare Strategy for this site, and the model of care structure associated with it, there is a need to develop a primary care hub which includes minor injuries, x-ray and GP out-of-hours services alongside GMS services. This will form an important part of the scope of the Care Village concept, delivering modern services, co-located with the GP Practices.

The majority of the remaining, existing NHS based community hospital services on the Stirling Community Hospital site (including outpatient services) will be unaffected by the integrated older people's care model and are not, therefore, included as part of this scheme.

However, these existing community hospital services will look to become fully integrated into the Care Village concept over the next few years.

Enhanced Partner Services - Forth Valley College

Both NHS Forth Valley and Stirling Council recognise that workforce and succession planning is crucial to the long term success of this project and that the inclusion of Forth Valley College as a strategic partner will provide the management skills and resources needed to ensure that the project can achieve its objectives by having the right people with the right skills in the right place at the right times both now and in the future.

As part of the development of this Full Business Case Forth Valley College has developed plans for vocational training for the Care Village site. The College are particularly interested in delivering vocational training in a community setting. .

The college will support the training and continued professional development of a future health and social care workforce through the utilisation of opportunities and facilities in the Care Village, providing employment, training, placement and volunteering opportunities for local people.

The involvement of the College will ensure a vibrant mix of people of varying ages working and living on the site which will promote better understanding of each other's point of view and a common goal to make sure that the Village is widely supported and sustainable in the longer term. As such the project has the potential to provide a platform from which to build an innovative intergenerational community with social and support networks across and between generations. Such innovation is at the heart of challenging the perception that older people are passive recipients of care and promoting their engagement as active citizens. The College's role is fundamental to the ambition that the Village will be an opportunity to deliver social innovation which will provide better ways of living longer, improving everyday life and better ways of providing support in an ageing society.

Scottish Ambulance Service

Through the co-location of the ambulance station and ambulance vehicle workshop on the Care Village, SAS aim to optimise their unique position to be able to work across boundaries in primary, secondary and tertiary care through a range of national clinical networks. This will be increasingly important in the current financial climate as they support the wider NHS partners to maintain high quality and cost effective care.

The move of the ambulance vehicle workshop to the Care Village site will enable a better operational footprint for the workshops to access Ambulances requiring maintenance, better staff and workshop facilities and has the potential to develop further into collaborative working in the public sector in future, should this be developed.

Housing Accommodation

In Stirling Council's Housing Need and Demand Assessment, Housing Services recognise a shortfall in properties suitable for older people and there is, therefore, a need to develop appropriate provision and approaches to address this. The introduction of the Care Village concept, which encourages the provision of housing for older people, has the potential to provide a viable part-solution to this problem: the ideal being housing designed with older

people in mind, with the ability to introduce either formal or informal personal care services as required to enable the resident to remain at home for as long as they choose. The development of housing for older people is part of the overall, longer term vision for the Care Village although it will not be developed as part of the project and will be taken forward separately.

Two key benefits to the Care Village concept of introducing focussed older people's housing on the same site as health and social care services is the improved access to care for those residents; and the amalgamation of service users and service providers in a focussed approach to service delivery. It should, however, be noted that the introduction of focussed housing accommodation as part of the Care Village will not in any way preclude or reduce the quality of service delivery to those in the Stirling community not resident in the actual Care Village.

Another important aspect of utilising surplus land on the Stirling Community Hospital site to develop focussed housing is that the land sale proceeds may help to fund other parts of the Care Village concept. By designating this land for housing use, whilst retaining a health & social care purpose, may also increase the land value and thus the potential financial support to the overall scheme.

Discussions have taken place between NHS Forth Valley and Stirling Council with regard to the development of housing and a potential housing 'mix' determined. A draft Planning Brief has been developed which will govern the development of the surplus land and ensure the correct 'relationship' (content and physical) with the Care Village. This Planning Brief will be progressing through consultative stages in 2015 prior to adoption by Stirling Council. The proposals contained within this FBC are not contingent upon the future development of the housing, however, they are seen as complementary rather than essential and are not included in this Full Business Case.

Implementation

With regard to implementation of the proposals on the existing site, which will remain operational during the project, the Project Team will be working closely with hubco and the contractor with a view to minimising disruption, though some will be inevitable. A detailed construction methodology and phasing plan has been developed as part of the Stage 2/Full Business Case.

11. Benefits

On the basis that the proposed service model is put in place, the following identifies the key benefits likely to be attributable to achievement of each investment objective:

Investment Objective: Increase integration & communication between health & social care services and delivery to service users			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Delivery of more effective care with improved user outcomes	High	Medium & longer term	Qualitative and quantitative
Greater collaboration between partner organisations to improve effectiveness of preventative and intermediate care	High	Medium & longer term	Qualitative
Improved staff engagement & communication between partner organisations	Medium	Medium & longer term	Qualitative
More service users able to return home following hospital care (based on draft intermediate care performance measures)	High	Medium	Quantitative
Shared use of partner resources	Low	Medium term	Cash & resource releasing
Improved working arrangements and facilities for staff resulting in greater job satisfaction and less turnover / sickness	Medium	Medium term	Qualitative & resource releasing

Investment Objective: Improve user experience of local health & social care service provision			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Positive experience of health and social care	High	Medium term	Qualitative
More people able to access care from their preferred location (i.e. at home)	High	Medium term	Quantitative
More people able to return home following hospital care (following rehabilitation and reablement)	High	Medium term	Quantitative & resource releasing
Better transition through each care journey	High	Medium term	Qualitative
Positive experience of the environment in which services are provided	Medium	Medium term	Qualitative

Investment Objective: Improve access to care			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Maximised range of health and social care services available locally	High	Medium term	Qualitative
Point of access to care is less confusing	Medium	Medium term	Qualitative
More likely to receive the most appropriate care	High	Medium term	Qualitative
Ability to access care at home	High	Medium term	Quantitative
Better physical access to care facilities	Medium	Medium term	Qualitative
Flexible bed usage enables more user focussed care	High	Medium term	Qualitative

Investment Objective: Improve care pathways, capacity and flow management			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
More people treated on a scheduled rather than unscheduled basis	High	Medium & longer term	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Flexible use of beds better meets service user needs	High	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Quantitative & cash releasing
Services users don't have to stay in hospital longer than necessary	High	Medium term	Quantitative

Investment Objective: Maximise flexible, responsive and preventative care - at home, with support for carers			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
More people able to access care from their preferred location i.e. at home	High	Medium term	Quantitative
More people able to return home following hospital care	High	Medium term	Quantitative & resource releasing
Providing care at home is more cost effective than institutional care	High	Medium term	Cash & resource releasing to Council
Carers feel better supported in their role	High	Medium term	Qualitative

Investment Objective: Make best use of available resources			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Affordable service delivery	High	Short, medium & longer term	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Service model is more flexible to future changes in demand	Medium	Medium term	Qualitative
Reduction in overall number of beds (from the baseline high of 161 in 2011)	High	Medium term	Cash & resource releasing to NHS & Council
Reduced demand for more expensive care pathways (through shift from health to social care models of care)	High	Medium to longer term	Cash releasing to NHS & Council

Investment Objective: Improve quality & effectiveness of accommodation used to support service delivery			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Improved user perception of quality of care	Medium	Medium term	Qualitative
Improved condition of available accommodation	Medium	Medium term	Qualitative
Accommodation meets modern service needs & enables flexibility of use	High	Medium term	Qualitative
Improved functionality of accommodation improves service effectiveness	High	Medium term	Qualitative

Investment Objective: Improve safety of health & social care, advice, support & accommodation			
Benefit	**Relative Value**	**Relative Timescale**	**Type**
Reduced risk of HAI incidents	High	Medium term	Qualitative
Reduced risk of harm from property related incidents	High	Medium term	Qualitative

12. Strategic Risks

Numerous national and international studies have shown that one of the main reasons for change projects being unsuccessful in terms of cost and time overruns and/or failing to deliver the expected benefits is as a result of the failure to properly identify and manage the project risks. The partners in the project have developed and maintained a comprehensive risk register from commencement of the Initial Agreement through to the development of this Full Business Case and covering all aspect of the project. The majority of these risks have been quantified financially and are included within the capital and revenue estimates for the project.

Extracts from the Risk Register are attached at Appendix C.

13. Constraints & Dependencies

Service Model Constraints

The two main constraints to the introduction of the new older people's care model are the unsuitability of the existing facilities and the need to move towards a more integrated approach to service delivery in order to attain the identified benefits from this scheme.

It is possible, to a certain extent, to provide a co-ordinated approach to service delivery from the current arrangements but this is unlikely to achieve the full benefits that a fully integrated, centralised Care Village approach will achieve.

The main barrier is the existing accommodation. AEDET reviews of the existing facilities identified the restrictions caused by this accommodation and the general poor condition and unsuitability for modern service provision. Also, the flexibility of bed usage inherent in the care model cannot be achieved from the outdated accommodation split over several sites.

Capital Funding Constraints

Due to the current funding constraints faced by public sector organisations at the moment, capital funding for the entire scheme is unlikely to be made available. On the basis of a revenue funded solution, and in recognition that capital injections are no longer permissible post ESA10, sources of capital funding have been sought from the partner organisations to support the moveable equipment requirements of the project.

In addition, NHS Forth Valley will utilise sales proceeds, with an estimated value of £ [redacted] m, from surplus land on the existing Stirling Community Hospital site to part fund required improvements to the retained estate.

Revenue Funding Constraints

Equally there are pressures on revenue funding. The additional capital charges and/or revenue based procurement charges mean that the property occupancy costs for this project are likely to cost more than they do now. However, the Scottish Government have instigated a mechanism whereby it will fund a large proportion of these additional property based revenue costs for schemes that it approves.

The current capacity planning model suggests that there will be a decrease in the workforce cost due to a change in skill mix if the new older people's care model is fully implemented and is contained within the parameters and assumptions used to build up the financial forecast.

The affordability of this scheme has been tested fully throughout the different approval stages of this project and a fully detailed revenue model is included in this FBC.

13.1 Dependencies

The development of an integrated approach to older people's care is dependent upon the continued collaboration between Stirling Council and NHS Forth Valley to deliver an effective and efficient system wide prevention based model of care of which the care village is a key component. The principles of care are based on:

Prevention - In the main, people wish to continue to make a positive contribution to society at the onset of their older years and although often relatively active, they need to be supported by a pro-active approach to health promotion and ill health prevention to avoid the need for care services.

Short term therapeutic intervention - As ‘older’ old age approaches and there begins a decline in health or ability, the focus shifts to services aimed at reducing incapacity and thus reducing the consequences of any decline. These ‘short–term therapeutic interventions’ require to be responsive to sudden changes in situation or health state, intervening to prevent or minimise e.g. hospitalisation or social crisis. Options including short stay

intermediate care, are designed to support the older person to return to family, social and cultural life as quickly as possible.

Long term continuing care and end of life care - intensity and therapeutic support will increase and decrease as crisis or events demand. This model requires to be responsive and focused on the individual's outcomes in relation to their ability and potential. As care needs increase the journey may flow into more regular care support. This could be at home with carer or respite support interspersed with short-term 24-hour care in order to maintain an individual within their home. The objective is to avoid admission to longer term care or at least delay this until living at home is no longer a possible option. This type of care is likely to support those with greater needs than is currently the case and for significantly shorter lengths of stay than currently.

Without this collaboration, not only would each organisation need to progress with its own individual care intervention services but achieving optimal outcomes throughout the wider care model would not be possible.

The Care Village concept is also dependent upon the collaboration and inclusion of other partner organisations, such at the local GP practices, the primary care hub development, the other community hospital services already on site, and in time the additional housing accommodation. NHS Forth Valley are currently in discussion with Stirling Council's Housing Service as to how the latter might be best taken forward and as noted in Section 9 above be developed in a separate but complementary way. Further support from Forth Valley College, local Charities and the Voluntary Sector will enhance the Care Village concept but the success of the scheme is not dependent on their inclusion.

The continued inclusion of the different partner organisations involved in this scheme, and their interdependency on each other, is one of the key challenges to the success of the scheme.

The Economic Case

14. Critical Success Factors for the project

In addition to the Investment Objectives set out in the previous section of this Full Business Case, the Care Village Partnership Group identified a number of factors which, while not direct objectives of the investment, will be critical for the success of the project, and are relevant in judging the relative desirability of options.

The agreed Critical Success Factors are shown in the table below.

Key CSF's	Broad Description
Strategic fit and business objectives	Fits with the strategic intention to shift the balance of care from acute to primary care and from institutional care to home care It is also in line with Stirling Council's Single Outcome Agreement. It is a priority for the Clackmannanshire & Stirling Health & Social Care Partnership and will form part of NHS Forth Valley's forthcoming Healthcare Strategy and associated Property & Asset Management Strategy
Potential VFM	It enhances service delivery, improves user experience, and achieves the project investment objectives from an efficient cost base, while at the same time reducing service delivery risks
Potential achievability	The key service providers are able to adapt to the proposed service changes and deliver an enhanced service from identified resources
Supply-side capacity and capability	Service providers have the resource capacity and capability to deliver the proposed service model and facilities; and the scheme will be able to attract the necessary investment.
Potential affordability	Available capital and/or revenue funds will be sufficient to provide the facilities and ongoing resources needed to deliver the proposed service model

15. Main Business Options

The main business options were developed in the Initial Agreement from a long list using the options framework approach and were re-visited as part of the development of the OBC. The short list of options for delivering the preferred way forward were subjected to a rigorous option appraisal at the OBC stage to identify a preferred option. Little has changed since the development of the OBC that is likely to have a material impact on the work done to explore the way forward in terms of the five categories of choice - scope, service solution, service delivery, implementation and funding for the project.

16. The Preferred Way Forward

The Preferred Way Forward identified in the Initial Agreement and revisited and reviewed at the both the OBC and FBC stages is considered to be the most effective way of delivering the investment objectives and achieving the critical success factors for the project. It is based on the appraisal of the main business options (long list) and is made up of the preferred option from each category of choice i.e. the scope, service solution, service delivery, implementation and funding options for the project.

The Preferred Way Forward can be described as the continued and further development of an integrated care model that combines primary & community healthcare with older people's care to create a joined-up holistic approach to the services delivered by NHS Forth Valley, Stirling Council and the newly established Health & Social Care Partnership. In this model the health and social care services for elderly people will be provided jointly by the NHS and Social Services from one facility – an Elderly Care Hub on the Stirling Community Hospital site. The model will co-locate services with the aim of enabling and facilitating their integration in terms of staffing and the built environment. The emphasis will be on providing a unique environment where service provision will be closely matched to people's needs and will be able to cover the broad continuum of health and social care needed by elderly people. This model of integrated service provision, provided in a purpose designed and built environment will result in a service user experience greatly enhanced and quite different from that provided in a hospital or care home setting. The capacity of the facilities will be based on needs projections that have been made for the period up to 2030 with a total of 116 beds being provided.

The continued development of the integrated model of care provision for elderly people, enabled by the creation of the Care Hub within the Care Village, will be further improved by the co-location on the site of General Medical Services delivered by local GP practices. Services will be further enhanced by a range of other service providers such as the Scottish Ambulance Service, Forth Valley College, local charities and the voluntary sector. It is this co-location and integration of services, together with the existing Community Hospital services on the site that gives rise to the Care Village concept that is used to describe the overall project described in this Full Business Case.

The Care Village concept also presents an opportunity for the development of commercial and social housing as part of the wider scheme which would not only enhance the financial viability of the project but also bring potential service users closer to service providers.

17. Short-listed Options

The short list of options for delivering the Preferred Way Forward was rigorously appraised at OBC stage and again revisited and reviewed for this FBC. The preferred option that emerged from this process now reflects the changes that have taken place since the development of the Initial Agreement, including the inclusion of the Scottish Ambulance Service in the scheme. This resulted in the rejection of the "Least Ambitious" option since, when reviewed by the Project Team, this was considered to be unable to deliver the key Investment Objectives relating to improving the integration and communication across health

and social care services since it does not co-locate health and social care services on the Care Village. The revised short list of options for delivering the Preferred Way Forward is shown in the table that follows.

	Summary Descriptions of Short Listed Options for Delivering the Preferred Way Forward			
	Do minimum	**Less ambitious**	**Reference Project**	**More ambitious**
Scope	Older people's health and social care services for the Stirling area including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care	Older people's health and social care services for the Stirling area including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care. In this option, NHS FV and the Council will be working together to deliver services but with a lower level of integration. The Council will move away from providing care through residential homes	Older people's health and social care services for the Stirling area including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care	Older people's health and social care services for the Stirling and a wider catchment area including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care
			General Medical Services	General Medical Services
			Urgent Care Services including Minor Injuries, X-ray and GP out-of-hours	An extended range of Urgent Care Services including Minor Injuries, X-ray and GP out-of-hours. This option would also accommodate Pain and Ophthalmology Services subject to affordability and value for money testing.
		Enhanced Partner Services – FV College, charities and voluntary sector provide training but separate from NHS FV and Council	Enhanced Partner Services – FV College, charities and voluntary sector provide training integrated with that of NHS and Council	Extended and enhanced Partner Services – FV College, charities and voluntary sector provide a wider range of service such as catering, administration training etc
		SAS ambulance station and ambulance vehicle workshop	SAS ambulance station and vehicle workshop	SAS ambulance station and vehicle workshop
Service Solution	As existing – no further development of the Integrated Service Model	Further development of the Integrated Service Model based on an increase in care at home and a rehabilitative approach where possible	Further development of the Integrated Service Model based on an increase in care at home and a rehabilitative approach where possible	Further development of the Integrated Service Model based on an increase in care at home and a rehabilitative approach where possible.
Service Delivery	Existing service delivery arrangements	Development of a Care Village – excluding Urgent Care Services(Minor Injuries, X-ray and	Development of a Care Village – integration and co-	Development of a Care Village - integration and co-location of existing health and

		GP out-of-hours)	location of existing health and social care services in Stirling	social care services in Stirling

18. NPC Findings

An economic appraisal of the short listed options was undertaken for the OBC and has been revisited and revised for this FBC. The Net Present Cost (NPC) of the options is shown in the table that follows. This appraisal takes into account the full capital and revenue costs of the options over 60 years using Discounted Cash Flow techniques. Hence, the economic appraisal enables the options to be compared in terms of their total costs (NPC). In accordance with SCIM and HM Treasury Guidance the NPCs have been calculated using the Treasury's Generic Economic Model (GEM) which uses a discount rate of 3.5% for the first 30 years of the appraisal and 3% thereafter. The results show that although the Do Minimum Option has the lowest net present cost over 60 years, it is only marginally lower than the Reference Project (Preferred).

	NPC £millions	
Option	**60 Years**	**Rank**
Do Minimum	329.7	1
Less Ambitious	337.3	3
Reference Project (Preferred)	337.2	2
More Ambitious	366.4	4

19. Benefits Appraisal

Non Financial Benefits

A rigorous appraisal of the shortlist of options in terms of their expected non-financial benefit was completed as part of the development of the OBC and has been revisited and reviewed for the development of this FBC. This is a very important appraisal since any investment in services and facilities is expected to deliver significant benefits for patients, staff and service users. This appraisal was undertaken at a workshop on 12 February 2013 which was attended by a broad range of representatives from the stakeholder organisations including members of the business case project team, service providers such as clinicians, service managers and staff, service users, public representatives and senior managers.

In summary, for the workshop appraisal involved:

- Reviewing each of the shortlisted options so that workshop participants clearly understand the scope, service model and differences between each option.

- Discussion and agreement on a set of non-financial benefit criteria and the weighting of these to reflect the workshop group's view of their relative importance.

- Examining each option against the criteria and agreeing how that option met the criteria and agreeing a score for each option against each weighted criterion.

- Computing an overall weighted benefit score for each option. This weighted benefit score is simply a measure of how well the workshop participants considered each option was likely to deliver the benefits required from the project

The workshop was facilitated by the independent business case adviser for the project who had no interest in the outcome of the appraisal but was able to guide the participants through the process to ensure that it was conducted in accordance with the guidance in the Scottish Capital Investment Manual.

Whilst the aim was to reach a consensus score on each option against each criterion, it was recognised that with a relatively large workshop group this was not always possible and the facilitator recorded pessimistic and optimistic scores where individual group members had reservation on the consensus score.

The results from the non-financial benefits appraisal workshop are summarised in the table that follows.

	Weighted Benefits Score			
	Scoring Scenario			
Option Description	**Optimistic**	**Consensus**	**Pessimistic**	**Rank** (Based on Consensus Scoring)
Do Minimum	**419**	**345**	**268**	**4**
Less Ambitious	**640**	**564**	**476**	**3**
Reference Project	**1000**	**962**	**884**	**2**
More Ambitious	**987**	**975**	**897**	**1**

A number of conclusions can be drawn from these results:

1. There is a considerable difference in Weighted Benefits Scores between the "Do Minimum" option and the "Reference Project". This is a good outcome since it confirms that the proposed investment in the Reference Project is expected to produce a step change in the non-financial benefits delivered to patients, service users and staff. Hence, it confirms that the project is a worthwhile one with an expected significant return on investment in terms of non-financial benefits. Further evidence of this is provided by the fact that both the Reference Project and the More Ambitious options have relatively high overall weighted benefits scores compared to the maximum possible score (1000).

2. The Less Ambitious option provides significantly lower benefits compared to the Reference Project and More Ambitious options.

3. The relatively small differences in weighted benefits scores between the three scoring scenarios (optimistic, consensus and pessimistic) broadly indicates high levels of consensus reaching by the workshop group.

4. There is very little difference between the weighted benefit scores of the Reference Project and the More Ambitious option. Hence, the decision on whether to increase the investment in the project to achieve the more ambitious option will depend on the value for money assessment undertaken as part of the economic appraisal.

Value for money

Weighted benefit scores can be directly compared with Net Present Costs to help assess trade-offs between costs and benefits. This enables options to be compared in terms of value for money. The results from this analysis are shown in the table below.

Option	Weighted Benefits Score (Consensus Scoring)	Net Present Cost over 60 years £million	Cost per Unit of Weighted Benefit Score £000
Do Minimum	345	329.7	956
Less Ambitious	564	337.3	598
Reference Project	962	337.2	351
More Ambitious	975	366.4	376

The results show:

- Although the Do Minimum and Less Ambitious Options are similar in cost to the Reference Project, they provide significantly less benefits than the Reference Project and therefore provide poor value for money.

- The More Ambitious option does provide more benefits than the Reference Project but does so at a higher total cost per unit weighted benefit score and therefore, is less cost effective.

20. Risk Assessment

Financially Quantifiable Risks

The majority of risks associated with the short listed options have been measured and quantified in monetary terms and included in the Net Present Cost calculations shown earlier. Hence, the costs used in the economic appraisal have been risk adjusted to reflect the main business, operational and project implementation risks including:

- Planning, design and construction risks

- Commissioning risks
- Operational risks
- Service Risks
- Business Risks

A full, costed risk register has been developed for the project and in place of Optimism Bias, the output from this has been factored into the economic appraisal and affordability analysis.

20.1.1 Non-financial Risks

Recognising that not all risks can be quantified in monetary terms, the non-financial risks associated with the shortlisted options were identified and appraised at the benefits appraisal workshop on 12 February 2013.

This appraisal was similar to that used for the non-financial benefits and involved.

- Reviewing each of the shortlisted option to identify potential non-financial risks.
- Assessing each risk in terms of its likelihood and impact
- Computing a risk score for each option by multiplying the likelihood and impact scores

The results from the appraisal of non-financial benefits is summarised in the table that follows.

	Risk Score			
	Option			
Non-financial Risks	1	2	3	4
	Do Min	Less Amb	Ref Proj	More Amb
Staff Retention	9	9	9	9
Staff Recruitment	18	9	9	9
New Legislation/Regulation (registration of new model)	45	9	18	18
Operational problems - service managment, logistics, car park managment etc	20	8	12	12
Cultural change for staff	8	16	24	24
Lack of flexibility to cope with change	90	18	9	9
Risk of demand not being met	90	60	30	30
Risk of over provision of institutional capacity	5	15	10	10
Short term implementation risk	12	12	12	12
Long term risk of model not being effective	90	45	27	27
Total Risk Score	387	201	160	160

The table shows that the Total Risk Scores for the options range from 160 to 387 which indicate that the workshop delegates considered all the options were relatively low risk

(maximum risk score is 1000) in terms of these non-financial risks. This is particularly so for the Reference Project (Option 3) and the More Ambitious (Option 4) which have very low overall risk scores.

As part of the development of this FBC the above non-financial risks have been included in the full risk register for the project and reviewed regularly at Project Team meetings. This has enabled risk management strategies to be developed to ensure that these risks are managed throughout the delivery and implementation of the project.

21. Sensitivity Analysis

Sensitivity analysis is fundamental to option appraisal since it is used to test the vulnerability of options to future uncertainties, the robustness of the ranking of options and selection of a preferred option. This was undertaken at the OBC stage and re-visited and reviewed for this FBC. It was undertaken for this project in two stages:

- Scenario analysis
- Switching values

Scenario Analysis

Scenario analysis has examined the impact of more optimistic or pessimistic outcomes for the project in terms of benefits, costs and risks.

In terms of non-financial benefits, the weighted benefits scores derived from the optimistic and pessimistic scoring scenarios have been used to calculate corresponding weighted benefit scores and these are shown in the table below.

	Scoring Scenarios					
	Optimistic		Consensus		Pessimistic	
Option Description	Weighted Benefits Score	Rank	Weighted Benefits Score	Rank	Weighted Benefits Score	Rank
Do Minimum	419	4	345	4	268	4
Less Ambitious	640	3	564	3	476	3
Reference Project	1000	1	962	2	884	2
More Ambitious	987	2	975	1	897	1

It can be seen that the ranking of options does not generally change as a result of adopting optimistic or pessimistic scoring scenarios. The exception to this is that under the optimistic scoring scenario the weighted benefits score of the Reference Project (Option 2) improves relatively more than that of the More Ambitious option which results in it improving its ranking from second to first in terms of non-financial benefits.

The optimistic and pessimistic weighted benefits scores have been used to replace the consensus score in the analysis of trade-offs between costs and non-financial benefits

shown earlier with the results shown in the table that follows.

	Scoring Scenarios		
	Optimistic	Consensus	Pessimistic
Option	Cost per Unit of Weighted Benefit Score £000	Cost per Unit of Weighted Benefit Score £000	Cost per Unit of Weighted Benefit Score £000
Do Minimum	787	956	1230
Less Ambitious	527	598	709
Reference Project	337	351	381
More Ambitious	371	376	408

The table shows that under all three scoring scenarios the Reference Project retains its superior Cost per Unit of Weighted Benefit Score compared to the other options.

Switching Value

The calculation of 'switching values' is a particular form of sensitivity test. It shows by how much a variable would have to fall or rise to switch the balance of advantage from the preferred option to another. Across the range of appraisals undertaken for this FBC, Option No 3: The Reference Project has emerged as the best performing in terms of benefits costs. The switching values which would enable the other options to equal the Reference Project's performance as measured by Weighted Benefits Score, Net Present Cost and Cost per Unit of Weighted Benefit Score.

Switching Values			
Percentage change required in current values to equal the Reference Project value			
Option	Weighted Benefit Score	Net Present Cost £m	Cost per Unit of Weighted Benefit Score £000
Do Minimum	179%	2%	-63%
Less Ambitious	71%	0%	-41%
More Ambitious	-1%	-7%	-7%

The results shown in the table can be interpreted as follows:

- For the Do Minimum option, very substantial change would be required in the Weighted Benefit Score to achieve the performance of the Reference Project. This percentage change is highly improbable and therefore unrealistic. Hence, the ranking of this option in comparison to the Reference Project is robust.
- For the Less Ambitious option, the significantly lower Weighted Benefit Score in comparison to the Reference Project means that it is unlikely that the underlying assumptions for this option could change sufficiently to enable it to compete with the performance of the Reference Project in terms of non-financial benefits.
- For the More Ambitious option, both its Weighted Benefit Score and its Net Present Cost are relatively similar to the Reference Project. Hence, a small change in either of these variables could change the ranking of these options.

22. Preferred Option

The results from the rigorous appraisals of the short listed options in terms of benefits, costs, risks and value for money are brought together in the table that follows which shows that ranking of each option in each appraisal and the overall ranking (1 is highest ranking i.e. best, 4 is lowest ranking i.e. worst).

The table shows that overall, the Reference Project is ranked highest indicating that overall it is the option most likely to maximise the non-financial benefits required from that project, provides best value for money and has an acceptable level of risk.

	Ranking of Options by Appraisal			
Option No/Description	**Do Minimum**	**Less Ambitious**	**Reference Project**	**More Ambitious**
Economic Appraisal (Net Present Costs)	**1**	**3**	**2**	**4**
Non-Financial Benefits Appraisal	**4**	**3**	**2**	**1**
Value for Money (Cost per Benefit Point)	**4**	**3**	**1**	**2**
Non-Financial Risks Appraisal	**4**	**3**	**1**	**1**
Overall Ranking	**4**	**3**	**1**	**2**

A copy of the full GEM model that was used for the economic appraisal can be obtained from the Project Director [moragfarquhar@nhs.net.

23. Value for Money Scorecard

In line with the guidance issued in 2013 in relation to primary healthcare premises, a Value for Money Scorecard is included at Appendix D of this document. The scorecard has been prepared in consultation with the hub East Central Territory team and Scottish Futures Trust. As the Primary Care building is only one element of the project, extrapolations have had to be made from the overall project cost data

The summary diagram shows an improved position from Outline Business Case stage with the majority of elements, Area per GP, Support Space Ratio and Overall Project Cost below the metric at -17%, -14% and -5% respectively. Prime Costs remain above the metric at +14% which is as a result of the extended programme, working on the existing, complex, operational site and the amount of earthworks required.

The Commercial Case

24. Scope & Services

It is intended that the Care Village will be delivered via the hub initiative, in partnership with Hub East Central Scotland Ltd (hubco). The hub route has been established to provide a strategic long-term programme approach to the procurement of community-based development through joint local venture arrangements. SCIM guidance states that this route should be the default for community based new builds over £750,000.

The Economic Appraisal undertaken at OBC and re-visited and updated for this FBC demonstrates that when compared with a capital solution the hub delivery route compared favourably in Value for Money (VfM) terms.

The Affordability Cap was calculated at New Project Request (NPR) Stage in liaison with hubco and confirmed at NPR acceptance. It was subsequently adjusted to account for the requirement for an automated fire suppression system within the Care Hub and remains in place until Stage 2 approval (on approval of the FBC) when it will require to be further adjusted.

The hub contract, with NHS Forth Valley as 'The Authority', will be a Design, Build, Finance and Maintain (DBFM) model. The contract will include hard facilities management (structural and external maintenance incl. lifts, boilers and insurance, internal wall and floor maintenance) but not soft facilities management (domestic and catering services, also internal decoration). Additionally, the clinical equipment and furnishings will be owned, operated and maintained by the Partners

At Outline Business Case stage, the Participants Brief was developed and has informed the developing design, to RIBA Stage 4, with detailed specification, room layout and services drawings. The Authority Construction Requirements have been drafted and agreed with hubco to be sufficient for Stage 2 pricing and the Service Level Specification agreed, again to appropriately inform Stage 2 pricing.

25. Key Contractual Arrangements

The Territory Partnering Agreement (to which NHS Forth Valley, Stirling Council, and Scottish Ambulance Service are signatories) requires its Participants to enter into a Design Build Finance Maintain Agreement (the Standard Project Agreement) for Approved Projects. The Template Standard Project Agreement is contained as a Schedule to the Territory Partnering Agreement and must be entered into in substantially the form set out in that Template. All changes to the Standard Project Agreement require SFT approval and which will only normally be given to changes required for project specific reasons or to reflect changing guidance or demonstrable changing market circumstances.

It has been agreed that NHS Forth Valley will enter into the Standard Project Agreement. NHS Forth Valley's contracting counter-party will be a Special Purpose Vehicle (SPV), (referred to in the Standard Project Agreement as "DBFM Co"). NHS Forth Valley will take up the option, under the Shareholders' Agreement, to invest in the subordinated debt of the SPV.

Consistent with the Scottish Government's requirement that equity returns on revenue funded projects must be fixed or capped, a mechanism has been provided in the Standard Project Agreement (Clauses 36 and 45) under which profits earned by the SPV that would otherwise be paid to the equity investors (i.e. the holders of the SPV's shares and subordinated debt) will be shared equally with NHS Forth Valley once a minimum threshold level of equity return as fixed in the Territory Partnering Agreement/ during the competitive dialogue process has been achieved. If profits are such that the equity return would exceed a second threshold were all the profits to be distributed to equity, all further profit distributions will be payable to NHS Forth Valley. NHS Forth Valley's shares of excess profits may either be paid to it in lump sums or be used to reduce the future service payments.

Where there will be more than one user of the facilities as in this Project, one Authority (from among the Participants) will be the lead Authority, which is NHS Forth Valley here, and will enter into the Standard Project Agreement with the SPV. NHS Forth Valley will in turn have appropriate back-to-back contractual arrangements with the other users. There is a template Interface Agreement in circulation which NHS Forth Valley will enter into with the other Participant users. NHS Forth Valley will consider whether the SPV should be required to procure collateral warranties in favour of the other authorities as well as those in favour of the lead Authority.

26. Personnel Implications

The Partners in the project have developed a robust process for assessing and managing the impact of the changes to staffing brought about by implementing the proposals contained within the FBC. This includes an assessment of the following areas:

- The factors that affect the workforce plan.
- How the Partners will identify future staffing requirements.
- How the change process will be managed

A number of national and local drivers impact on the approach to workforce planning.

- The 2020 Workforce Vision
- The National Clinical Services Strategy and local Clinical Services Review
- Clackmannanshire & Stirling Health & Social Care Partnership Strategic Plan

Other significant factors which will shape the workforce in the future include a number of specific regulatory and policy drivers such as the European Working Time Directive and the impact of Modernising Medical Careers and Reshaping the Medical Workforce Project. In addition, it is widely recognised that the working age population is set to significantly reduce over the life of this project and both the NHS and Stirling Council, as the two largest employers for the project will be competing for this reduced pool of potential employees.
The model of service provision proposed for the Care Village, firmly focussed on the integration of Health and Social Care, is designed to reduce duplication and make best use of the available workforce. A continuation of the current workforce development plan will be a crucial element in delivering the new model of care and ensuring a safe, skilled and effective workforce. Future focus will be on the continued development of integrated team working and work has already been undertaken to identify the learning and development

needs of staff in relation to the model of care. Staffing numbers and skill mix will be adjusted and adapted in line with local workforce plans in the period up to the opening of the new facilities and are expected to continue to change and develop as the new model of service provision continues to evolve.

Recognising the complexities of multiple long term conditions, the partners in the project are committed to developing a multidisciplinary, multi-specialty team approach to all care needs and the development of hybrid roles. It is anticipated that there will be a requirement for significant change to practice and to staff roles over the next five years both in respect of the Care Hub and new models of multi-disciplinary teamworking within primary care. A change strategy involving all disciplines will be developed and engagement and involvement of all staff will be crucial to the change process. Key changes will be identified and prioritised and staff will be fully supported and developed. Changes to current practice will then be planned and implemented through a staged approach. This will be implemented well before the move to the new facilities; however the pace of change must be commensurate with staff needs and abilities.

In moving forward through the various stages of the development of this project, it will be essential to ensure full compliance with the staff governance standards and to utilise the benefit of the project to ensure that staff are:

- Well informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community

It is fully envisaged that at the appropriate milestones in the project timetable, staff side colleagues will be fully involved in agreeing processes for the transfer of staff to the new facilities and how that will be facilitated for all staff groups. It will be imperative that these working relationships with staff side colleagues are positive as they will assist with the process of implementing change, supporting staff and ensuring all processes are fair and equitable. The issues that will be addressed in partnership going forward will include the following:

- An open and transparent process for the allocation of staff into posts
- Staff communications
- Full and comprehensive training needs analysis
- Changes to work patterns / service redesign that impact on staff
- Management of redeployment and protection costs and excess travel
- Managing vacancies in order to maximise flexibility and opportunities for change including redeployment

- Appropriate induction to the new build for all staff

In order to assess the workforce impact of moving to a new site, the Project Board will work in partnership with staff side colleagues to develop comprehensive workforce plans for each work stream to ensure that the model of care developed is aligned to the required workforce. Detailed workforce plans will be required to identify training and competency needs and training plans will be required in line with identified 'shadow' structures and staff will need to be prepared for the new models of care and the operational policies associated with the new facilities.

The ongoing education and learning of staff will be critical to meeting the challenges of transitioning into the new model of service provision and the new facilities. A range of opportunities will be available to support staff:

- Clinical Leadership Programme
- Teambuilding and Self-Awareness Development Sessions
- Leading Better Care and Releasing Time to Care
- Supporting staff in the use of new technology.

Annual development reviews (ADRs), will provide the framework for individual discussions around career development and planning. The identification of associated learning and development activity required to achieve personal and professional career goals will be identified. During 2016/17 and beyond, the ADR cycle will provide an opportunity to have discussions with all staff about their role in delivering the changes required to implement the new models of care and their individual development.

27. Implementation Timescales

Key dates are provided below**.**

Stage	Activity	Date
Stage 1	Commencement	24th May 2013
Stage 1	Report Submission	18th November 2013
Stage 2	Participant requests Hubco to make a Stage 2 submission	June 2014
Stage 2	Commence RIBA Stage D Scheme Design	June 2014
Stage 2	Full Planning Consent Determination	June 2015
Stage 2	Report Submission	March 2016
Stage 2	Participant Approval to Proceed to	June 2016

	Financial Close	
Financial Close	Contract Finalisation	June 2016
Construction	Start on Site	July 2016
Construction	Completion/ Handover of Facility	March 2019

The programme has been under continual review up to Stage 2/FBC in relation to meeting the projected Financial Close date.

28. Accounting Treatment

- The project will be delivered under a DBFM agreement over a period 25 years term with NHS Forth Valley retaining all of the assets for no additional consideration at the end of the contract term.
- The DBFM contract is defined as a 'Service Concession' arrangement under International Financial Reporting Interpretation Committee Interpretation 12 ('IFRIC 12') and will be 'on balance sheet' in NHS Forth Valleys accounts.
- The contract and payment mechanism follows the hub DBFM standard form which incorporates transfer of construction and availability risk in order to deliver a 'private' classification under ESA10 per the announcement by the Deputy First Minister on 26 November 2015.
- NHS Forth Valley will recognise the cost, at fair value, of the property plant and equipment underlying the service concession as a non-current (tangible) fixed asset and record a corresponding long term liability. The asset's carrying value will be determined in accordance with IAS 16 subsequent to financial close.
- The 'lease rental' paid on the long term liability will be delivered by deducting all operating, lifecycle and maintenance costs from the contract amounts paid to the DBFM Co. The 'lease rental' Annual Service Payment' will be split between repayment of the liability, interest charged on the liability and contingent rentals determined according to the indexation provisions in the Project payment mechanism.
- The annual charge to the Statement of Comprehensive Net Expenditure (SOCNE) will consist of all operating, lifecycle and maintenance costs, contingent rentals, interest and Depreciation calculated on a straight line basis.
- On the expiry of the contract term the Net Book Value of the asset will be equivalent to the residual value assessed in accordance with IAS 16.
- The land occupied by the project will continue to be accounted for by NHS Forth Valley as a non-current (fixed) asset.

The Financial Case

29. Capital Requirement

Capital costs (excluding VAT, Fees, Equipment and Contingencies) for each of the short-listed options are provided in the table below. The Summary Pricing Report detailing the cost for the Project is attached at Appendix E

Shortlisted Options	Estimated Capital Costs (£'000)
Reference Project	[redacted]
Less Ambitious	[redacted]
More Ambitious	[redacted]
Do Minimum (Undertake backlog maintenance works of existing properties)	[redacted]

Other costs outwith construction have been identified as follows:

- External Advisor, masterplanning and other fees £500,000 (from hub enabling funds)
- Furniture, Equipment , IT, Arts (NHS FV contribution) £2,500,000
- Indirect costs associated with demolitions on the site have been met from NHS Forth Valley's Capital Plan and consideration is currently being given to upgrading the retained estate via the same means.

30. Net Effect on Prices

Unitary Charge

The preferred way forward will be procured through a revenue solution by way of hub and a unitary charge will be payable. The unitary charge is the amount of money paid by the public sector procuring body to the private sector consortium over the duration of the contract. Unitary charge payments begin once the project is fully operational or individual phases have been completed. The total unitary charge payment will cover:

- Construction costs (including VAT where applicable)
- Private sector development costs (including staffing, advisory and lenders' advisers' fees)
- Financing interest (which is necessary to fund the project through construction)
- Financing fees
- Running costs for the project's Special Purpose Vehicle (SPV) during construction,
- including insurance costs and management fees
- SPV running costs during operations, including insurance costs and management fees

- Lifecycle maintenance costs
- Hard facilities maintenance (FM) costs

The estimated Unitary Charge (UC) payable by the partnership is £[redacted]pa and is based on the Reference Project i.e. full integration of Health & Social Care services & enhanced partner services through the development of a Care Village. This Unitary Charge has been provided by hubco, the development partner for the Care Village and is wholly subject to inflation. The UC will be subject to variation annually in line with the actual Retail Price Index (RPI) which is estimated at 2.5% p.a. in the financial model.

In line with Board approval, subject to CIG approval of a hub revenue based solution for the project, the net revenue requirement for NHS Forth Valley has been included in the 5 year financial plan.

31. Impact on Balance Sheet

Accounting for the Design, Build, Finance & Maintain (DBFM) Contract

The Project will be delivered under a DBFM agreement over a 25 year term with NHS Forth Valley retaining all of the assets for no additional financial consideration at the end of the contract term.

The contract is defined as a 'Service Concession' arrangement under International Financial Reporting Interpretation Committee Interpretation 12 ('IFRIC 12').

NHS Forth Valley will recognise the cost, at fair value, of the property plant and equipment underlying the service concession as a non-current (tangible) fixed asset and record a corresponding long term liability. The asset's carrying value will be determined in accordance with IAS 16 subsequent to financial close but for planning purposes fair value is assumed to be cost.

The unitary charge paid on the long term liability will be derived by deducting all operating, lifecycle and maintenance costs from the contract amounts paid to DBFM Co. The unitary charge will be split between repayment of the liability, interest charged on the liability and contingent rentals determined according to the Indexation provisions in the Project payment mechanism.

Depreciation calculated on a straight line basis will be charged to the operating cost statement annually.

On expiry of the contract term the Net Book Value of the asset will be equivalent to the residual value assessed in accordance with IAS 16.

The equipment (c £5m across the Partners) procured to enable the project, from participant capital resources, will be accounted for separately by the participants as a non-current (fixed) asset.

Budget Implications of the (DBFM) Contract

As outlined above the DBFM contract is assessed as a 'service concession' and "on balance sheet" under the terms of IFRIC12. Hub DBFM structures have been amended in light of ESA10 and confirmed as meeting the requirements for private classification as announced by the Deputy First Minister on 26 November 2015. Exact funding requirements will be confirmed at Financial Close.

32. Impact on Income and Expenditure Account

Affordability in a Service Context

Given the integrated nature and organisational complexity of this project it is imperative to view affordability in the context of enabling transformational service change and, with particular regard to the Care Hub, an integrated care and workforce model.

This is demonstrated in the affordability statement provided below .

Affordability Statement

Direct Service Costs	[redacted]
Soft FM & Energy Costs	[redacted]
Unitary Charge, Capital Charges, Rates and Property Cost Reimbursements	[redacted]
Income	[redacted]
TOTAL COSTS	[redacted]
FINANCED BY	
Existing Budgets and Net Investment in Services by Participants	[redacted]
Revenue Funding From Stirling Council in Lieu of Capital Injections	[redacted]
Assumed Revenue Support for Unitary Charge from Scottish Government	[redacted]
TOTAL RESOURCES AVAILABLE	[redacted]

33. Overall Affordability

This FBC has been prepared on the assumption that the project is procured through a hub revenue solution and in which case the Scottish Government (subject to meeting the required conditions) will commit to provide the NHS Board with revenue support for the following elements of the unitary charge:

- 100% of construction costs (subject to the agreed scope of the project);
- 100% of private sector development costs (subject to an agreed cap);
- 100% of financing interest and financing fees (at prevailing Financial Close rates);
- 100% of SPV running costs during the construction phase (subject to an agreed cap);
- 100% of SPV running costs during the operational phase (subject to an agreed cap); and
- 50% of lifecycle maintenance costs.

On the above basis, the partners will be required to support the following elements of the unitary charge:

- 100% of Hard FM (facilities management) costs; and
- 50% of lifecycle maintenance costs.
- 100% of Construction Costs equal to value of previously planned capital injections from Stirling Council
- Additional cost components for soft FM, services, utilities costs and equipment costs (not included in the overall construction cost)

Based on the above percentages the element of the UC in the first operational year to be funded by SGHD is £[redacted] m which represents 81.6% of the total UC, leaving the participants to fund the remaining £[redacted]m (18.4%). This split is detailed below.

UNITARY CHARGE	Unitary Charge £'000	SGHD Support %	SGHD Support £'000	NHSFV Cost £'000
Capital Costs	[redacted]	100	[redacted]	
Capital Costs in Lieu of Stirling Council Capital Injections	[redacted]	0		[redacted]
Life cycle Costs	[redacted]	50	[redacted]	[redacted]
Hard FM	[redacted]	100	-	[redacted]
Total	[redacted]		[redacted]	[redacted]
			81.6%	18.4%

The following table, along with section 31, demonstrates that at FBC stage, the Board has a break even revenue position and the project is therefore affordable.

Summary of Revenue position	£'000
SGHD Unitary Charge support	[redacted]
Participants recurring funding	[redacted]
Total Recurring Revenue Funding	[redacted]

Recurring Revenue Costs	£'000
Total Unitary charge(service payments)	[redacted]
Depreciation on Equipment	[redacted]
Facility running costs	[redacted]
Total Recurring Revenue Costs	[redacted]

34. Financing & Subordinated Debt

Hubco's Financing Approach

East Central hubco will finance the project through a combination of senior debt, subordinated debt and equity. The finance will be drawn down through a DBFM Co special purpose vehicle that will be set-up for the project.

The senior debt facility will be provided by either a bank or insurance company. It is likely they will provide up to 90% of the total costs of the projects. The remaining balance will be provided by ECT' shareholders in the form of subordinated debt (i.e. loan notes whose repayment terms are subordinate to that of the senior facility) and pin-point equity. It is currently intended that the subordinated debt will be provided to the DBFM Co directly by the relevant Member.

Current Finance Assumptions

The table below details the current finance requirements from the different sources, as detailed in the financial model submitted with hubco's Stage 2 submission.

	SCV
Senior Debt (£000)	[redacted]
Sub debt (£000)	[redacted]
Equity Bridge	[redacted]

Equity (£000)	[redacted]
Revenue (£000)	[redacted]
Total Funding	[redacted]

The financing requirement will be settled at financial close as part of the financial model optimisation process.

Senior Debt

At the time of writing, it is likely that the senior debt will be provided by Aviva. Hubco's review of the funding market has advised that Aviva currently offers the best value long term debt for the projects. This is principally because of:

- Aviva's knowledge and experience in the health sector
- Aviva's appetite for long term lending to match the project term
- Aviva's lower overall finance cost in terms of margins and fees
- Aviva's reduced complexity of their lending documentation and due diligence requirements.

Hubco has not run a formal funding competition, as Aviva offers the best value finance solution within the senior debt market. However, hubco are constantly reviewing the funding market, and if long term debt options appear in the market that are competitive with Aviva's offer, then a more formal review will take place. As part of the hub process, no funding competition is required at this stage of the process.

The principal terms of the senior debt, which are included within the financial model, are as follows:

Metric	Terms
Margin during construction	[redacted]
Margin during operations	[redacted]
Arrangement fee	[redacted]
Commitment fee	[redacted]
Maximum gearing	[redacted]

Whilst Aviva will generally lend up to [redacted]% of total project costs, the current Financial Model has a gearing of c.[redacted]

An Aviva term sheet, or confirmation of Aviva's terms have not yet been received from hubco, though the Participants' financial advisors confirm that these terms modelled are in line with Aviva's approach in the market currently.

35. FINANCIAL MODEL

The key outputs of financial models are detailed below:

Output	
Capital Expenditure (capex & development costs)	[redacted]
Total Annual Service Payment	[redacted]
Nominal project return (pre-tax)	[redacted]
Nominal blended equity return	[redacted]
Gearing	[redacted]
All-in cost of debt (including [redacted] buffer)	[redacted]
Minimum ADSCR[1]	[redacted]
Minimum LLCR[2]	[redacted]

The all-in cost of senior debt includes an estimated swap rate of [redacted] and a margin during both construction and operations of [redacted] The current (20th May 2016) [redacted] Gilt, which the underlying debt is priced off, is [redacted] Therefore, the current swap rates is significantly below that assumed in the financial model, however this can be seen as a prudent assumption as this should allow a reasonable 'buffer' to compensate for any movements in rates between now and financial close.

The financial model will be audited before financial close, as part of the funder's due diligence process.

36. Composite Tax Treatment

DBFM Co undertakes to carry out, in consultation with the Authority, an assessment as to the viability of adopting a composite trader tax treatment for the Project (a "Tax Restructuring") and the likely benefits to be derived therefrom and undertakes to use its reasonable endeavours to obtain clearance from HMRC that supports a Tax Restructuring prior to the Payment Commencement Date.

If DBFM Co obtains clearance from HMRC that supports a Tax Restructuring or otherwise determines that a Tax Restructuring is viable, the parties shall together in good faith seek to agree the basis on which to implement the Tax Restructuring such that 100% of the Net Tax Adjustment is passed to the Authority.

[1] Annual Debt Service Cover Ratio: The ratio between operating cash flow and debt service during any one-year period. This ratio is used to determine a project´s debt capacity and is a key area for the lender achieving security over the project

[2] The LLCR is defined as the ratio of the net present value of cash flow available for debt service for the outstanding life of the debt to the outstanding debt amount and another area for the lender achieving security over the project

The Management Case

37. Procurement Strategy

Under the hub initiative, NHS Scotland has provided an exclusivity arrangement which requires all Health Boards to consider hub as the procurement option for all community based projects in excess of capital construction value of £750.000. Only if the project does not demonstrate value for money is there the opportunity to consider other procurement options.

One of the benefits which hub will deliver is improved procurement efficiency. The Procurement legislation requirements have been met in the procurement for the Private Sector Development Partner and the associated contract documents. This means that projects procured through the hubco are not required to undertake these stages saving cost and time.

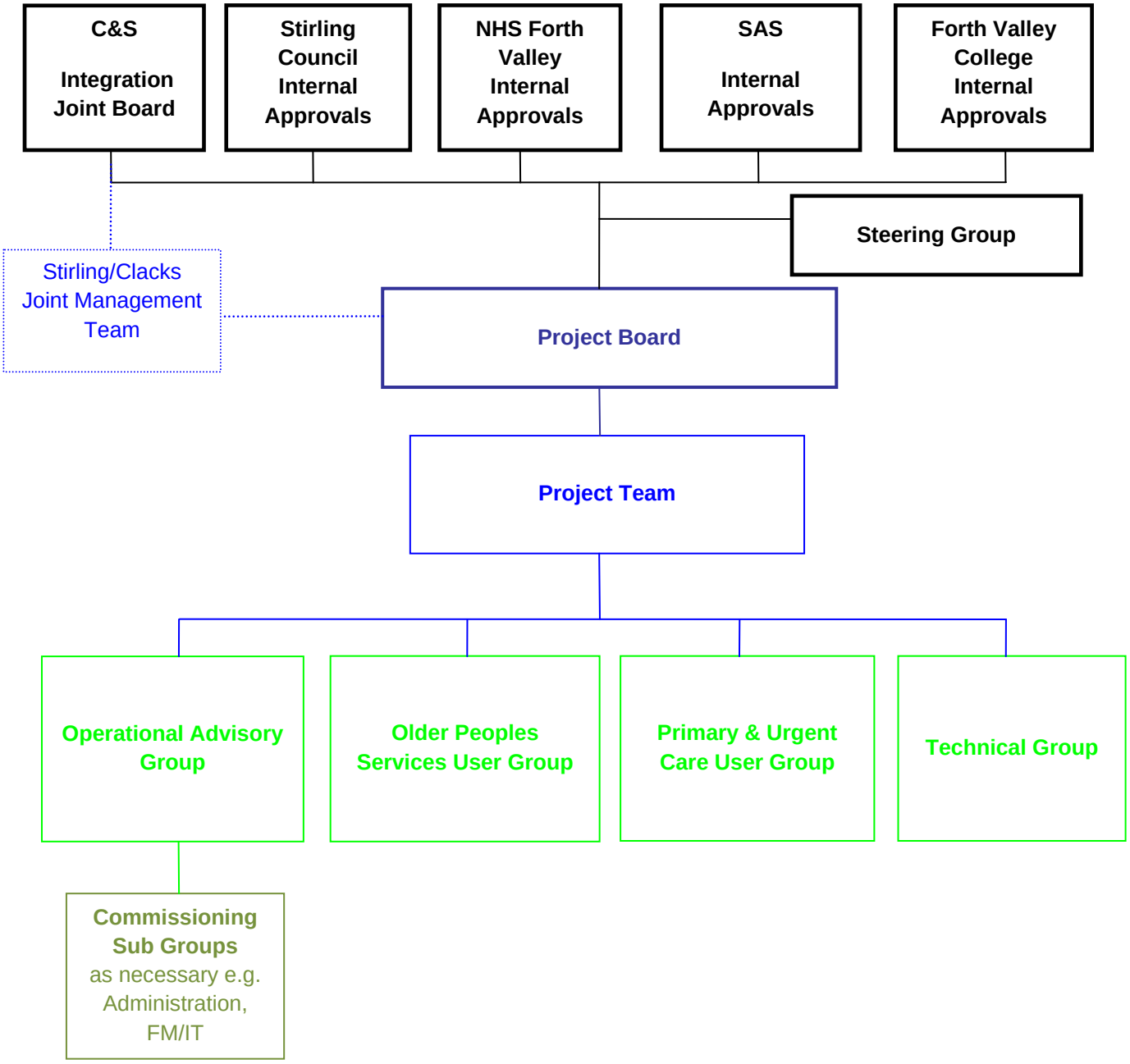
Template project agreements have been developed by the Scottish Futures Trust Design, Build Finance and Maintain contracts. The bulk of the clauses (except for definitions used for parties) are taken from the Scottish NHS standard form PPP contract insofar as relevant. These template agreements are designed to be applicable for use by all of the public sector organisations as participants in the National Hub Programme as a basis for improved efficiency in contract procurement and delivery.

NHS Forth Valley, Stirling Council and SAS will also enter into an Interface Agreement whereby the rights and obligations entered into by NHSFV under the DBFM contract are passed down to Stirling Council and SAS on an appropriate and equitable basis

38. Project Management

It is proposed that this work be managed as a project by the 'Stirling Care Village Project Board, chaired by a senior officer of one of the Partners. The Project Board will report to the partner organisations' internal governance structures as well as to the Steering Group (which includes Elected Members and Non Executive Directors of NHS Forth Valley), and externally to the Scottish Government.

The proposed governance structure is shown in the diagram that follows:



The above will be applied to the full life of the project to ensure maximum control, quality and financial benefit. This will ensure that:

- A process and audit control framework is applied to the projects.
- Resource planning considers the needs of all partner organisations.
- Project risks are managed effectively by those most suitable to manage them.
- Learning and good practice points can be transferred across partner organisations.

39. Change Management

The partners in the project have developed a series of principles that will underpin the change process:

- Recognise the need to maximise the benefits of the change for patients and service users, who are at the heart of the changes made
- Take advantage of the time available to complete the new facilities to start the change process and thereby avoid risks related to a 'big bang' approach
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned
- The change management philosophy and principles will be communicated to all staff.
- Work in partnership with staff and other stakeholders both within and outside the Care Village to engage all those involved in the delivery of care in the change process
- Focus on staff skills and development required so that staff are both capable and empowered to deliver care effectively and to a high quality standard in the new facility through new models of care.

40. Benefits Realisation

The benefits envisaged from the project and as set out in this FBC will require active management if they are to be fully realised. Benefits Realisation is the overarching process which incorporates the Benefits Realisation Plan (BRP) as part of a process of continuous improvement. It takes due account of changes in the project during the delivery phase which impact on, or alter the anticipated benefits. As such the benefits management approach is a cycle of identification, planning, execution and review.

In developing the BRP shown in Appendix F the Partners have sought to ensure that stakeholders are at the centre of the benefits realisation process. In this regard a workshop was held in February 2013 involving members of the Project Team as well as wider clinical and non-clinical stakeholders. As part of the workshop activities a number of stages were identified in the development of the BRP process, namely:

- How benefits will contribute to the local and to National Strategies
- How benefits will be delivered
- The owner's roles and responsibilities for defining, realising and managing benefits
- The mechanism for monitoring benefits and identify corrective actions, if required
- The arrangements for transition to the operational phase

- The schedule for benefit reviews and identification of further benefits

As part of the further development of BRP the partners have agreed sample baseline measures reflecting the current status of each benefit area and also cross-referenced the investment objectives to the nine national outcomes for health and social care. This will also be linked to the Change Management Plan to provide assurance on delivery.

The benefits of each Investment Objective were identified in the Initial Agreement and have been reviewed and updated throughout the development of this FBC as shown in Section 10 of this document.

41. Risk Management

The Project Board identified the key high level risks associated with this project and these were set out in the Initial Agreement. This formed the basis of a more detailed risk register which has been regularly reviewed and updated as the FBC has been developed.

The philosophy for managing risks considers effective risk management to be a positive way of achieving the project's wider aims, rather than a mechanistic exercise, to comply with guidance. Inadequate risk management would reduce the potential benefits to be gained from the project.

The partners recognise the value of an effective risk management framework to systematically identify, actively manage and minimise the impact of risk. This is done by:

- Having strong decision making processes supported by a clear and effective framework of risk analysis and evaluation
- Identifying possible risks before they crystallise and putting processes in place to minimise the likelihood of them materialising with adverse effects on the project
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions
- Implement the right level of control to address the adverse consequences of the risks if they materialise;

The Risk Register has been reviewed monthly by the Project Team as the FBC has been developed. The initial activities focused on establishing a range of project risks reflecting the scope of the project as well as the likely procurement route. Primary risks were identified across a range of categories incorporating:

- Clinical risks
- Contractual risks
- Design risks
- Enabling works risks
- Equipping risks
- FM risks

- Legal risks
- Procurement risks
- Project management risks

These risks were further allocated across a range of categories depending on where these risks would apply within the overall structure of the project. These include:

- The phase of the project to which they apply
- Those that would have a major impact on the cost of the project
- The ownership of the risks including those which can be transferred to the hub (Tier 1) contractor

Each risk has subsequently been assessed for its probability and impact, and where relevant its expected value. Where risks have been valued this has resulted in the following key outputs:

- A risk value of c£[redacted] is attached to risks transferred to the hub operator via the standard form contract. These risks have been priced by the Tier 1 Contractor involved in the procurement process and form part of their overall financial proposals. This value is included, therefore, within the input costs used to derive the shadow Unitary Charge as described within the Financial Case.
- A risk value of c£[redacted] is attached to risks retained by the public sector which would result in an increased capital cost of the project. Further revenue/operational risks have been identified with a value of c£[redacted].

The risk register is maintained as a dynamic document and will continue to be reviewed and updated as the project progresses through the FBC stages to contract close. The top risks are reported to the Project Board on a regular basis.

Extracts from the Risk Register are attached at Appendix C and a copy of the Risk Register is available from the Project Director moragfarquhar@nhs.net.

42. Contract Management

The primary aim of Contract Management is to ensure that the needs of the project are satisfied and that NHSFV receives the service it is paying for, within the boundaries of the Project Agreement whilst achieving value for money. This means optimising efficiency, effectiveness and economy of the service or relationship described by the Project Agreement, balancing costs against risks and actively managing the customer-provider relationship. Contract Management also involves recognising the balance of the roles and responsibilities as defined under the Project Agreement and aiming for continuous improvement over the life of the Project Term.

Good Contract Management will:

- Maximise the chances of contractual performance in accordance with the Project Agreement requirements by providing continuous and robust contract management which supports both parties;
- Optimise the performance of the project;

- Support continuous development, quality improvement and innovation throughout the Project Term;
- Ensure delivery of best value;
- Provide effective management of commercial risk;
- Provide an approach that is open to scrutiny and audit ;
- Support the development of effective working relationships between parties;
- Encourage effective and regular communication underpinned by clear communication mechanisms;
- Allow flexibility to respond to changing requirements;
- Demonstrate clear roles, responsibilities and lines of accountability, and
- Ensure that all works and services are in compliance with the Authority's Requirements, current legislation, relevant changes in Law and Health & Safety requirements, and NHS Scotland policies and procedures.

In terms of good Contract Management NHSFV will ensure that competent and appropriate management resource is allocated to make sure that the services which the Authority have procured are delivered and that the Project Agreement continues to provide a high level of compliant service to its end users and wider stakeholders.

42.1 Construction Phase Contract Management

The management and monitoring responsibilities following Financial Close, and up to full operation and service commencement, will be within the Project Board's and Project Manager's remit.

The Project Agreement, through the Authority's Representative contains provisions for governing liaison and monitoring during the construction period. NHSFV representatives will have unrestricted access during the construction period at all reasonable times during normal working hours to (a) view the works (on reasonable prior notice appropriate to the circumstances) or (b) visit any site or workshop where materials, plant or equipment are being manufactured, prepared or stored for use in the Works. DBFM Co is obliged to ensure that there are monthly progress meetings and site meetings to which the NHSFV representative/s are invited to attend.

The role of the Authority's representative during construction will be undertaken by NHSFV Estates department.

The Project Manager will provide leadership and direction to the scheme for internal and external stakeholders. The role will include:

- Providing overall leadership of the project through implementation at Financial Close and into operational use;
- Acting as a focal point for resolving issues that might arise
- Acting as a focal point for Stirling Council, Scottish Ambulance Service, GP Practices and 3rd Sector co-occupants
- Working with Project Board, Clinical and non-Clinical Service Managers to deliver and realise the project's benefits;
- Exercise the functions and powers of the Authority's Representative in relation to the Project Operations as defined in the Project Agreement

- Management and control of change (Change Protocol) within the Project Agreement; and
- Directing the work of the implementation teams.

While this FBC relates primarily to the NHSFV actions necessary to deliver the benefits of implementation of this project, DBFM Co plays a critical part in delivering, though partnership, these benefits to the public sector.

During the construction period the NHSFV lead for the interface with DBFM Co on construction issues will be the Authority's Representative, the Project Director in respect of DBFM interpretations and external Technical Advisors where appropriate.

The day to day construction management will rest with DBFM Co and the Tier 1 Construction Contractor. However, the interface meetings between all relevant parties to deliver the Project Agreement and fulfil the parties' responsibilities in a cooperative and harmonious spirit of partnership will be essential.

42.2 Progress Meetings

There will be a monthly meeting involving DBFM Co and NHSFV to monitor progress. This forum will monitor progress on site against programme; the Authority's Construction Requirements and manage any issues which may arise. The individuals attending these meetings, dependant on the stage of the Project Operations and not exhaustively are likely to include:

- The Independent Tester;
- DBFM Co Representative, Project Manager and technical/ diligence advisors;
- Tier 1 Construction Contractor (sub contractors as required);
- Design Team (i.e. architect, engineer) as required;
- Funders Technical Advisor;
- FM Service Provider; and
- Authority's Representative and wider technical/soft FM project team.

The meeting will primarily involve the examination of reports prepared by the Tier 1 Construction Contractor, Independent Tester and FM Service Provider in terms of progress with the mobilisation items.

42.3 Commissioning Phase Contract Management

Commissioning the new Facility will involve the development of a range of processes to ensure that the planned benefits are achieved in a timely fashion. Having made a significant investment, it is important to ensure that the facilities come into operation smoothly.

A series of specific commissioning periods have been build into the construction programme to facilitate testing, commissioning of plant and equipment and fixing of NHSFV's Group 2 equipment. NHFV will also have a further period of time post hand over to facilitate operational commissioning. NHSFV's Project Manager will be responsible for liaising with DBFM Co to agree a programme for both of these commissioning periods. The operational commissioning will require the careful co-ordination of the equipment installation (that NHSFV are responsible for), staff training and the implementation of workable operational

policies, systems and joint working protocols between hard and soft FM responsibilities to ensure familiarisation in a completely new environment. Detailed planning and good project management are essential to ensure the new facilities are made operational as soon as practical after handover from DBFM Co.

The Project Manager, supported by the wider Project Team and external Technical Advisors, will work together with DBFM Co and the FM Service Provider to ensure the smooth transition from building construction to hand over and operation.

At the same time they will assist in the development of a Building Users Operational Manual which shall ensure the transfer of operational management to those who will ultimately be responsible for the operation of the facility.

42.4 Operational Phase Contract Management

At full operational service commencement the provisions of the Project Agreement in terms of liaison will be implemented.

The Project Agreement provides for the Partner Representatives to exist throughout the Project Term and the Joint Contract Monitoring Group. The Joint Contract Monitoring Group has the following functions:

- Joint review of day-to-day issues relating to the Project Agreement;
- Joint strategic discussion looking at actual and anticipated changes or for more efficient performance of the service provision; and
- Amicable resolution of disputes or disagreements

The Joint Contract Monitoring Group makes recommendations to the Project Director but does not itself have authority to vary the Project Agreement or make any decision that is binding on the parties.

The Administrator of the Project Agreement will establish formal means to:

- Enable effective monitoring to ensure compliance with the Project Agreement;
- Verify or ascertain any changes or additions to the Monthly Service Payment which may occur;
- Monitor that Payment Mechanism in terms of availability, performance, notices and failure rectification is compliant with the Project Agreement
- Monitor all pass through costs in the Monthly Service Payment and monitor NHSFV direct costs not forming part of the Monthly Service Payment
- Confirm that all insurance obligations are met; and
- Establish and maintain a comprehensive system to record all action taken and changes authorised throughout the project.

The Administrator of the Project Agreement will be responsible for initiating any necessary action for non-compliance, breach of rules and regulations, poor quality of performance, events of default, termination events etc. in relation to the Project Agreement.

42.5 Service Monitoring

The Project Agreement includes 'hard' facilities management only. NHSFV are, therefore, responsible for providing soft facilities management services such as, catering, domestic services and grounds maintenance throughout the Project Term.

The issue of split hard and soft facilities management services are a key component of joint working arrangements, in particular ensuring that neither service causes disruption to the obligations of the other provider to perform their service.

Subject to the service specification of the Project Agreement, the hard FM Service Provider is responsible for providing method statements on how the service will be carried out and having a computerised monitoring system in place to monitor performance. . Each service unit of the facility has a service level specification detailing frequencies, tasks and response times. A Service Report detailing all service events together with details such as rectification times will be produced monthly so that the appropriate availability deduction can be made. NHSFV will carry out spot investigations and the Project Agreement details the procedure if DBFM Co fail to monitor, report a failure correctly (whether deliberate or not). Details of each service specification will be made available to each department within the Facility and the Operational Policies will define guidelines for use of the FM Helpdesk so that each service request will be logged correctly having a reference number and requesting department.

In the event that there are adjustments/amendments to the monitoring mechanisms these will be communicated through the Service Interface Meetings and managed through the variation procedures where necessary.

42.6 Management and Monitoring

Throughout the course of the Project Term it is crucial that the NHSFV teams fully understand the roles and obligations imposed by the Project Agreement in respect of management and monitoring of the services. Contract monitoring will be delivered by the Authority and will include consideration of the following:

- Arrangements for staffing and resources for monitoring during the construction phase;
- Arrangements for enhanced staffing leading up to and around service availability;
- Arrangements for day to day contract management;
- Staffing and responsibilities during the operational phase, including the management of any services not included in the Project Agreement;
- Skills and experience of the monitoring team;
- Governance arrangements for the construction and operational phases;
- Role of users and other stakeholders and how the contract management team will interface them;
- Communications strategy;
- How the authority will carry out any post contract evaluation over the life of the Project Term;
- Arrangements for the authority's internal auditing of the project; and

- Review of services specification and arrangements for market testing and benchmarking.

43. Post Project Evaluation

The partners in the project are committed to ensuring that thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that the expected benefits from the project are realised and that positive lessons can be learnt from the project.

Scottish Government has published guidance on PPE, which supplements that incorporated within the Scottish Capital Investment Manual (SCIM). The key stages applicable for this project are set out in the table below:

Stage	PPE Evaluation Undertaken	Timing
1	Develop PPE Plan with benefits measures	Completion of OBC
2	Monitor progress and evaluate project outputs	On completion of facilities
3	Evaluation of Service Outcomes	6 months after commissioning of the new facilities
4	Post occupancy evaluation	2 years after commissioning of the new facilities

Within each stage, the following issues will be considered:

- The extent to the project objectives have been achieved
- The extent to which the has progressed against the PPE plan
- Where the plan was not been followed, what were the reasons
- Where relevant, how plans for the future projects should be adjusted

The Project Owner will be responsible for ensuring that the arrangements have all been put in place and that the requirements for PPE are fully delivered. The Project Director will be responsible for day to day oversight of the PPE process, reporting to the Project Owner and Project Board. The Project Owner and the Project Director will set up an Evaluation Steering Group (ESG), which will:

- Represent interests of all relevant stakeholders
- Have access to, professional advisers who have appropriate expertise for advising on all aspects of the project.

The Project Manager will coordinate and oversee the evaluation. The key principle is that the evaluation is objective. The Evaluation Team will be multi-disciplinary and include the following professional groups, although the list is not exhaustive:

- Clinicians including nursing staff, clinical support staff, Allied Health Professionals and social workers
- Healthcare Planners, Estates professionals and other specialists that have an expertise on facilities
- Accountants and finance specialists, IM&T professionals, plus representatives from any other relevant technical or professional grouping

- Patients and service users and/or representatives from patient and public groups

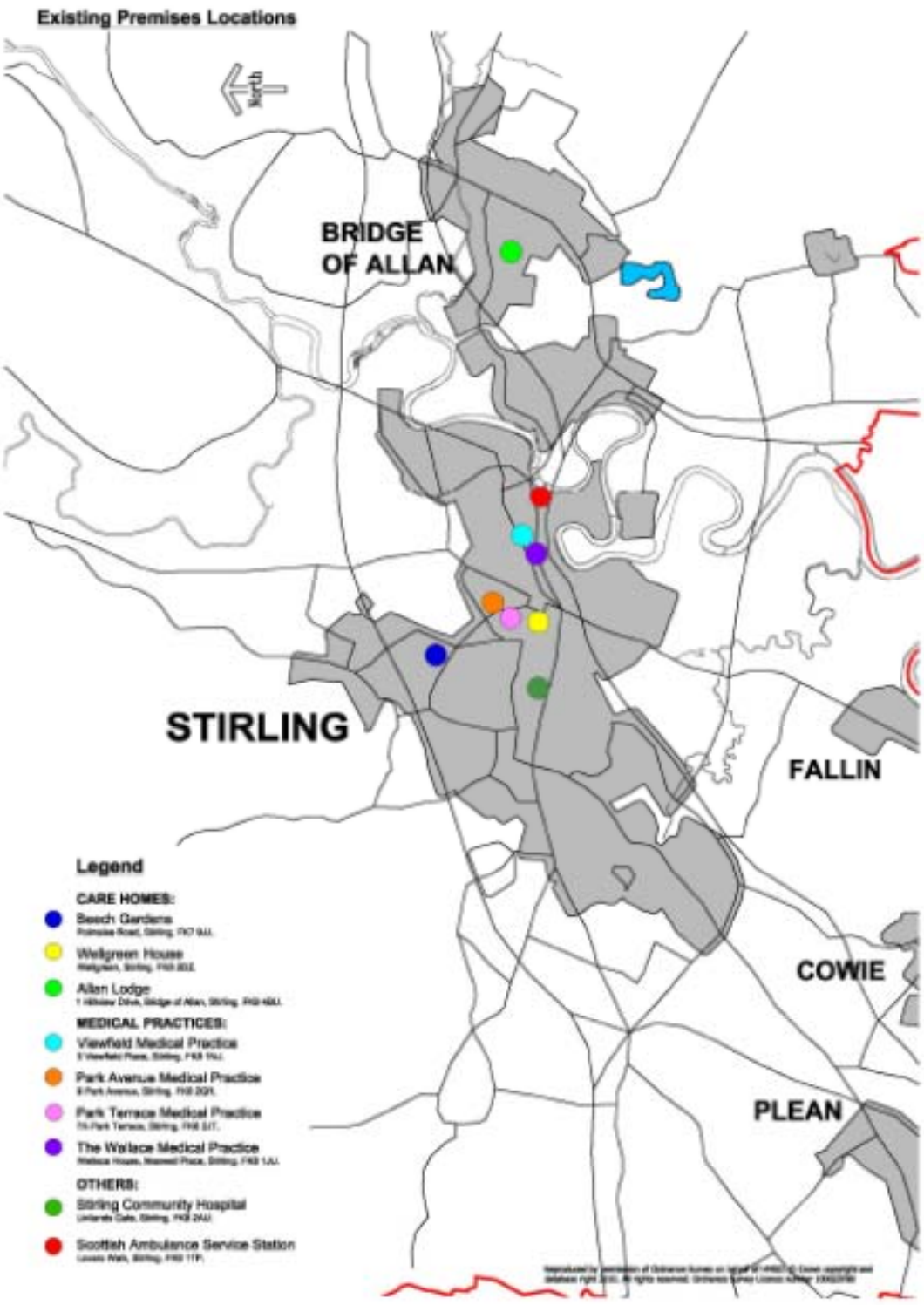
The Benefits Realisation Plan, against which this project will be measured, is included at Appendix F. The measures agreed here will not be replaced within the project evaluation plan. The PPE will be linked with the Benefits Realisation Plan to review where appropriate, whether the objectives of the project have been achieved.

44. Contingency Plan

As the clinical services will (with the exception of some aspects of new service) be delivered on other sites prior to the new facilities being opened, The ultimate contingent position should the new facilities not be completed on time would involve continuity of clinical service through continued delivery at the current sites and re-appraisal of the timing and implementation of the Board's transfer programme and plans. This would have communication and logistics (as well as cost) impacts, but does provide an overall contingent position.

From a construction (including commissioning and handover) perspective the achievement of key dates and ultimately having the facilities complete and ready for occupation is a managed activity that is reported accurately and frequently. This will allow identification of issues and reporting to be escalated and contingent steps implemented should the service delivery dates be threatened.

Appendix A
Existing Services Location Plan


Existing Premises Locations
North
BRIDGE OF ALLAN
STIRLING
FALLIN
COWIE
PLEAN
Legend
CARE HOMES:
Beech Gardens
Wellgreen House
Allan Lodge
MEDICAL PRACTICES:
Viewfield Medical Practice
Park Avenue Medical Practice
Park Terrace Medical Practice
The Wallace Medical Practice
OTHERS:
Stirling Community Hospital
Scottish Ambulance Service Station

Appendix B
Design Statement

STIRLING CARE VILLAGE
DESIGN STATEMENT (AS DEVELOPED AND AGREED AT INITIAL AGREEMENT STAGE)

INTRODUCTION: Stirling Care Village will bring together on one site a range of health, local authority and potential partner organisation services within the centre of Stirling. These include: Older People's Services (including inpatient, rehabilitation, re-ablement, residential care and day services), General Practitioners, Community Nursing, a Minor Injuries Unit, Diagnostics and GP Out of Hours service. The potential is being explored for Forth Valley College to provide training and education for students (in health and social care as well as catering and other disciplines) and staff within the development and also for third sector organisations to be involved. Also included is an Ambulance Station and Workshop facility for the Scottish Ambulance Service. Housing for older people and for the general population is an aspiration. The project will be further enhanced by its location on the Stirling Community Hospital site, adjacent to a wide range of outpatient services and health professionals.

At this stage and pending further discussion with stakeholders and design/masterplanning input, it is not known how the various service requirements (outwith extra care or other housing) will be met in terms of premises, ie one building, two or three and the Design Statement is deliberately silent in that regard. Whether in a single one or multiple buildings, the non-negotiables set out herein apply across the project.

There is no single example that the partners are aware of that encompasses all of the services/functions that are planned within the Care Village, therefore, views of "what success might look like" are to an extent limited to individual elements of it and there are opinions of "what success will not look like". As to the overall vision for the Care Village and the design required to achieve it, the phrase "we will know it when we see it" has possibly never been more appropriate. This should not be seen as a weakness or lack of knowledge but more as a willingness to explore the options and work positively with designers and others (Planning and Roads Departments for example) in order to develop the design.

THE NON-NEGOTIABLES FOR SERVICE USERS

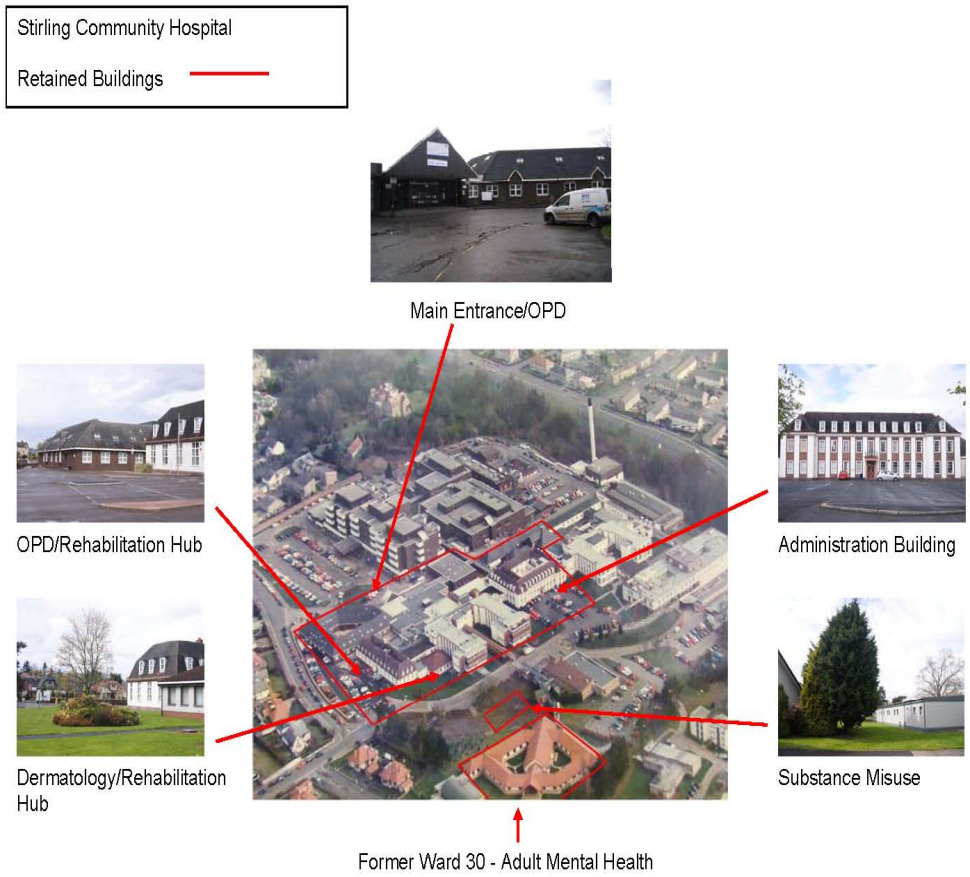
Agreed Non-Negotiable Criteria (Investment Objective/Customer Quality Expectation)	Benchmarks The Criteria to be met and / or some views of "what success might look like"
1.1 Site Must be in Stirling close to the population which it will serve and accessible to them, and maximise the opportunity for contact with family and friends during residential stay.	For example, for those patients of the GP practices, the new site must be close to (less than 1.5 miles) from the existing premises.
1.2 Accessibility The development requires good public transport and road links to and within the site and adequate (safe) provision for pedestrians and cyclists. Parking provision to be sufficient in number and appropriate in location.	Bus stop(s) not more than 5-10 minutes walk away from the main entrance(s). Drop off points close to the main entrance(s) but not obscuring them, with parking as close as possible but not dominating the site Safe pedestrian and cycle travel around the site with adequate cycle parking and related facilities. Within the site in general and between and within buildings there is a need to ensure DDA compliance including wheelchair user accessibility – appropriately designed, barrier-free paths, automatic entrance doors to be provided, corridor doors to be appropriate (either easy to manipulate or held open)

1.3 Impression and Ethos

The Care Village must be welcoming yet give the impression of the ability to deal with everyone's requirements. Any new build should not be intimidating in nature and landscaping and any retained natural features should be used to enhance the 'feel' of the Care Village.

The front door(s) for services should be easily identifiable and accessible. Finding your way to where you want to go should be as intuitive as possible, negating the requirement for a plethora of external signage

The Community Hospital site, as shown below, has a number of buildings which are to be retained and which have differing architectural styles. The Care Village development whilst creating and maintaining its own identity must also sit comfortably with this existing framework.



Use of soft landscaping to create a welcoming feel externally along with artwork/sculpture.
Routes into and around the site must be safe for all users and in all conditions.
The experience for those arriving at the site by any means ie car, public transport, bicycle or on foot should be equal with no one mode of transport dominating another.
No route for pedestrians should necessitate crossing car parking areas.
Routes from car parking areas to entrances should be safe and as short as possible.
Maggie's Centres noted as examples of good practice of a welcoming, non-institutional external (and internal) environment.

The following are images of different types of projects selected to show examples of differently scaled buildings fitting their environment/creating their own impression.

Stratheden Hospital, Waterford Health Park, David Walker Gardens

The external environment will be extremely important within the Care Village, with the spaces around and between buildings forming part of the ethos of the development as noted in later sections of the Design Statement. The following images represent examples of where external spaces promote their use, in particular in encouraging older people outdoors, with seating in a variety of settings and landscaping to facilitate multi-generational use.

Springfield Village Redevelopment, Images from I'DGO website

1.4 Organisation and Wayfinding

The design should be user focussed. User journeys within the premises should be as short as possible with clear and appropriate signage to make wayfinding as easy as possible.

The premises should be designed to facilitate ease of access, travel around them and wayfinding by a number of client groups, including those with disabilities and dementia, while ensuring the security and safety of residents/inpatients.

Minimum number of entrances and reception points

Reception/Sub-Reception areas should be easy to locate

Routes to services should not be overly complex allowing patients to find their way to appointments on time and without undue stress

Where corridors are longer by necessity, areas for taking a rest should be provided.

Of particular note is the need for the GP practices to maintain their 'identity' and for their patients to be able to identify with this. This is to be achieved within the specification of a single/shared reception and waiting area for the practices.

Good use of natural daylight and links to external spaces for orientation

Good use of colour/finishes to distinguish service locations and assist with wayfinding.



Dumfries Dental Centre,
Girvan Community Hospital,
Dumfries Dental Centre

1.5 Human Needs

Comfort, dignity and privacy are paramount, therefore, the design must support users to retain their independence and dignity by considering all issues of physical, cognitive and sensory impairment.

There should be space for social interaction, access to toilets plus facilities for children and food/drink, likely associated with reception and waiting areas.

The design of the facilities must enhance the user's experience of services.



Lewisham Children and Young People's Centre,
David Walker Gardens,
Maggies Cancer Caring Centre London

1.6 Key Spaces

1.6.1 Reception

As the first point of contact and spaces where clients will spend much of their time, these areas must be well designed, safe and comfortable and enhance, not detract from, their experience.

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Provision to be made for clients to be received and called to their appointments in the most appropriate manner.

Design to be inclusive and take account of specific requirements, eg wheelchair user interface at reception desks, induction loop provision

Reception areas should allow for confidential discussion when required – if necessary separate rooms/areas should be provided for this.

The design should protect confidentiality between staff and public areas.

Plean Street Centre for Health,
Villa Street Medical Centre, Waterford Health Park

1.6.2 Waiting

Following on from reception, waiting areas must present a welcoming environment and should be close to staffed areas to allow support to be provided to clients and others should it be required.

Design to be inclusive and take account of specific requirements, eg client group and potential mix. Sufficient area to be allocated for wheelchairs and prams.

Access to toilets and to food and drink/provision of drinking water.

Space for information on health/health promotion and complimentary services such as those for carers.

Positive, age-appropriate distractions to be provided such as views to outside, internal/external artwork to alleviate stress, play areas.

The West Centre,
New Stobhill Hospital,
Lewisham Children and
Young People's Centre

1.6.3 External spaces

Garden/other external space to be provided in a range of locations for a variety of uses.

Spaces to be planned according to their function, orientated appropriately with consideration given to how they will be used in differing weather conditions, eg provision of shelter to extend this use on colder/wetter days

The environment created should encourage use whilst taking cognisance of the function of adjacent accommodation – external spaces must be usable spaces planned in such a way as to be complimentary to the surrounding buildings/functions and in their own way therapeutic and health promoting.

Spaces to be level, thus maximising opportunities for pedestrian use, and directly accessible to inpatients/residents and others. A mixture of hard and soft landscaping, ideally with some art features to make attractive to users. Consideration to be given to the incorporation of water features.

Spaces to be designed with low/minimal maintenance in mind as poorly maintained areas will discourage/prevent their use.

Firhill Respite Centre,
As above,
Pulross Intermediate Healthcare Centre

THE NON-NEGOTIABLES FOR STAFF

Agreed Non-Negotiable Criteria (Investment Objective/Customer Quality Expectation)	Benchmarks The Criteria to be met and / or some views of "what success might look like"	
2.1 Site Matters Must be in Stirling close to the population which it will serve and large enough to allow implementation of the vision for co-located and integrated health and social care services, for older people and other sections of the community. Good public transport and road links to and within the site and adequate (safe) provision for pedestrians and cyclists.	Bus stop(s) not more than 5-10 minutes walk away from the main entrance(s). Parking space numbers to be determined by standard formula and within the limits set by BREEAM and green travel plan agenda. Safe pedestrian and cycle travel around the site with adequate cycle parking and related facilities. Car parks to be safe – well lit and with adequate footpath links to buildings   	Dumfries Dental Centre, Girvan Community Hospital, Easterhouse Community Centre
2.2 A good place to work The premises must be an attractive place to work with a high quality working environment contributing to the recruitment and retention of staff- the design of the facilities must encourage people to want to come to work in the Care Village and to continue to do so.	All working and support areas to reflect the importance placed upon staff and their role in the Care Village. Primary working areas, where accessed by users are described elsewhere in the design statement, requirements for staff only areas are noted below Offices to be designed with due care and attention to staff needs and comfort- maximising natural daylight and ventilation, provision of long views. Where provided, multi-occupancy offices to allow for sound attenuation to facilitate concentration and allow protection of confidentiality, with adjacent space for meetings or conversations to take place.	

2.3 Key Spaces

2.3.1 Consulting/Treatment Rooms

These should be:

- Welcoming and calming
- Appropriate for their intended use but of 'generic' design to promote flexibility/maximise utilisation
- Safe for staff
- Adequately soundproofed for confidentiality

Good use of colour and natural daylight

Design/specification to have staff safety in mind eg alarm systems where necessary, layout to allow emergency egress

Barrhead health & Social Care Centre, Waldron Health Centre

2.3.2 Bedrooms

To be appropriate for the differing client groups.

They should::

- Ensure ease of access for attending to and for moving clients.
- Be of inclusive design, with particular attention to be paid to the needs of those with dementia
- Maximise staff opportunities for observation

All bedrooms must be en suite with appropriate space for visitors and the ability to easily call for staff if there is a need. Maximising use of light and visibility to external areas.

As comfortable an environment as possible and in some cases, for longer stay clients where the facility is essentially their home, less clinical/institutional, more like a hotel.

David Walker Gardens, Brent Birth Centre, Stratheden Hospital

2.3.3 Ancillary Spaces –
Day rooms, fitness studio, shop/hairdressers, resident(s) lounge(s) and canteen/dining
Equal importance is to be placed upon the design of these areas and they should be appropriately located to provide ease of access.

The spaces will be attractive and will maximise daylight, thus encouraging use.
The location of the dining room for inpatients/residents to be such that it offers views and access to an external area which is suitably landscaped
Residents to be provided with a choice of day space including a 'quiet room' without television or other entertainment.



David Walker Gardens,
As above,
Maggies Cancer Caring Centre, Highlands

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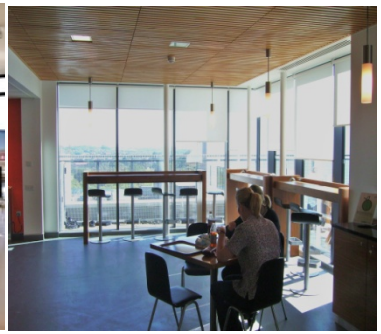
2.3.4 Staff Areas
Staff areas to be provided to cater for staff's personal needs.

Rest areas to be provided to within 5 minutes of work stations. To be designed to encourage use by individuals and groups of staff, facilitating interaction and recognising staff needs to 'breakaway' from their immediate working environment for comfort/social reasons. Access to natural daylight and pleasant views.
Access to external areas to be provided. Changing areas to be provided split between genders.

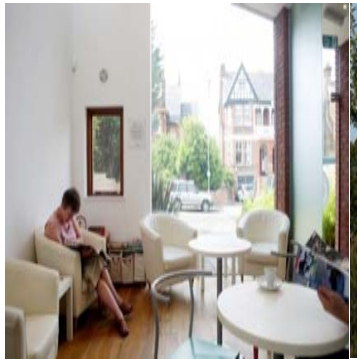




New Stobhill Hospital,
The Carlisle Centre,
New Stobhill Hospital

2.4 Integration Between Services The design must facilitate interaction, professionally and socially, between the various staff groups, promoting the benefits of co-location and enhancing opportunities to overcome any barriers, be they physical or cultural.	From an integration, and resource, perspective, shared space is to be maximised, particularly for 'non-clinical' functions, including offices, catering/rest/social spaces. A key driver for the project is the provision of integrated services for Older People, therefore inpatient, residential and other accommodation for this client group is to be planned and located jointly from a health and social care perspective, including support spaces such as offices. Space to be provided, within or adjacent to offices or on circulation routes for informal staff discussion.
2.5 Flexibility in use The design must allow for changing models of care and service provision in response to local and/or national policy change etc without the need for major physical alterations.	'Generic' design of bedrooms (within the health and social care areas whilst respecting patients' individual needs per category of patient) and consulting/treatment rooms. Logical layout of accommodation, including circulation routes to allow for further flexibility between services using rooms
2.6 Ability to clean and maintain The building must be easy and cost effective to clean and maintain with appropriate provision for addressing Healthcare Associated Infections (HAI)	Surfaces/finishes to be durable and easy to clean: use of the HAI-Scribe process and input from Infection Control advisors is essential. Service routes to be planned appropriately with safe access and to allow maintenance/replacement without undue disruption to service users/providers. FM routes should be separate from public ones. M&E systems to be specified with due attention to lifecycle costs, ease of maintenance, replacing fittings etc.

THE NON-NEGOTIABLES FOR VISITORS

Agreed Non-Negotiable Criteria (Investment Objective/Customer Quality Expectation)	Benchmarks The Criteria to be met and / or some views of "what success might look like"	
3.1 Integration With The Surroundings The Care Village must be integrated with its surroundings, feel part of the community.	The content and layout of the facilities as well as the overall planning of the site must encourage engagement with the wider community so that the Care Village is a place to go to as a part of daily life not just by necessity to use the services located there. Routes through the site to encourage people into and around it. External spaces not reserved specifically for inpatient/resident use should be accessible to the public. This integration is to be achieved whist protecting patient/residents' privacy and dignity, therefore, careful consideration is to be given to the relationships between the various functions on the site.	
3.2 Human Needs The needs of those visiting residents or accompanying those accessing other services should be catered for.	Waiting areas to be comfortable with appropriate environments, with access to facilities for children and to external space. A café or other area for drinks and food should be provided. Toilets to be adjacent to waiting areas. Drinking water to be freely available. Quiet areas for those in need of confidential discussion/comfort/dealing with distress should be available. Space to allow visitors to engage in private discussion with residents/clients/inpatients. Space for health services, health promotion and other information (eg on services available to carers) to be provided   	Waterford Health Park, Advance Dental Clinic, Glasgow Homeopathic Hospital

ALIGNMENT OF INVESTMENT WITH POLICY

Agreed Non-Negotiable Criteria (Investment Objective/Customer Quality Expectation)	Benchmarks The Criteria to be met and / or some views of "what success might look like"
4.1 Local Needs The project must make use of the opportunity to transform a large part of what is a significant site in the midst of a residential setting, providing amenities which are well designed and sustainable in its widest sense, providing an appropriate fit with its immediate environs	The development must take cognisance of the surrounding area and foster good relationships with neighbours – ensuring that traffic impacts during construction and operations are minimised and that sufficient parking is provided on-site to prevent on-street parking becoming a nuisance. The potential exists for the development to contribute to Stirling Council's 'Stirling City Vision' by connecting directly to the A9, improving access to the site and adding in general to the amenity of the area.
4.2 Future Flexibility and Expansion It is anticipated that the balance of care for older people will increasingly shift away from health to social services, therefore, the 'residential care' element of the development must be designed in such a way as to cope with that shift. Similarly, the shift from acute to primary and community care in health services is expected to continue and must be taken account of. As well as the design of individual buildings, the overall masterplan for the site must take account of future needs prior to any disposal of surplus land.	Flexibility of structure and services needs to be built into the design of the residential and GP/Primary Care areas. Types of accommodation to be located logically to allow for flexibility between uses/types of care eg MIU/GP Out of Hours/GP practices locations and specifications to be such to allow use by all 3 services on an ad hoc or more permanent basis. In general 10% expansion space to be allowed. The masterplan for the site must allow for future development zones.

4.3 Sustainability Scottish Government targets for sustainability to be met.	BREEAM accreditation as appropriate – at this stage of the project, it is not known what the design/split of services between buildings will be, therefore, advice will be sought early in the Outline Business Case process as to BREEAM assessment. It may be that a bespoke assessment is required where more than one function occupies a building. Every opportunity to be taken to implement sustainable building solutions, particularly where these are linked to carbon reduction and energy saving measures.

The above have been agreed in consultation with the following:

Tom Steele, Director of Projects & Facilities
Morag Farquhar, Programme Director
Lesley Middlemiss, Healthcare Planner
David Whipps, Healthcare Planner
Kathy O'Neill, General Manager, Stirling & Clackmannanshire Community Health Partnership
Dr Stuart Cumming, Clinical Lead, Stirling & Clackmannanshire Community Health Partnership
Fiona Gordon, Clinical Nurse Manager Older People's Services
Dr Philip Gaskell, General Practitioner
Dr Scott Williams, General Practitioner
Members of Stirling and Clackmannanshire Public Partnership Forums including representation from the Scottish Health Council
Bob Gil, Head of Corporate Projects, Stirling Council

SELF ASSESSMENT PROCESS – V1 AT INITIAL AGREEMENT STAGE

Decision Point	Authority of decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision Information needed	Information needed to allow evaluation
Site Development Strategy	Decision by NHS Board and Council with advice from the Project Board		Analysis considering the capacity of the proposed site to deliver the required development including fulfilling the above criteria	Feasibility study based on the best available information to be developed in accordance with the overall site Masterplan. The latter is agreed as a necessity to ensure that the best solution is provided for the site for current and future purposes.
Completion of brief to go to market	Decision by the Project Board with advice from the Project Director	Stakeholders including service providers and internal technical advisors	Inclusion of the Design Statement in the brief	Early engagement with hubco and their process to assess the affordability/ deliverability of the brief

Selection of Delivery/Design team	Decision by the Project Board with advice from the Project Director	Technical advisor external to the design team to be appointed	Selection process per hubco method statements to be applied, with quality and cost considerations, to ensure that the best design team for the development is chosen from the hubco Supply Chain. Designers will have already been through a qualification process to become part of the Supply Chain. 'Participants' will be involved in the selection process for the project and can influence the outcome including, if necessary, nomination of other designers for consideration (providing they meet the standards set by hubco).	Previous experience/ examples of the designers' work on similar commissions. Interview process to include presentation/ questions regarding design approach and potential to fulfil the set criteria. As it is unlikely that previous experience will be an exact match for the proposed project, careful consideration will require to be given to the quality criteria set.
Selection of early design concept from options delivered	Decision by the Project Board with advice from the Project Director	Comment to be sought from NDAP	AEDET or other assessment of options to determine whether they meet the criteria	Proposals developed to Stage C with sufficient detail to allow distinction between the main uses of the building(s) including circulation and external space. Elevations/3D visuals.
Approval of design proposals to be submitted to planning authority	Decision by the Project Board with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Selected design to Stage D with elevations etc.
Approval of detailed design proposals to allow construction	Decision by the Project Board with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Design developed to at least Stage E with agreed specification.

Post occupancy evaluations	Consideration by appropriate internal governance groups with report to SGHD	Independent analysis by technical adviser/service providers	Assessment by stakeholders to determine whether the completed development met the set objectives.	

SELF ASSESSMENT PROCESS

REVIEWED AT OUTLINE BUSINESS CASE STAGE

REVIEWED AT FULL BUSINESS CASE STAGE

Decision Point	Authority of decision	Additional skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision Information needed	Information needed to allow evaluation
Site Development Strategy	Decision by NHS Board and Council with advice from the Project Board		Analysis considering the capacity of the proposed site to deliver the required development including fulfilling the above criteria	Feasibility study based on the best available information to be developed in accordance with the overall site Masterplan. The latter is agreed as a necessity to ensure that the best solution is provided for the site for current and future purposes.

OBC Review Draft Masterplan completed prior to submission of New Project Request (NPR) and based on Initial Design Brief. Design Statement formed part of briefing information. Capacity of site including car parking and external works confirmed along with potential for future proofing (additional services and parking) Preferred option from Masterplan appraisal approved by the Project Board and partner organisations. Masterplan finalised post NPR and formed basis of application for Planning Permission in Principle. Interim Design Assessment undertaken on Masterplan and initial design development and comments received by project team/Local Authority Planners.				
FBC Review N/A				
Completion of brief to go to market	Decision by the Project Board with advice from the Project Director	Stakeholders including service providers and internal technical advisors	Inclusion of the Design Statement in the brief	Early engagement with hubco and their process to assess the affordability/ deliverability of the brief
OBC Review Project Brief developed by Project Team, approved by the Project Board and submitted with the NPR in April 2013. Design Statement included as an appendix. Confirmation received from hubco in May 2013 that project deliverable within the terms of the NPR.				
FBC Review N/A				

Selection of Delivery/Design team	Decision by the Project Board with advice from the Project Director	Technical advisor external to the design team to be appointed	Selection process per hubco method statements to be applied, with quality and cost considerations, to ensure that the best design team for the development is chosen from the hubco Supply Chain. Designers will have already been through a qualification process to become part of the Supply Chain. 'Participants' will be involved in the selection process for the project and can influence the outcome including, if necessary, nomination of other designers for consideration (providing they meet the standards set by hubco).	Previous experience/ examples of the designers' work on similar commissions. Interview process to include presentation/ questions regarding design approach and potential to fulfil the set criteria. As it is unlikely that previous experience will be an exact match for the proposed project, careful consideration will require to be given to the quality criteria set.
OBC Review Engagement with hubco on inception of masterplanning process to select design team (Architect, M&E, Civil Structural) via prescribed process. Participants represented by Morag Farquhar (NHS Forth Valley, Project Director) and Bob Gil (Stirling Council, Head of Corporate Project Implementation). For Architect selection Lesley Middlemiss (NHS Forth Vallley, Healthcare Planner) also present at interviews. Selection criteria and quality/cost ratio agreed for Pre-Qualification and interview. Previous experience in health and social care given high weighting. In a separate process, Mott MacDonald selected as client Technical Adviser following guidance laid down for selection from SFT Framework.				
FBC Review N/A				
Selection of early design concept from options delivered	Decision by the Project Board with advice from the Project Director	Comment to be sought from NDAP	AEDET or other assessment of options to determine whether they meet the criteria	Proposals developed to Stage C with sufficient detail to allow distinction between the main uses of the building(s) including circulation and external space. Elevations/3D visuals.

OBC Review
Masterplan finalised post NPR and formed basis of application for Planning Permission in Principle (August 2013).
Initial discussion held with A&DS on completion of Masterplan appraisal, resulted in further option being considered and enhancements to design in particular to externals/landscaping.
Interim Design Assessment undertaken on Masterplan and initial design development and comments received by project team/Local Authority Planners. Commentary on actions taken provided with OBC Design Assessment submission.
Stage 1 design development process undertaken with extensive involvement of key stakeholders to reach sign off for that stage in line with programme. Acknowledged, however, that further work to be done in Stage 2.
Project Board to sign off with OBC.
AEDET review undertaken, results included with OBC Design Assessment submission.

FBC Review
N/A

Approval of design proposals to be submitted to planning authority	Decision by the Project Board with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Selected design to Stage D with elevations etc.

OBC Review
N/A

FBC Review

- Planning Permission in Principle (PPP) (planning reference: 13/00505/PPP) for this development proposal was approved by the Council's Planning Panel on 24th June 2014.
- The exercise to discharge the comments received from the Local Authority Planners was undertaken with extensive involvement of key stakeholders.
- ADET review undertaken at OBC stage, continuous assessment of proposals against stated criteria.
- Full Planning Application to address Matters Specified by Conditions was submitted on the 2nd March 2015. This application was approved by Stirling Council on 27th August 2015.

Approval of detailed design proposals to allow construction	Decision by the Project Board with advice from the Project Director		AEDET or other assessment of the proposals to determine whether they meet the criteria	Design developed to at least Stage E with agreed specification.

OBC Review
N/A

FBC Review

- Stage 2 design development process undertaken with extensive involvement of key stakeholders.
- The Stage 2 submission made by the designers, Tier 1 Contractor, FM Service Provider and hubco has been reviewed by the appropriate User Groups and Project Team and comprehensive packages of comments returned for auctioning
- Project Technical Advisors have undertaken reviews of the Facilities Management, Civil Structural, Technical Costing and Mechanical and Electrical proposals
- Stage 2 and Stage 2 Addendum AEDET reviews undertaken which show improvements from OBC.

Post occupancy evaluations	Consideration by appropriate internal governance groups with report to SGHD	Independent analysis by technical adviser/service providers	Assessment by stakeholders to determine whether the completed development met the set objectives.	

OBC Review
N/A

FBC Review
N/A

Appendix C
Extracts from Risk Register

Joint Risk Register

				Prior to Mitigation				Post Mitigation					
Ref No:	Risk Description	Risk Category Ref	Risk Category	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Time / Cost Impact	Agreed Hubco Provision	Agreed Participant Provision
7	Centralisation of services is perceived as a reduction in access to care and will create a large, impersonal, institutional facility	A&D	Clarity and Understanding of Client Brief and Objectives	3	2	6	1. Public consultation has been carefully managed to ensure that the benefits of this scheme are at the forefront of the message portrayed. 2.Design statement supplied by NHS FV used as basis of design intent and for MP exercise. Robust MP exercise conducted taking account of service brief	1	1	1	T&C		
8	Stakeholder / public expectations are unduly raised following announcement of the preferred way forward prior to formal approval of the project	A	Clarity and Understanding of Client Brief and Objectives	2	3	6	1. Obtain Full Business Case Approval 2.. Ryden's to be fully briefed to ensure joined up approach 3. Obtain full planning approval-planning approval in place with conditions	2	3	6	C		£[redacted]
22	UPGRADING REQUIRED TO OFF-SITE INFRASTRUCTURE/ Potential Vehicular Access off A9 by installation of traffic light controlled junction/bridge upgrade/ (programme mgr advised A9 upgrade does not form part of current scheme). Other off site conditions may be imposed/junction S75's	G	Planning, Statutory Approvals and Health & Safety	5	5	25	1. PPIP now in place.Number of conditions imposed one of which is bridge upgrade/replacement. Feasibility report conducted by Woolgars. Sketch proposals submitted to Planning as at 2nd March 15. Outwith project scope currently. Funding to be confirmed. Detailed design now instructed on preferred option, submitted to planning. 2. NHSFV to confirm agreement with Stirling Council to complete works in time for occupation of PC building. 3 Agreement of proposals for and / or completion of works to the A9 may preclude RCC from concluding purification of planning conditions 4. Contract may require to be amended	2	4	8	T&C		£[redacted]
27	Ecology & archaeology – protected species identified (e.g. bats etc) (programme issues)	F	Third Party and External Disruption to Operations	5	5	25	1. Ecological report and early discussion with Stirling council re Archaeology to confirm all requirement. (Planning have confirmed archaeology report not required)	1	3	3	T&C		
32	Potential issues regarding secure capacity of utilities	G	Planning, Statutory Approvals and Health & Safety	4	5	20	1.Agreement with Participants on connection to existing building/ services 2.Design intent is to utilise existing capacity with no new utility connections. Sub metering proposed. ACR's to be issued. 3. FM provider to be consulted	1	5	5	T&C		£[redacted]
33	Maintenance responsibilities need to be defined should incoming connections be obtained from existing on site networks.	L	Unresolved Issues	4	3	12	1.Design intent is new Electrical supplies to CH and PCH buildings 2. FM Contractor selected and involved as required 3. Approval of design 4. Agreement of SLS 5. Further dialogue with NHS Estates / Scottish Water / Scottish Gas	2	2	4	T&C		
36	Nursery position on site/Mental Health Building/Substance Misuse Centre	M	Design and Specification	4	4	16	1. NHSFV to confirm if building can be relocated. -buildings do not hinder MP - building to remain in current position 2.MF will investigate lease dates re nursery building. 3. Site set up to be established. (Risk re location of nursery building-construction in close proximity)	1	1	1	T&C		

37	**Giant Hogweed identified on site as stated within Ironside Farrar Ecology Report**	**H**	**Construction, Site Conditions, Ground and Weather**	5	2	10	**1.JMA have indicated on site plan areas where identified.** **2.NHSFV Estates department have ongoing treatment plan in place including ongoing treatment of areas. Update to be provided by Estates. (Ian Kinloch)**	2	2	4	**T&C**		**£[redacted]**
39	**Proposed design splits buildings into separate locations. Potential impact on Building Warrant, Planning and BREEAM processes, i.e. separate applications for each building?**	**M**	**Design and Specification**	3	2	6	**1. Early liaison with Building Control, Planning and BRE to ascertain their views and requirements.** **2.Tier 1 to confirm with design team correct approach and determine if 2 sep warrants required**	1	2	2	**T&C**		**£[redacted]**
43	**Kitchen block being demolished in proximity of vulnerable steam main**	**H**	**Construction, Site Conditions, Ground and Weather**	3	3	9	**1. T1 appointed** **2. Record information to be supplied/survey** **3. Protection of steam main during construction/include in CPP** **4. Undertake trial pits** **5. Steam main to be made redundant by NHS prior to commencement of demolition works**	2	4	8	**T&C**		
53	**Inflation / market conditions create procurement risk by increasing costs and tender returns above allowances included in Pricing Report**	**I**	**Procurement Uncertainties, Cost, Time and Quality**	3	3	9	**1. Transfer risk to supply chain** **2. Early purchasing / placing orders/fix prices** **3. Tender review ongoing** **4. Focus on FC activities**	3	3	9	**T&C**	**£[redacted]**	
54	**Ground conditions encountered on site are more onerous than anticipated in costs / programme**	**H**	**Construction, Site Conditions, Ground and Weather**	4	5	20	**1. Undertake additional trial pits** **2.Undertake CBR tests where areas available**	2	3	6	**T&C**	**£[redacted]**	
55	**Underground services are encountered not identified in Existing Services Information**	**H**	**Construction, Site Conditions, Ground and Weather**	3	5	15	**1.** Undertake additional surveys 2. Trial pits dug	2	4	8	**T&C**	**£[redacted]**	
56	**Planning Approval - programme**	**G**	**Planning, Statutory Approvals and Health & Safety**	1	5	5	**Dialogue with Planning Department at earliest possible stage**	1	3	3	**T&C**		
58	**Planning Approval - Section 75 requirements**	**G**	**Planning, Statutory Approvals and Health & Safety**	1	5	5	**Dialogue with Planning Department at earliest possible stage**	1	4	4	**T&C**		
59	**Environmental / Ecology Issues not highlighted in surveys**	**G**	**Construction, Site Conditions, Ground and Weather**	2	4	8	**1. Arrange watching brief with specialist** **2. Appoint on-site ecology champion** **3. Undertake additional surveys**	1	3	3	**T&C**		
60	**Unknown archaeology requirements**	**G**	**Construction, Site Conditions, Ground and Weather**	2	4	8	**Early consultation with Planning Department / local specialist**	1	3	3	**T&C**		**£[redacted]**
61	**Unexploded Ordnance (UXB)**	**G**	**Construction, Site Conditions, Ground and Weather**	1	5	5	**Employ specialist survey company**	1	4	4	**T&C**		**£[redacted]**
62	**Design Development**	**M**	**Design and Specification**	4	5	20	**1. Design validation workshops** **2. Design being challenged in line with costs to make more cost effective** **3. Obtain approvals / sign-offs for all proposals prior to Stage 2 submission-construction issue drawings not yet concluded/ditto fully coordinated design**	3	4	12	**T&C**	**£[redacted]**	

63	Third Party issues - boundaries, over sailing, wayleaves, etc	F	Third Party and External Disruption to Operations	2	5	10	1. Early identification of requirements 2. Early involvement of Client's legal team 3. Early establishment of legal workstream	1	3	3	T&C		
64	Asbestos encountered - in addition to that identified in surveys / reports	G	Planning, Statutory Approvals and Health & Safety	4	3	12	1. Undertake additional surveys. 2. Check surveys for areas not inspected.	3	3	9	T&C		£[redacted]
65	Drainage - condition / capacity of existing system	M	Design and Specification	1	5	5	1. Early consultation with water authority 2. Undertake CCTV surveys	1	4	4	T&C		
66	Under measurement / under assessment of scope of works in Stage 2 cost plan	I	Procurement Uncertainties, Cost, Time and Quality	4	4	16	1. Undertake regular cost checks- ongoing/no final construction issue drawings	2	2	4	T&C	£[redacted]	
67	Changes in legislation	I	Procurement Uncertainties, Cost, Time and Quality	1	4	4	Consultant's to provide early warning	1	3	3	T&C		
68	Client Change	E	Programme, Information Release, Decision Making, Timing and Adequacy	3	4	12	1. Agree / implement Change Control protocol	3	3	9	T&C		£[redacted]
69	Utilities - programme	I	Procurement Uncertainties, Cost, Time and Quality	3	3	9	1. dialogue with utility companies 2. Up front payments to utility companies 3. At present service connections are to be made to existing site infrastructure. (gas/water) Further dialogue required specifically for the electrical supply connections. (new) 4. Further dialogue with NHS Estates / Scottish Water / Scottish Gas	2	3	6	T&C	£[redacted]	
70	Utilities - existing capacity and agreed strategy, and condition of existing services distribution on site	M	Design and Specification	2	5	10	1. ongoing dialogue with NHSFV -Estates Team to advise on condition of existing services distribution systems on site, to which supplies to the new buildings are to be connected, based on condition surveys.	2	4	8	T&C		
71	Utilities - costs / inability to obtain fixed prices	M	Design and Specification	5	4	20	1 dialogue with utility companies 2. Up front payments to utility companies 3. Final agreement required on sub station locations. 4. Dialogue with Scottish Power / Scottish Gas / Scottish Water	2	3	6	T&C	£[redacted]	
73	Programme - construction period / LADs	M	Design and Specification	1	5	5	1. Develop robust programme based on historical data from previous projects 2. Obtain buy-in from key supply chain 3. Early agreement of DPC programme	1	3	3	T&C	£[redacted]	
75	Programme - adverse weather conditions	E	Programme, Information Release, Decision Making, Timing and Adequacy	3	4	12	1. Develop robust programme based on historical data from previous projects 2. Consult weather records for local area 3. Develop robust protection procedures	1	3	3	T&C	£[redacted]	

76	Condition of existing water supply system LEGIONELLA / FM	G	Planning, Statutory Approvals and Health & Safety	3	4	12	1. Undertake inspections / surveys at early stage 2. Liaise with hospital maintenance team / review existing records 3. NHSFV to confirm condition of existing site mains water distribution system to be connected in to as noted in item 70	1	2	2	T&C		
78	Sub Contractors - availability of resources	M	Procurement Uncertainties, Cost, Time and Quality	2	4	8	1. Early dialogue with key supply chain 2. Consider splitting packages	1	3	3	T&C		
79	Sub Contractors - insolvency	M	Design and Specification	3	4	12	1. Early dialogue with key supply chain 2. Consider splitting packages3. Careful selection of supply chain / undertake financial checks	2	3	6	T&C	£[redacted]	
80	Damage to existing trees / root zones	J	Contractor Competency and General Site Management	2	2	4	Implement robust protection measures	1	1	1	T&C		
81	Condition of retained / legacy equipment	M	Design and Specification	3	3	9	1. Identify any legacy equipment 2. Employ specialists 3. NHSFV to provide schedule and condition survey	2	2	4	T&C		
82	Neighbours - restrictions on working hours / methodology	H	Construction, Site Conditions, Ground and Weather	4	3	12	1. Early dialogue 2. Agreement of method statements 3. Outline planning specifies hours 4. Confirm NHS any restrictions 5. Regular liaison with neighbours	2	2	4	T&C		
86	Late receipt of client approvals	E	Programme, Information Release, Decision Making, Timing and Adequacy	3	4	12	1. DVM's being held 2. Continuous dialogue with NHS to seek approval Programme dates to be met/design freeze	3	4	12	T&C		
92	Existing service tunnel - working over / around	H	Construction, Site Conditions, Ground and Weather	3	3	9	1. Undertake inspections / surveys at early stage 2. Liaise with hospital maintenance team / review existing records 3. Dialogue with Estates/technical solution to be established then any legal implications 4. Install protection measures above tunnel.	2	2	4	T&C		
93	Fire Engineering - Fire Officer's specific requirements are not defined at Stage 2	M	Design and Specification	5	3	15	1. Fire engineer appointed - NHS Fire and Fire and Rescue officer consultation ongoing 2. Further meeting to be arranged with NHSFV fire officer	2	2	4	T&C	£[redacted]	
94	Acoustics - input from specialist acoustician at Stage 2 may introduce additional scope of works	M	Design and Specification	5	2	10	1. Early dialogue with client 2. Employ specialist consultant 3. Acoustician confirmed that standard window and trickle vent specification achieves dB ratings stipulated by Planning for traffic noise (when windows are in the closed position). There is no traffic noise restriction for windows in the open position, therefore natural ventilation is allowed. 4. Further review of proposals by RMP prior to STage 2 submission	2	2	4	T&C	£[redacted]	
97	Programme - sequencing / early handovers	E	Programme, Information Release, Decision	1	2	2	Early agreement of client requirements	1	2	2	T&C		

			Making, Timing and Adequacy										
98	Hand-over protocol / programme	E	Programme, Information Release, Decision Making, Timing and Adequacy	1	1	1	Early agreement of client requirements	1	1	1	T&C		
99	Damage to existing roads within site	H	Construction, Site Conditions, Ground and Weather	4	2	8	1. Condition Surveys 2. Robust protection 3. Appropriate plant	2	2	4	T&C		
100	The existing client owned utilities infrastructure may be in poor condition necessitating repair works / replacement which results in additional costs and programme delays	H	Construction, Site Conditions, Ground and Weather	4	4	16	1. CCTV survey will assess condition of drainage runs/manholes. Visual inspection already carried out. Photographs/levels provided 2. On-going trail pits/inspections to determine exact location/condition 3. NHS replace infrastructure ahead of contract commencement 4. Agreement of connection locations and services ownership prior to Stage 2 submission	4	3	12	T&C		£[redacted]
101	The client owned electricity cable in the proposed location of the new Care Hub Building is not diverted prior to start on site - impact is additional costs and programme delays	H	Construction, Site Conditions, Ground and Weather	5	5	25	1.Works planned by NHSFV. Works to be carried out. Tender is about to be issued.	2	5	10	T&C		£[redacted]
103	Buildings scheduled for demolition by the client are not demolished prior to start on site - impact is additional costs and programme delays	F	Third Party and External Disruption to Operations	5	5	25	1.Works planned by NHSFV. Works to be carried out. Tender is about to be issued.	2	5	10	T&C		£[redacted]
104	Programme delay resulting from late sign off poses risk to costs and programme	E	Programme, Information Release, Decision Making, Timing and Adequacy	4	4	16	1. Programme review meetings . Client approval programme produced. Validation meetings commenced. Timeous robust design information to be issued and timeous client sign off.	2	4	8	T&C		£[redacted]
105	Asbestos Surveys for buildings to be demolished are not carried out to suit RCC's programme	H	Construction, Site Conditions, Ground and Weather	3	2	6	1. Asbestos reports provided. Subway duct info to be provided. 2. Relates to the risk of encountering asbestos materials for which surveys have been carried out and information on the underground services duct is awaited.	1	2	2	T&C		£[redacted]

		Prior to Mitigation				Post Mitigation			
Ref No:	**Risk Description**	**Probability (1-5)**	**Impact (1-5)**	**Risk Rating (1-25)**	**Mitigation**	**Probability (1-5)**	**Impact (1-5)**	**Risk Rating (1-25)**	**Agreed Participant Provision**
4	**Organisations can't agree to work in partnership towards delivering the new Care model, particularly the manner in which resources and the flexible use of beds are allocated between organisations.**	5	3	15	**1.High level agreement has already been agreed between each organisation to this approach but a more formal mechanism will need to be agreed to allow a seamless delivery of services. 2.Mitigation needs to align with timescales as per current programme and agreement in place to suit programme requirements 3.Detail of model to be confirmed within Service Brief 4. Strategy/operational policies to be developed as to how local authority & SCV will work together (patient journey/flexibility) 5. Align budget as no of beds ebb & flow**	1	3	3	£[redacted]
11	**It becomes difficult to identify and quantify workforce and professional development needs across all partner organisations supported by Forth Valley college (and existing providers) can plan effectively to meet new level / range of demand**	2	3	6	**1. This needs to be built into the project work plan and progressed in a collaborative way 2. Gaps within OBC to be completed/succession planning/Sub Group Established/Training & HR 3. Completed workforce plan 4. Transitional plan in place/commenced/manage transition**	1	3	3	£[redacted]
12	**Delays in implementation of parts of the project mean that the full service model cannot be implemented at same time**	4	3	12	**1. Service model prepared 2. Highlight on Programme key critical dates 3. Detailed method statements to bring facilities on stream 4. Preferred option confirmed as No 3 (post option appraisal on option 4)**	1	2	2	£[redacted]
15	**Procurement plans do not appropriately consider and reflect on the complex VAT implications and the ability of organisations to reclaim their VAT**	4	4	16	**1.Ensure that VAT experts are consulted at OBC stage when considering the financial / affordability implications of the preferred option 2. Financial relationship between parties & VAT advice required 3. Draft VAT report issued 4. HMRC precedent of recovery set with NHS Grampian project**	1	4	4	£[redacted]
50	**Model of Care does not achieve objective of H/Care Strategy**	3	5	15	**1. Build in futureproofing 2. Expansion demographics 3. Tested model of smaller scale**	2	3	6	£[redacted]
51	**Sub Debt & treatment of sub debt**	3	3	9	**Agreement to be reached on how this is apportioned**	3	2	6	£[redacted]
60	**Economics/Funding Market**	2	5	10	**1. HubCo establish Funder 2. Early engagement with Hub/Funder**	1	5	5	£[redacted]
64	Sale proceeds from SCH surplus land will not match expectations and affect investment in the retained estate	3	3	9	**1. Valuation by competent property advisor. 2. Early engagement with disposal process. 3. Phasing of funding can be implemented if requiired**	3	2	6	£[redacted]
65	**Sale proceeds from SC and SAS sites will not match expectations and affect capital contributions to the project, partners will have to source other funding.**	3	3	9	**1. Valuation by competent property advisor. 2. Early engagement with disposal process. 3. Contingency plans to be devised to ensure limited/no impact on capital injections. 4. SC and SAS funding of shortfall between receipt and contribution to be confirmed.**	3	2	6	£[redacted]

Appendix D
Value for Money Scorecard

REDACTED

Appendix E
Pricing Report

REDACTED

Appendix F
Benefits Realisation Plan

Stirling Care Village – Benefits Realisation Plan

This Benefits Realisation Plan (BRP) is a fundamental part of this project, running from the project's beginning to its end, and beyond. The aim is to ensure that the intended benefits from the project are delivered and that the resources allocated to the project are fully utilised. The BRP is also intended to demonstrate how the investment in this project is contributing to overall service improvement for the partners in the project. By focusing on benefits realisation planning, the partners will be able to track whether intended benefits have been realised and sustained after the end of the project. Furthermore, it helps to ensure a clear signposting of who is responsible for the delivery of those benefits.

The benefits realisation plan has been reviewed and updated throughout the project and this process will be continued at regular intervals once the project has been completed. It will form part f the ongoing performance monitoring of the Stirling Care Village and wider partnership arrangements. This will help the partners to monitor the changes made as a result of the project and if necessary enable corrective action to be taken to ensure that the original benefits are being achieved.

The format of the BRP is structured around the 8 Investment Objectives of the full business case and considers; benefit, stakeholder impact, enabler, outcome if benefit realised, measure, baseline, responsibility and timescale.

In terms of measurement, as noted in Section 5.1, work has been undertaken to review the Investment Objectives and link these, where possible, to the 9 National Outcomes for Health and Social Care and the Core Suite of Indicators developed by the Scottish Government along with other relevant KPIs. There are a significant range of measures available from which to assess benefits against the investment objectives e.g. LDP Standards, SOAs etc. The following table provide a sample baseline.

Linked National Outcome(s)	Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer. Outcome 2. People, including those with disabilities or long term conditions, or are frail, are able to live as far as is reasonably practicable independently and at home or in a homely setting in their community.

Investment Objective 1: Increase integration & communication between health & social care services and delivery to service users

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measures	Baseline (where available)	Who is responsible	Timescale
Delivery of more effective care with improved user outcomes	Patients /Service users and Carers	Deliver service redesign influenced by public involvement	Network enabling access to high quality, safe and cost effective services as locally as possible. More people supported to live well in their own home	% respondents registered with GP practices in the area who were positive that The help, care or support improves service users' quality of life".	Health and Care Experience Biennial Survey 2013/14 *Stirling 81%*	Integration Joint Board	Annual as available
				% social services service users who agreed I had received the help I need at the time I needed it.	Social Services Service User Annual Survey 2014/15 *Stirling 80%*		
Greater collaboration between partner organisations to improve effectiveness of preventative and intermediate care.	Patients/ Service users and Carers All Health and Social Care Providers	Deliver service redesign influenced by public involvement.	People are able to look after and improve their own wellbeing/living for longer. People are able to live independently and at home.	-Reduction in Emergency admission rates for catchment population -Reduction in ED Attendance for catchment population -Dementia Post Diagnostic support (LDP)	Baseline under review Measurement in d/w SG	Integration Joint Board	Varying reporting time frames
				Number of older people in care homes by local authority	Care Home Census 2015 *Stirling* 609		
				Delayed Discharge Total standard delays (between 3 days and 2 weeks) 2 week target introduced 15/16 Expected move to 72hrs	ISD 2014/15 *Stir 56* 2015/16 *Stirling 43*		
				"% service users who agree that Social Services have helped me to lead a more independent life''	Social Services Service User Annual Survey 2014/15		

					Stirling 77%		
				Rates per population of clients aged 65 and over receiving Home Care	Home Care Census up to 2012, Social Care Survey from 2013 2014 *Stirling* 17.8 2015 *Stirling* 18.9		
Improved staff engagement & communication between partner organisations	Staff	Co-location, joint and integrated working,	Enabled partnership culture & care coordination. Effective coordination of care	'-I am happy to go the extra mile at work when required' '-I would recommend this workplace as a good place to work' *Future data iMatter at Dept level.* *Evidence of staff engagement – Qualitative data.*	NHS Scotland Staff Survey 88% 59%	Hub Manager Practice Managers/Service Manager	Annual /Biennial
				'My team has good working relationships with health services in this local authority - Adult & Child Care'	Social services staff survey 2014/15 *Stirling* 69%		
				Social Services managed services regulated by Care Inspectorate with quality of staff Grade 4 and above. Adult Care Only	2014/2015 *Stirling* 100%		
More service users able to return home following hospital care/intermediate care	Patients/service users	Service redesign influenced based on a whole systems approach	Increased numbers of persons returning home following hospital care	*Developing Intermediate(Int.) Care measures – draft baselines* -Total number of Int. Care beds occupied by clients (25 beds) -Number of clients who moved from Int. Care to Long Term Care -Number of clients who went home from Int. Care with a package of care - Number of clients who went	15/16 96 18 15 49	Care Home Manager/ Registered Care Manager	Annual

				home from Int. Care with no package of care ALoS – data awaited.	(14 alternative outcome)		
Shared use of partner resources	NHS Board and partners in delivery of Health and Social Care	Co-location of service providers Flexible working arrangements	Facilitate new ways of working and delivery of care between partners	Future evidence of integration: (a)Workforce (b) Management (c) Pooled budgets (d) Facilities.	Integration Care Joint Board	Various	Varied time frames

Linked National Outcome(s)	Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Investment Objective 2: Improve user experience of local health & social care service provision

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measures	Baseline (where available)	Who is responsible	Timescale
Positive experience of health and social care	Patients/Service Users	Increased involvement in management of own condition(s).	Delivery of service redesign influenced by public involvement.	% Service users have a say in how their help, care or support is provided	Health and Care Experience Biennial Survey 2013/14 *Stirling* 75%	Integration Joint Board	Annual /Biennial
				% Service users are treated with respect	Health and Care Experience Biennial Survey 2013/14 *Stirling* 92%		
				% Social Services service users who agree that they have been treated with dignity and respect when using Social Services	Social Services Service User Annual Survey 2014/15 *Stirling* 88%		
				% Social Services service users who agree that they have been fully involved in deciding what help or services would help me	Social Services Service User Annual Survey 2014/15 *Stirling* 83%		
Better transition through each care journey improving experience	Patients/Service Users/Carers	Implementation of continuity of care in all care pathways	Increase involvement in management of own condition(s).	% respondents registered with GP practices in the area who are treated with respect	Health and Care Experience Biennial Survey 2013/14 *Stirling* 92%	Integration Joint Board	Annual /Biennial
				% Social Services service users who agree that they have been treated with dignity and respect when using Social Services	Social Services Service User Annual Survey 2014/15 *Stirling* 88%		
Positive experience of the environment in which services are provided	Patients/Service Users		Environment created where excellence & safety can flourish	*Outcomes from:* - Care Inspectorate Quality of Environment Standard		Hub Manager	Annual /Biennial

			efficiently	-Quality of Care and Support Standard -HEI Inspections			
				Social Services managed services regulated by Care Inspectorate with quality of Environment standard Grade 4 and above. Adult Care Only	2014/2015 *Stirling* 100%		
More people able to access care from their preferred location i.e. home	Patients/Service Users	Systematic support for long term conditions	Enabled and convenient access to modernised services. Access to community resource with acceptable accommodation.	Delayed Discharge Total standard delays (between 3 days and 2 weeks) 2 week target introduced 15/16 Expected move to 72hrs Balance of Care: % adults age 65+ with intensive needs(10+) receiving care at home	ISD 2014/15 *Stir 56* 2015/16 *Stirling 43* Social Services 2014/15 *Stirling* 35.2% (Local tgt 45%)	Hub Manager/Care Home Manager/ Registered Care Manager	Monthly/ Annual
More service users able to return home following hospital care/intermediate care	Patients/service users	Service redesign influenced based on a whole systems approach	Increased numbers of persons returning home following hospital care	*Developing Intermediate(Int.) Care measures – draft baselines* -Total number of Int. Care beds occupied by clients (25 beds) -Number of clients who moved from Int. Care to Long Term Care -Number of clients who went home from Int. Care with a package of care - Number of clients who went home from Int. Care with no package of care ALoS – data awaited.	15/16 96 18 15 49 (14 alternative outcome)	Care Home Manager/ Registered Care Manager	Quarterly/ Annual

Linked National Outcome(s)	Outcome 4. Health and social care services are centred on helping maintain or improve the quality of life of people who use those services Outcome 5. Health and social care services contribute to reducing inequalities						
Investment Objective 3: Improve access to care							
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Sample Measures**	**Baseline (where available)**	**Who is responsible**	**Timescale**
Positive experience of health and social care, improving transitions of care	Patients/Service Users	Having capacity to sustain range and amount of services needed to match growing demand	User will have positive experience of the service and have their views respected.	% respondents registered with GP practices in the area who felt that people take account of the things that matter to service users	Health and Care Experience Biennial Survey 2013/14 *Stirling* 84%	Integration Joint Board	Annual /biennial
				% Service Users who found Social services easy to access	Social Services Service User Annual Survey 2014/15 *Stirling* 67%		
				GP Access 48hr access Advanced booking	2013/14 Survey 91.6% 80.6%		
				ABIs – (Primary Care element of tgt.)	2015/16 6414		
More people able to return home following hospital/intermediate care	Patients/Service Users	Improved support for carers. Creation of a local base for delivery of services	People are able to live as far as reasonably practical at home.	*Developing Intermediate(Int.) Care measures – draft baselines* -Total number of Int. Care beds occupied by clients (25 beds) -Number of clients who moved from Int. Care to Long Term Care -Number of clients who went home from Int. Care with a package of care - Number of clients who went home from Int. Care with no package of care ALoS – data awaited.	15/16 96 18 15 49 (14 alternative outcome)	Integration Joint Board	Varying time frame

Positive experience of the environment in which services are provided	Patients/Service Users	Accessible facilities and premises	Easy to access facilities and premises	% Service Users who found Social services easy to access	Social Services Service User Annual Survey 2014/15 *Stirling* 67%	Integration Joint Board	Annual
Maximised range of health and social care services available locally	Patients/Service Users Service Provider Organisations	Integrated health and social care model of service provision	Service provision closely matched to needs	Balance of Care: % adults age 65+ with intensive needs(10+) receiving care at home	Social Services 2014/15 *Stirling* 35.2% (Local tgt 45%)	Integration Joint Board	Annual
				% social services service users who agreed I had received the help I need at the time I needed it	Social Services Service User Annual Survey 2014/15 *Stirling* 80%		
				% of clients with reduced care hours at end of reablement (*developing Int Care measure*)	*Stirling* 47%		

Linked National Outcome(s)	Outcome 1. Health and social care services are centred on helping maintain or improve the quality of life of people who use those services Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Investment Objective 4: Improve care pathways, capacity and flow management

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measures	Baseline (where available)	Who is responsible	Timescale
More people treated on a scheduled rather than unscheduled basis	Patients/Service Users	Increased focus on anticipatory and preventative care and intervention.	Prevention of crisis/emergency through more anticipatory care planning	Percentage of people with anticipatory care plans	Total KIS uploads as a percentage of the board area list size is 4.38% of the total population, against a local target of 3%.	Practice Managers	Quarterly
Service capacity meets service demands	Patients/Service Users	Integrated care and service model based on service demands	Having capacity to sustain range and amount of services needed to match growing demand.	Delayed Discharge Total standard delays (between 3 days and 2 weeks) 2 week target introduced 15/16 Expected move to 72hrs	ISD 2014/15 *Stir 56* 2015/16 *Stirling 43*	Practice Managers Service Managers	Monthly
				Service users' health and care services seem to be well coordinated	Health and Care Experience Biennial Survey 2013/14 *Stirling* 70%		
Flexible use of beds better meets service user needs	NHS Board	Integrated care and service model based on service demands	Sustainable match between service capacity & population change driven demand	Refer to bed model for proposed bed use – see below	LoS	Care Hub Manager	Annual
Services users don't have to stay in hospital longer than necessary	Patients/Service Users	Integrated care and service model	More people discharged home	Reduction on Length of stay is core to the proposed bed model	2015 SCH 7-8weeks	Care Hub Manger	Annual
				Total Code 9 Delayed Discharges	2014/2015 *Stirling* 69		

Linked National Outcome(s)	Outcome 2. People, including those with disabilities or long term conditions, or are frail, are able to live as far as is reasonably practicable independently and at home or in a homely setting in their community. Outcome 4. Health and social care services are centred on helping maintain or improve the quality of life of people who use those services Outcome 6. People who provide unpaid care are supported to look after themselves reducing any negative impact on their wellbeing.

Investment Objective 5: Maximise flexible, responsive and preventative care - at home, with support for carers

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measures	Baseline (where available)	Who is responsible	Timescale
More people able to return home following hospital care/intermediate care	Patients/Service users	Provision of local services and support driven by care and needs assessments	Sustainable local services closely matched to peoples demand for flexible support and care	People are able to live as far as reasonably practical at home.		Integration Joint Board	Annual
				Percentage of last 6 months of life spent in home or community setting	2013/2014 *Stirling* 90.5%		
Providing care at home is more cost effective than institutional care	NHS Board	A care and service model focussed on patient centeredness delivering care in most appropriate, safe setting	Better use of resources – staff, buildings, finance	SW 1: Home Care Costs per Hour for people aged 65 or over	2014/2015 *Stirling* £14.10 ph	Finance Manager	Annual
				SW 5: Net Residential Care Costs per Hour for people aged 65 or over	2014/2015 *Stirling* £396 pw		
Carers feel better supported in their role	Carers	Comprehensive information and support network for carers	Carers able to provide and meet an increasing percentage of service user's needs	% respondents who are carers and registered with GP practices in the area who felt supported to continue caring	Health and Care Experience Biennial Survey 2013/14 *Stirling* 45%	Service Manager	Annual/Biennial/Qtrly
				% of carers assessments completed as a proportion of those offered by Social Services	Q1 2015/16 *Stirling* 100%		

Linked National Outcome(s)	Outcome 9. Resources are used effectively and efficiently in the provision of health and social care.

Investment Objective 6: Make best use of available resources

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measures	Baseline (where available)	Who is responsible	Target Date
Affordable service delivery	NHS Board and partners in delivery of Health and Social Care	Integrated Health and Social Care Model implemented	Facilitating the use of technology to support both care and administrative processes.	IRF Cost indicators		Finance Manager	Variation in time frame
Service capacity meets service demands	Patients/Service Users	Integrated Health and Social Care Model implemented	Right care in right place at right time.	Delayed Discharge Total standard delays (between 3 days and 2 weeks) 2 week target introduced 15/16 Expected move to 72hrs	ISD 2014/15 *Stirling 56* 2015/16 *Stirling 43*	Service Manager	Variation in time frame
Service model is more flexible to future changes in demand	NHS Board and partners in delivery of Health and Social Care	Flexible service model	Better patient/user outcomes Increased patient/user satisfaction	Reduction on Length of stay is core to the proposed bed model. Balance of Care: % adults age 65+ with intensive needs(10+) receiving care at home	2015 SCH 7-8weeks Social Services 2014/15 *Stirling* 35.2% (Local tgt 45%)	Service Manager	Variation in time frame
Reduction in overall number of beds	NHS Board and partners in delivery of Health and Social Care	Shift in the balance of care	Better patient/user outcomes Increased patient/user satisfaction	Based on bed projections	From baseline high of 161 in 2011 to 116 in 2019		

Linked National Outcome(s)	Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Investment Objective 7: Improve quality & effectiveness of accommodation used to support service delivery

Benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefit realised	Sample Measure	Baseline (where available)	Who is responsible	Target Date
Improved user perception of quality of care	Patients and staff	Provision of accommodation that is purpose planned and designed to meet service need	Everyone has a positive experience of healthcare	*Outcomes from:* - Care Inspectorate Quality of Environment Standard -Quality of Care and Support Standard -HEI Inspections Care -Health and Care Experience Biennial Survey	Various sources – broad benefit – final measures tbc.	Service Managers	Annual PAMS
Improved condition of available accommodation	Patients and staff	Investment in eradication of backlog and development of modern facilities	High quality accommodation standards	Six facet property appraisals	As per FBC	Director of Estates and Facilities	Annual PAMS
Accommodation meets modern service needs & enables flexibility of use	Patients and staff	Provision of accommodation that is purpose planned and designed to meet service need.	Modern design and planned spaces	Functional suitability surveys High space utilisation rates	As per FBC	Director of Estates and Facilities	Annual PAMS
Improved functionality of accommodation improves service effectiveness	Patients and staff	Provision of facilities based on functional design focussed on service delivery	High quality accommodation standards. Efficient working practices adopted	Functional suitability surveys with user participation	As per FBC	Director of Estates and Facilities	Annual PAMS

Linked National Outcome(s)	Outcome 7. People who use health and social care services are safe from harm						
Investment Objective 8: Improve safety of health & social care, advice, support & accommodation							
Benefit	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes displayed if benefit realised**	**Potential Measure**	**Baseline (where available)**	**Who is responsible**	**Target Date**
Reduced risk of HAI incidents	Patients/Service Users NHS Board	Implementation of HAI guidance	Continuing progress towards achieving national standard	Hand Hygiene SABS - Staphylococcus aureus bacteraemia (SABs) cases are 0.24 or less per 1000 acute occupied bed days.(Note source can be Community acquired) CDI - Rate of Clostridium difficile infections (CDIs) in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.	March 2016 SCH 100% April 2016 12 month rolling average to April 2016 is 0.35 SABs per 1000 acute occupied bed days. April 2016 Rolling year rate is 0.1 CDIs per 1000 total occupied bed days.	Infection Control Manager	Quarterly Reports
Reduced risk of harm from property related incidents	Patients/Service Users NHS Board	Risk assessments	Property and facilities that feel safe to the people who will use it to deliver or receive service	Reported accidents and adverse events	Baseline for SCH IR1s	Director of Estates and Facilities	Monthly Reports