



# **Initial Agreement for a Care Village in Stirling (A Health & Social Care Partnership Venture)**

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## 1. Executive Summary

### 1.1. Introduction

This initial agreement describes the supporting case for the NHS Forth Valley and Stirling Council partnership 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 across the two organisations. It proposes the development of a Care Village based on the existing Stirling Community Hospital site. To further enhance this Care Village model of service provision, General Medical Services (GMS) delivered by local GP practices will become a key service partner along with other service providers such as Forth Valley College, local charities and the voluntary sector, to deliver enhanced services as part of the concept.

The Care Village concept also presents an opportunity for the development of commercial 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.

The Initial Agreement explores the Care Village concept and demonstrates the case for change from current arrangements. It identifies a preferred way forward which is supported by a short list of options which need to be taken forward for further investigation as part of the development of an Outline Business Case.

The aims of the proposed model of service provision are:

- Improving people's experience of the whole system of health & social care
- Delivering better outcomes (nationally agreed)
- Increasing the number of people who live in their own homes rather than a care home or hospital
- Reducing the number of unplanned admissions to hospital
- Reducing delayed discharges
- Better use of resources across the public sector

The broader concept of the Care Village will allow a complete remodelling of care currently provided for in care homes, community hospital beds and at home. This will create a hub for community care provision and providers and will create an opportunity to remodel and integrate health based community hospital beds as well as community based teams including GPs.

The integrated approach to service delivery will be delivered through a partnership between all service providers that aims to provide the flexibility of care provision that is needed. It also provides opportunities for economies of scale both now and in the future.

The involvement of Forth Valley College as a strategic partner will ensure a vibrant mix of people of varying ages working and living on the site with opportunities for employment, training and continuing professional development. 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 involvement of the College will provide an opportunity for the Village 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.

The Initial Agreement brings together all of the previous and historical work undertaken to date by the partner organisations in developing the older people's care model, the community hospital model, primary care development and the Care Village concept for the Stirling community. It takes the work undertaken by Stirling Council to deliver a needs led service for Older People and that undertaken by NHS Forth Valley to deliver Community Hospital and related services for Older People and integrates them into a unique service delivery model which delivers better outcomes, pathways and value for money.

This proposal also addresses significant and longstanding deficits in the provision of Primary Care Services to the population of Stirling city, co-locating them within the overall Care Village. This will bring together extended primary healthcare teams in modern 21<sup>st</sup> century accommodation, and promote closer joint working across primary, community hospital and social care interfaces.

## **1.2. Inclusive Development of the Initial Agreement**

The work of preparing the information for this Initial Agreement builds on that already done in developing the '*Reshaping Older People's Care*' model of care, and associated capacity planning implications of the integrated Care Village concept, along with planning for the Community Hospital and Primary Care development. This further work for the Initial Agreement was largely undertaken through a series of meetings and workshops held between November 2011 and January 2012 involving a range of stakeholders associated with this project. The purpose of these events was to engage with the stakeholders in gathering current relevant information / issues and to explore the options for change. In doing so, it also provided stakeholders with an opportunity to influence the direction of the project and to contribute to this Initial Agreement document.

Consultation events have also previously been carried out to support the key information and direction of travel used to support the developing older people's care model and Care Village concept. A summary of these consultations is as follows:

- Kaizen event for Older People's Service in November 2010 involving key stakeholders including older people and carers.
- Staff consultation event (January 2011).
- NHS Forth Valley's Joint Management Team and Nurse, Palliative, AHP consultants, the General Managers of Acute Services and the CHP were consulted on the models of care.
- Strategic Forum for Care, Health and Wellbeing (February 2011, April 2011).

### 1.3. Structure of the Initial Agreement

The Initial Agreement 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

At Initial Agreement stage, the primary focus is on the Strategic and Economic Cases, with a brief outline reference to Commercial, Financial and Management Cases.

### 1.4. The Strategic Case

This Initial Agreement clearly demonstrates that there is a strong Strategic Case for investment in the proposed integrated approach to health & social care. The proposals are fully in line with national and local policies and the strategic direction of Stirling Council, NHS Forth Valley and their partners in the delivery of health and social care in Stirling. In particular, the proposals align with the following:

- Stirling Council's proposed new care model 'Reshaping Older People's Care' with the improvement drivers associated with 'Shifting the Balance of Care' and 'Reshaping Care for Older People'.
- Integrated Health & Social Care community health models of care with community care both in community settings and in bed based intermediate care settings.
- NHS Forth Valley's Integrated Healthcare Strategy, which is aligned with the aims of the Healthcare Quality Strategy for NHSScotland.
- The initiative of closer partnership working and integration between local public service groups across Forth Valley, particularly with regard to the development of Health and Social Care Partnerships.
- It responds to the projected increase in the elderly population and restrictions on available resources across Stirling and the wider Forth Valley area.
- It forms a fundamental part of Stirling Council's and NHS Forth Valley's property and asset management strategies.

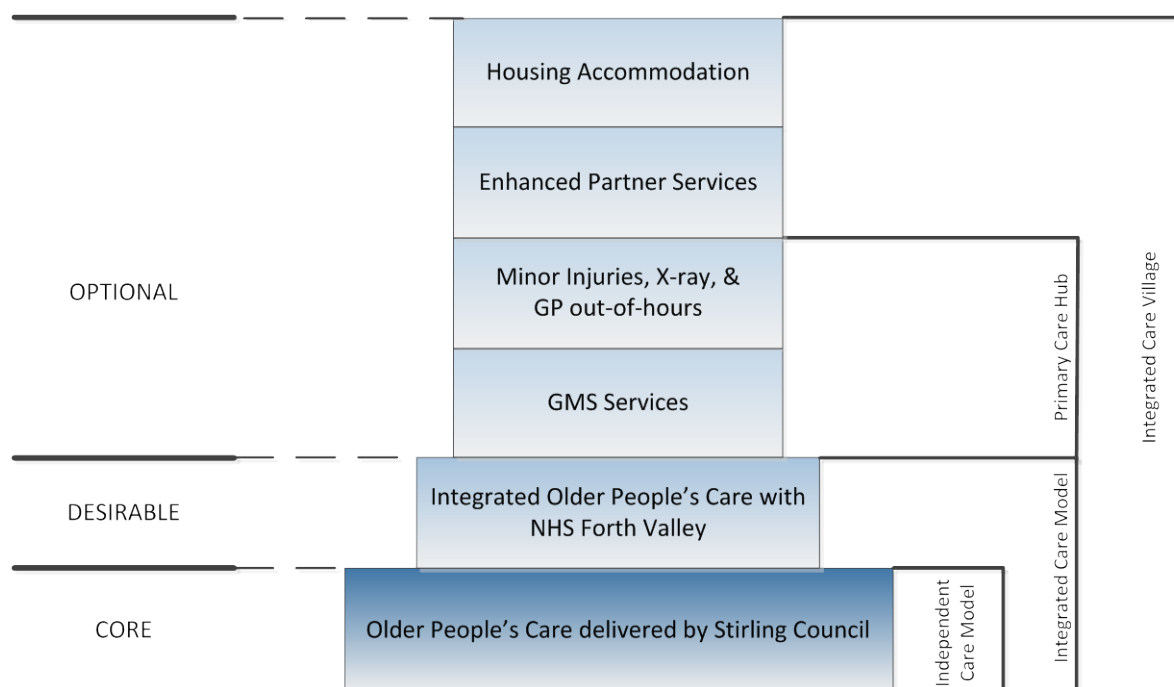
The Initial Agreement proposes the introduction of an enhanced partnership approach and integrated model for community health and care provision, including delivering Stirling Council's *'Reshaping Older People's Care'* service model, NHS Forth Valley's Integrated Healthcare Strategy and Stirling CHP's approach to Reshaping Care and the Change Fund Programme, which together seek to achieve the following objectives:

- Increase integration & communication between health & social care services and delivery to service users.
- Improve user experience of local health & social care service provision.
- Improve access to care.
- Improve care pathways, capacity and flow management.
- Maximise flexible, responsive and preventative care - at home, with support for carers.
- Make best use of available resources.
- Improve quality & effectiveness of accommodation used to support delivery of health & social care services.
- Improve safety of health & social care, advice, support & accommodation.

The case for change for this project is driven by inadequacies in the current approach to provision of services, increasingly unaffordable demand for services, and the unsuitability of current facilities. The main problems to overcome are:

- The existing Older People's Care service does not enable 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.
- A lack of integration between services compromises patient / client flow thus increasing the possibility of more people than necessary being discharged to care homes rather than their own homes.
- Projected future increases, for Stirling, of people over 65 years old will put increasing pressure on existing services to cope with such demand.
- Financial restrictions will make it unaffordable to cope with the related increase in demand for older people's health & care beds.
- Existing facilities are currently run at full capacity and will find it difficult, if not impossible, to cope with this increased demand.
- Restrictive accommodation affects functional effectiveness of service provision.
- Existing properties will struggle to support delivery of the proposed new service model and are inflexible to change.

The business scope and the key service requirements considered necessary to overcome these problems is outlined in the following diagram:



The 'core' business scope is the provision of older people's care services delivered by Stirling Council. However, in order to provide an improved model of care that seeks to achieve the project's investment objectives, an integrated approach to service delivery with NHS Forth Valley is required and there is strong commitment to achieving this through this Initial Agreement. The business scope continues to grow in a layered approach as both desirable and optional elements are added and other partner organisations are introduced.

### 1.5. The Economic Case

The Economic Case in the Initial Agreement sets out how a short list of options has been selected to be taken forward to the next stages of planning (the Outline Business Case). A long list of options was generated in accordance with the SCIM guidance which required the group to systematically work through the available choices for the project in terms of scope, service solution, service delivery, implementation and funding.

The long list of options was examined through a rational assessment process which involved assessing options against a set of investment objectives and critical success factors for the project. This enabled the "preferred way forward" to be identified together with a short list of options which will be taken forward to the Outline Business Case where they will be subjected to a rigorous cost, benefit and risk appraisal. This shortlist of options is summarised in the table overleaf.

# An Initial Agreement for a Care Village in Stirling

	Do minimum	Least ambitious	Less ambitious	Reference Project (The Preferred Way Forward)	More ambitious
Scope	Older peoples 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 peoples 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 peoples 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 peoples 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 peoples health and social care services for the Stirling <b>and a wider catchment area</b> including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care
				General Medical Services	General Medical Services
				Minor injuries, Diagnostic & Treatment and Out of Hours GP Service	<b>Extended</b> minor injuries, Diagnostic & Treatment and Out of Hours GP Service
			Enhanced Partner Services – FV College, charities and voluntary sector	Enhanced Partner Services – FV College, charities and voluntary sector	<b>Extended and</b> enhanced Partner Services – FV College, charities and voluntary sector
			Housing	Housing	<b>Extended</b> Housing
Service Solution	As existing – no further development of the Integrated Service Model	Further development of the Service Model by co-location and integration of Social Services	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 for only Social Services	Development of a Care Village – excluding health services	Development of a Care Village – integration and co-location of existing health and social care services in Stirling	Development of a Care Village - integration and co-location of existing health and social care services
Implementation	No change	Existing social care services co-located on a single site in Stirling	Single development	Single development	Single development for health & social care services - & phased housing
Funding	As existing	Stirling Council Capital through Prudential borrowing	Stirling Council Capital through Prudential borrowing + commercially funded housing	Hubco revenue solution + commercially funded housing	Hubco revenue solution + commercially funded housing



## 1.6. The Outline Commercial Case

For new build community based projects such as this the hubco revenue solution is the default route. This solution offers a flexible financing and procurement route for community health and care projects which may otherwise not happen because of the decline in available capital

Third party development via commercial finance is seen as the most viable route for the housing development within the Care Village. The type and content of housing included in such a development has still to be confirmed but will need to be fully co-ordinated with the main components of the Care Village project.

## 1.7. The Outline Financial Case

The purpose of the Financial Case is to set out clearly the financial impact of the investment proposals. Given that the Initial Agreement is an early stage of the overall development of a business case for the project, the SCIM guidance states that these costs need only be indicative and can be expressed as a range of costs.

If, as expected, the preferred way forward is procured through a revenue solution by way of East Central Hubco then 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 private sector development costs, financing interest, insurance and management fees)
- Lifecycle maintenance costs
- Hard facilities maintenance (FM) costs

The table that follows shows the indicative unitary charge payable by the partners (based on the preferred way forward).

		<b>Indicative Unitary Charge (£m) based on:</b>	
<b>Accommodation</b>	<b>Capital Cost Estimate (£m)</b>	<b>Low capital cost estimate</b>	<b>High capital cost estimate</b>
Council Elderly Care Accom.	£20 to £24	£2.00	£2.40
NHS Elderly Care Accom.	£13 to £16	£1.30	£1.60
Primary Care Accom.	£3 to £3.5	£0.30	£0.35
GP Accom.	£9 to £11	-£0.90	£1.10
Enhanced Partner Services Accom.	£0.50	£0.05	£0.05
<b>TOTAL:</b>	<b>£45 - 55</b>	<b>£4.55</b>	<b>£5.50</b>

This Initial Agreement has been prepared on the broad assumption that if the project is procured through a hubco revenue solution then the Scottish Government (subject to meeting the required conditions) will commit to provide the partners with approximately 85% of the unitary charge.

The overall cost of the project can be further reduced by taking into account the savings on hard FM costs associated with the existing buildings that will close as a result of the scheme.

The table below summarises the impact of the SG support on the unitary charge and the net cost to the partners after taking into account the savings on hard FM from existing buildings.

Accommodation	Capital Cost Range (£m)		Unitary Charge (£000) based on:		85% SG Support based on High & Low Capital Cost estimates (*see below)		Revenue Savings on existing hard FM (£000)	Net Cost of the project to partners £000(*see below)	
	Low	High	Low capital cost estimate	High capital cost estimate	Min (£000)	Max (£000)		Min	Max
Council Elderly Care Accom.	£20	£24	£2,000	£2,400	-£1700*	-£2040*	-£80	£220*	£280*
NHS Elderly Care Accom.	£13	£16	£1,300	£1,600	-£1,105	-£1,360	-£250	-£55	-£10
Primary Care Accom.	£3	£4	£300	£350	-£255	-£298	£0	£45	£52
GP Accom.	£9	£11	£900	£1,100	-£765	-£935	-£110	£25	£55
Enhanced Partner Services Accom.	£0.50	£0.50	£50	£50	£0	£0	£0	£50	£50
<b>TOTAL:</b>	<b>£45</b>	<b>£55</b>	<b>£4,550</b>	<b>£5,500</b>	<b>-£3,868</b>	<b>-£4,675</b>	<b>-£440</b>	<b>£243</b>	<b>£385</b>

This Initial Agreement, has been prepared on the assumption that revenue support will be made available for the NHS Board elements of the project in accordance with Derek Feely's letter to NHS Boards of 22 March 2011. This support will enable a unique, first opportunity to demonstrate a successful joint venture between health & social care and deliver the Scottish Government's plans to integrate older people's health & social care.

**\* Although the table above illustrates revenue funding support for the Council element of the project, it must be highlighted that under current funding arrangements for hub DBFM projects there is no commitment that funding is available to support the local authority element of unitary payments. In the event that this support was not available, then the net cost of the project to the Council would increase to £1.920M - £2.320M. Further, alternative funding sources for that element of the project would require to be fully evaluated with a view to meeting the stated aims within the available resources. This would include a review of the phasing/timescales, procurement method and scope of the project.**

## **Non-property related revenue costs**

In addition to the property related revenue costs described above, consideration has also been given to other revenue costs associated with the Care Village.

Stirling Council's paper, *'Reshaping Older People's Care'*, published on 30 June 2011, identifies that social care services for people over 65 costs around £18m per annum. Almost 50% of this amount is spent on over 85's, and this is the age group expected to increase by the biggest proportion – by around almost 40% in 10 years. Applying the projected increases in these age bands to the existing levels and patterns of spend would result in an estimated increase from £18m to £23.5m – an increase of £5.5m in 10 years (based on the existing service model).

The proposed new service model described in this Initial Agreement will be more cost effective on a per person basis but the projected increase in the elderly population will inevitably increase the overall cost in the long term. Initial indicative estimates show that by year 10 the cost of the new service model could be £21.3m, which is £2.2m less than the traditional model of service delivery but still higher than the current level of spend by £3.3m.

The partnership approach to the new service model is likely to affect how resources are deployed between health and social care. It is anticipated that the proposed new service model will result in shorter stays in hospital and increased preventative activity resulting in reduced need and demand for beds. Overall, across the health and social care economy in Stirling, this preventative model is expected to result in less care per head of population and, therefore, reduced costs. However, this will be counteracted somewhat by the increase in people served due to population increases, plus potentially more expensive but shorter healthcare intervention.

Although there is confidence in the philosophy and broad commissioning approach to the proposed new service model, there are many areas to be examined and developed in further detail. As part of the value for money assessment process required at the Outline Business Case stage, a detailed model of anticipated project costs and financial flows will be prepared. This model will aim to confirm projections of the various cost components of the project and how these will change over both the short and long term.

## **1.8. The Outline Management Case**

The purpose of the Management Case is to describe how the organisation will ensure the project will be managed effectively and the investment objectives and benefits will be delivered successfully.

It is proposed that this work be managed as a project by the 'Stirling Care Village Project Board, to be chaired by the Assistant Chief Executive for Care Health and Well-being. The Project Board will report (via the Assistant Chief Executive) to the partner organisations' internal governance structures as well as to the Joint Partnership Board (which includes Elected Members and the chair of the NHS Board), and externally to the Scottish Government. Further detail regarding the governance structure for the project is included in Appendix B.

The Project Board will be responsible for managing the risks associated with the project, its timely progress and the delivery of the expected benefits from a successful outcome. The current programme suggests that the facilities required to implement this project and to fully deliver the proposed new service model will be fully operational by mid-2016.

## 2. Strategic Context

### 2.1. Introduction

This initiative forms a partnership between NHS Forth Valley and Stirling Council to develop a care model that combines primary & community healthcare with older people's care to create a joined-up holistic approach to service delivery between the two organisations. This will result in the formation of a Care Village based on the existing Stirling Community Hospital site. To further enhance this Care Village model of service provision, GMS services delivered by local GP practices will become a key service partner within the partnership, along with other service providers such as Forth Valley College, local charities and the voluntary sector, to deliver enhanced services as part of the Care Village concept.

The Care Village concept also presents an opportunity for the development of commercial 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.

The Initial Agreement has examined the viability of the Care Village concept and demonstrated the case for change from current arrangements. It has identified a preferred way forward which is supported by a short list of options which will be taken forward for further investigation as part of the Outline Business Case process. This Initial Agreement describes the processes followed to confirm the appropriateness of the preferred way forward.

### 2.2. National Policy Direction: Older People

#### **Shifting the Balance of Care**

A vision for the future development of the National Health Service in Scotland was set out in the Kerr report: A National Framework for Service Change in the NHS In Scotland: Building a Health Service Fit for the Future (2005) and the Scottish Executive response Delivering for Health (2005). Both these reports emphasise a major shift from hospital-based care to preventative, anticipatory care and more supportive and responsive care in the community.

Shifting the balance of care from hospital to the community is a key challenge within Delivering for Health (2005). The document stresses the need for effective hospital discharge processes in order to minimise delayed discharge and inappropriate readmission, as well as the availability of rapid community response services including the availability of intensive specialist assessment and support if needed, which should focus on those people who might otherwise require admission to hospital. Clearly, this policy has a major impact on the local authority's capacity to deliver social care services.

Better Health, Better Care, The Action Plan (2007) emphasises that CHPs should work with partners to tackle inequalities, support community hospital developments and shift the balance of care by managing demand in the community and reducing unnecessary admissions wherever possible.

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

More recently, in March 2009, the Ministerial Strategic Group for Health and Wellbeing (MSG) agreed to develop a strategy for reshaping care for older people in the light of a shared aspiration to improve the quality and outcomes of our current models of care; the implications of the projected demographic change which will increase service requirements; and financial pressures which will reduce available resources.

The Reshaping Care for Older People programme provides a long term and strategic approach to delivering that change so that its vision for future care for older people in Scotland can be achieved.

Achieving this vision involves helping older people to have the best possible quality of life by:

- feeling safe;
- having opportunities to meet and support each other;
- ensuring no-one is socially isolated or lonely;
- staying as well as they can;
- living where and how they want;
- being free from discrimination or stigma; and
- being listened to, having a say in the services they receive and being treated at all times with respect and dignity.

It also requires statutory, voluntary, independent and third sectors to work together with older people and their carers in a way that empowers, enables and promotes their confidence and capability for 'supported self care and self management'. This mutual partnership is at the heart of outcomes focused and person centred care and support.

Its policy goal is to optimise the independence and wellbeing of older people at home or in a homely setting. This will involve a substantial shift in focus of care from institutional settings to care at home – because it is what people want and provides better value for money.

Reshaping Care aims to design a new model of health and social care in Scotland that is fair, affordable and sustainable into the future.

Specific outcomes targeted for achievement by 2021, to address the shortcomings of the current arrangements, are

- A philosophy of co-production embedded as mainstream practice in both the development and the delivery of all services for older people;
- All care and support providing personalised care based on outcomes/goals agreed with the older person (and their unpaid carer) and on assessments which focus on personal outcomes;

- Services focused on prevention, maintenance of independence, recovery, rehabilitation and re-ablement, with a corresponding reduction in the need for emergency admission to hospital or a care home;
- More older people living in housing which suits their needs and helps maintain their independence;
- Community support for older people enlisted and mobilised, through volunteering, community enterprises and care co-operatives;
- A readily accessible, comprehensive information, advice and support resource available for all older people to help them make decisions about life choices, including adoption of personal budgets for care and matters relating to housing choice;
- Public sector resources from all sources (NHS, Councils, Benefits) available to jointly fund any agreed aspect of care;
- Clear and agreed care pathways for all older people, particularly those with complex care and support needs, to enable them to move smoothly through the care system, accessing timely and effective community and hospital care as necessary;
- Community based support for end of life care to increase the proportion of older people who are able to die at home or in their preferred place of care; and
- An infrastructure designed to facilitate and sustain the changes and outcomes we want to achieve through the Reshaping Care programme.

The framework sits comfortably alongside the ambitions of the NHS Quality Strategy and is a key driver to achieve the 'effective' ambition within this Strategy. It sits above, and supports the delivery of, other strategies for particular groups or issues including the Dementia Strategy, Carers Strategy, Self Directed Support Strategy and Living and Dying Well. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

### **NHS Quality Strategy**

The Quality Strategy for NHSScotland sets the overall direction for delivering high quality healthcare services to the people of Scotland. It is based on the *Better Health, Better Care: Action Plan* which sets out actions for ensuring better, local and faster access to healthcare using six dimensions of quality, which have been further developed in the Healthcare Quality Strategy for NHSScotland into 3 more succinct Quality Ambitions. The three Quality Ambitions are Patient Centred, Safe, and Effective. These are intended to provide the focus for everything NHS Scotland does in its aim to deliver the best quality healthcare to the people of Scotland and, through this, make NHSScotland a world leader in healthcare quality. This is supported by an action plan for implementing the Quality Strategy within the Primary Care Sector.

## 2.3. Organisational Fit - Stirling Council

*Shaping Stirling*, the Council's Strategic Plan for 2008 – 2012, is closely aligned with its Single Outcome Agreement and describes the actions needed to achieve the outcomes agreed. It is viewed as the delivery plan for its Single Outcome Agreement and includes the following eight strategic priorities:

- Making Stirling a place with a vibrant economy that is open for business.
- Making Stirling a place with jobs and opportunities for all.
- Making Stirling a place where lifelong learning is valued and encouraged.
- Making Stirling a place where improved wellbeing adds life to years, not just years to life.
- Making Stirling a place with a high quality environment.
- Working together to make services better.
- Encouraging participation and responsibility.
- Making Stirling more sustainable

Stirling Council's vision for the health & wellbeing of people in Stirling, and its intention to improve the journey of care for older people, forms the main focus for its proposed new service model: *Reshaping Older People's Care*'. This vision and strategic intention is particularly focussed on Stirling Council's strategic priority of *Making Stirling a place where improved wellbeing adds life to years, not just years to life*.

It also addresses strategic themes for: 'Making Services Better', and 'Making Stirling a place where participation and responsibility are encouraged' and the local outcomes of 'Improved care and support for those in need', 'Effective, efficient and modernised service delivery' and 'Our people will be enabled to work together to engage in and influence the shape of our communities'. In particular, activity will be delivered from the Single Outcome Agreement Platforms for Action of Ageing Well, and Care and Support, where key priorities are to:-

- Co-ordinate services to better meet the expressed needs of older people;
- Modernise care services to provide more care at home and deliver appropriate support arrangements.

Within this local context, Stirling's *Reshaping Older People's Care* will also contribute to the National Outcomes Framework:-

- National Outcome 6: We live longer, healthier lives;
- National Outcome 15: Our public services are high quality, continuously improving, efficient and responsive to local people's needs;
- National Outcome 11: We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.



## 2.4. Organisational Fit - NHS Forth Valley

NHS Forth Valley's Integrated Healthcare Strategy has played a pivotal role in directing how healthcare services have been delivered across Forth Valley since 2002. Since then it has had several reviews; with the latest receiving Board approval in May 2009. This reflected on the impact of current drivers for change and re-confirmed the aims and goals of the organisation.

Whilst its vision has remained unchanged, the Strategy now proposes a threefold approach to achievement which focuses on the simultaneous pursuit of three objectives :-

- Improving the health of the population; addressing health inequality.
- Enhancing the patient experience of care (including quality, access and reliability).
- Reducing or at least controlling the per capita cost of care.

The Strategy also highlights two major environmental drivers which will impact on how the NHS in Scotland functions; projected demographic changes and unprecedented climate of financial constraint.

Strengthening partnership arrangements between staff, patients, the wider public, local authorities and the third sector is a common theme throughout its Strategy and is critical in terms of achieving its vision.

The Strategy acknowledges that NHS Forth Valley must continue to shift the balance of care away from acute to community based care, address health inequalities and provide a supportive infrastructure and new models of care to enable this to happen. Improving patient safety remains a top priority as does improving the quality of care by improving consistency.

In support of this strategic emphasis, a recent review (2011 refresh) was carried out of NHS Forth Valley's Primary and Community Services Development Plan which confirmed that addressing inequalities should remain as the underlying principle of the Plan, while achieving further shifts in the balance of care should be seen as a primary mechanism for delivery rather than an end in itself.

As a direct consequence of the Integrated Healthcare Strategy, NHS Forth Valley 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.

The outcome of these two strategies has seen NHS Forth Valley move forward with the centralisation of acute services through the development of a new acute hospital in Larbert, whilst also delivering as much as possible from its network of community hospitals and healthcare centres. The implementation of the new acute hospital is now complete with services having continued to move in on a phased basis during 2011. The most recent major strategic challenge for NHS Forth Valley has been to continue with the implementation of its Integrated Healthcare Strategy through the development of community hospital bases at the existing Stirling and Falkirk Hospital sites in the constrained financial environment.

These community hospitals, plus those in Bo'ness and Alloa, are crucial to the success of the new low bed based model of care being implemented in Forth Valley Royal Hospital.

## 2.5. NHS Local Delivery Plan and Performance Targets (HEAT) 2012/2013

Local Delivery Plans set out a delivery agreement between the Scottish Government Health Department and each NHS Board, based on the key Ministerial targets. Local Delivery Plans reflect the HEAT Core Set - the key objectives, targets and measures that reflect Ministers' priorities for the Health portfolio. For 2012/13 the NHS Forth Valley HEAT performance targets particularly relevant to this project are:

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12% between 2009/10 and 2014/15.
- To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14.
- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015.
- NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.
- Further reduce healthcare associated infections so that by 2012/13 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

## 2.6. Strategic Fit with Policy Direction & Organisational Focus

Stirling Council's proposed new care model *Reshaping Older People's Care* 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. When the only option is longer term care then the care model shifts the emphasis towards care at home; where appropriate and possible, with admission to a care home planned carefully at the right time in relation to individual choice and need.

NHS Forth Valley's *Primary & Community Care Services Development Plan (2011 refresh)* aligns with Stirling Council's *Reshaping Older People's Care* strategy by focussing its attentions towards addressing inequalities while continuing to ensure that further shifts in the balance of care remains a key objective and a primary mechanism for delivery.

NHS Forth Valley's commitment to NHSScotland's Quality Strategy is imbedded into its Integrated Healthcare Strategy. The strategy was originally based around the six dimensions of quality and is, therefore, fully aligned with the new Quality Strategy; as is its Property & Asset Management Strategy. The proposed Investment Objectives for this

project will therefore be able to demonstrate that they have been developed to ensure alignment with the Quality Ambitions and Quality Outcome Indicators.

The partnership approach towards *Reshaping Older People's Care* fits with the initiative of closer partnership working and integration between local public service groups across Forth Valley. In this instance Stirling Council are working closely with NHS Forth Valley, and other key service partners such as local GP practices, Forth Valley College, local charities and the voluntary sector, to facilitate shifts in the balance of care from institutional to primary and community settings, and to support the delivery of new approaches, improved quality and outcomes for people in Stirling.

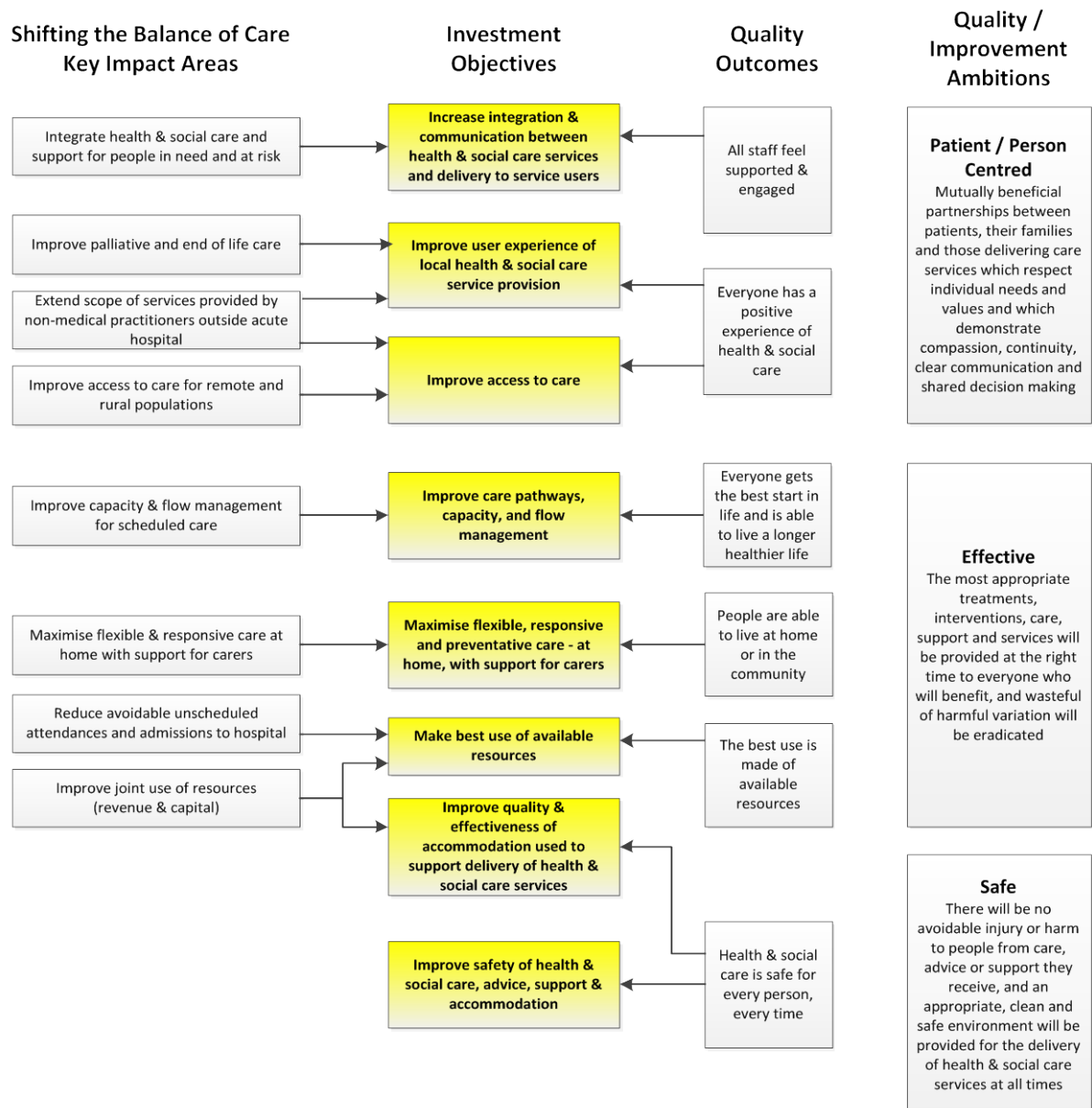
The development of a Care Village based on elderly care will, therefore, support all of these strategic intentions whilst also responding to the projected increase in the elderly population and reduced available resources across Stirling and the wider Forth Valley area.

The move towards improved accommodation and services for the Stirling community also forms a fundamental part of Stirling Council's and NHS Forth Valley's property asset management strategies.

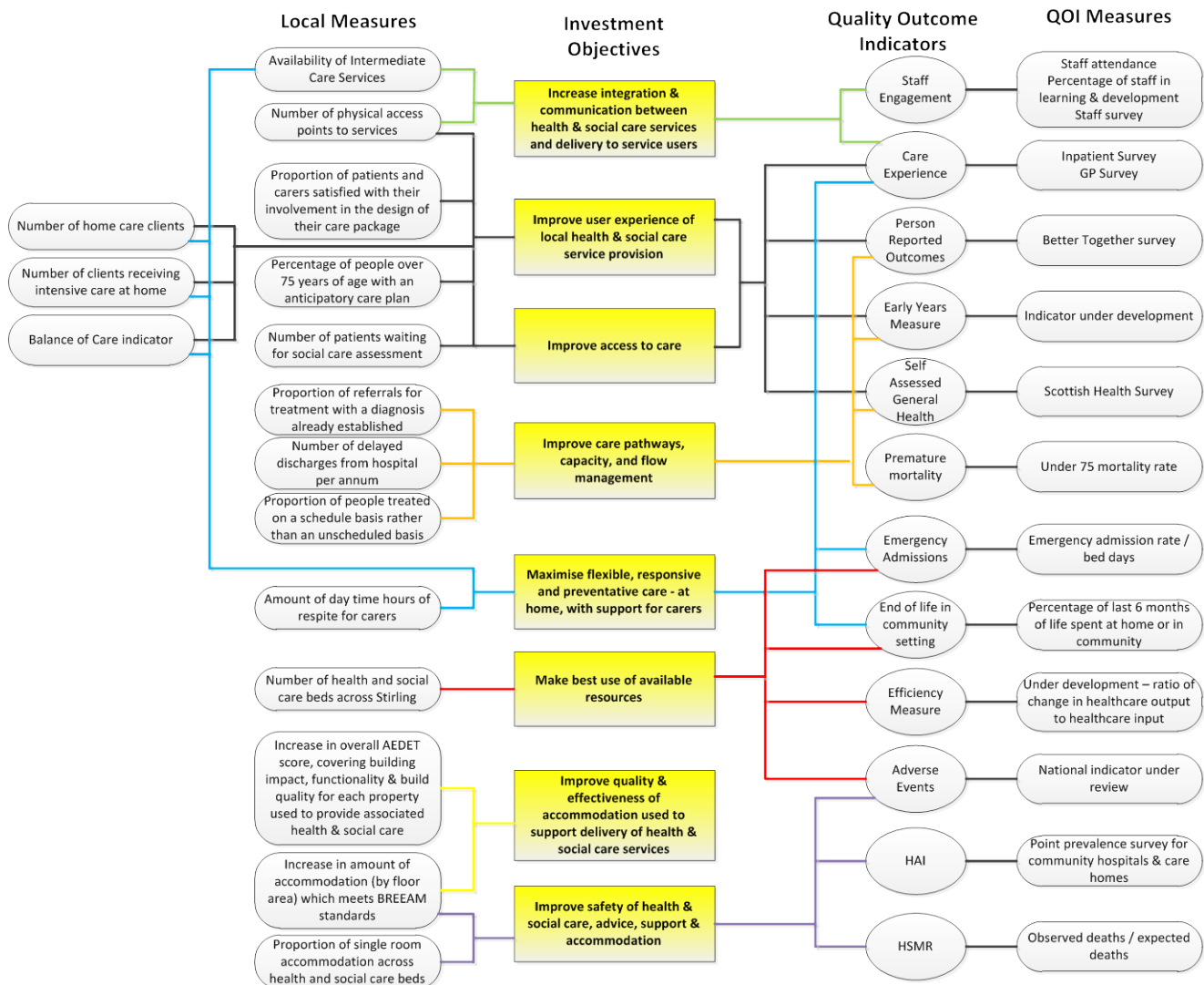
### 3. Investment Objectives, Existing Arrangements and Business Needs

#### 3.1. Investment Objectives (what we are seeking to achieve)

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.



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:



### 3.1.1 Design Quality Objectives

The design quality objectives for the scheme have been set out in the attached Design Statement (Appendix C). 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 will be used as the initial tool with which to communicate the vision of the Care Village to designers and those 'non-negotiables' which from a variety of perspectives the design must achieve. It will in due course be developed into a more detailed design brief, again developed in consultation, which will form the basis of construction information.

### 3.2. Existing Arrangements

This scheme is a potential collaboration between Stirling Council, NHS Forth Valley, and the GP practices local to Stirling. It also has the potential to attract other service providers such as Forth Valley College, local charities and the voluntary sector to deliver enhanced services as part of the Care Village model.

Stirling Council currently has 4 care homes providing therapeutic and long stay services (75 beds in total) and NHS Forth Valley has a further 96 community hospital beds within Bannockburn Hospital. These health based beds are due to shift to the former maternity building on the current Stirling Community Hospital site in the Spring 2012. Bed usage is a flexible mix of rehabilitation (25-30), continuing care / palliative care (27-32), old age psychiatry (19-24) (of which 14 relate to patients from the Falkirk area which are anticipated to return there in due course) and transition patients awaiting discharge (average 15).

Community Teams are currently based in separate locations, with Social Care teams based in Viewforth, 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.

There are five GP practices, with a combined list size of just over 26,000 patients, located in separate premises with the city of Stirling (two have branch surgeries at St Ninians Health Centre which would also be incorporated into this scheme). The five practices are:

- Viewfield  
3 Viewfield Place, Stirling FK8 1NJ
- Park Avenue  
9 Park Avenue, Stirling FK8 2QR
- Park Terrace  
7A Park Terrace FK8 2JT
- Allan Park  
19 Allan Park, Stirling FK8 2QD
- St Ninians  
St Ninians Health Centre, Mayfield Street, Stirling, FK7 0BS

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

### 3.3. Existing Property Arrangements

Each partner organisation 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; particularly Strathendrick and Wellgreen Care Homes.
  - Engineering systems to buildings are old and outdated.
  - General access to buildings is poor; particularly vehicular access to Strathendrick Care Home.
  - Available space is inadequate for needs; particularly at Wellgreen Care Home.
- 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.



Any new or remodelled accommodation used to provide the services described in this Initial Agreement will need to overcome the existing accommodation deficiencies as described above. Also, and more specifically, the design objective will be for that accommodation to attain a minimum AEDET score of 5 for each Design Area, with an average overall score of 5.5. The sustainability objective associated with this accommodation is to obtain a BREEAM "Excellent" rating for all new build accommodation or "Very Good" for all existing accommodation associated with this project.

### 3.4. Business Needs

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 outlines 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.

<b>Investment Objective</b>	<b>Increase integration &amp; communication between health &amp; social care services and delivery to service users</b>
<b>Existing Arrangement</b> The status quo	Service providers are currently split over 12 different 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 the occasional joint meeting when circumstances demand. Even though joint collaboration between organisations has improved more recently, the above situations tend to remain dominant.
<b>Business Need</b> 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. 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 an holistic co-ordinated approach between health and social care professionals. Communication between professionals is disjointed and has the potential to confuse service users and to not attain the best possible service.
<b>Potential Scope</b> What is needed to overcome these problems	Centralise services to increase opportunities for integration Develop intermediate care services to provide rehabilitation and reablement services Provide holistic, co-ordinated approach towards preventative care Engender opportunities for joined-up working & improved communication between different service providers

Investment Objective	Improve user experience of local health & social care service provision
<p><b>Existing Arrangement</b> The status quo</p>	<p>Consultation with the Stirling community suggests that they want:</p> <ul style="list-style-type: none"> <li>• The opportunity to stay in their own home, with friends and family around them for as long as possible.</li> <li>• To have a service that can respond to changing need.</li> <li>• Prevention from having to stay in hospital longer than needed.</li> </ul> <p>In response, Stirling Council's Capacity Planning paper (for the Delivery of Social Care Services to Older People) indicates that:</p> <ul style="list-style-type: none"> <li>• The number of home care clients is 54.7, which is lower than the Scottish average of 68.2.</li> <li>• Provision of intensive (10+ hours per week) care at home is 9.4 (per 1000 population) which is significantly lower than the Scottish average of 17</li> <li>• Whilst the number of residential Care Home places per 1000 population for Stirling is the same as the Scotland average, the 'Balance of Care Indicator' for Stirling is much lower (19%) than the Scotland average (32%), thus confirming a greater reliance on institutional residential care.</li> <li>• There is limited use of reablement / rehabilitative approaches</li> <li>• Overnight respite provision in Stirling has reduced since 2006/07 but the figures for 2008/09 of 300 nights per 1000 population over 65 is the same as the Scottish average</li> <li>• However, daytime hours of respite for Stirling of 503 hours is much lower than other authorities (ranked 26th)</li> </ul> <p>Service users may need several transitions through the care journey to access the appropriate care (based on at least 12 different locations for service delivery), which creates a fragmented approach to the delivery of health and social care services</p> <p>Service users access care via old, outdated accommodation that impacts on user perception of their overall experience (see AEDET review of existing accommodation)</p>
<p><b>Business Need</b> Problems with the status quo</p>	<p>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.</p> <p>The limited use of reablement and rehabilitative approaches via intermediate care results in increased likelihood of admission to hospital and delays in discharge from care home and acute hospital services.</p> <p>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.</p> <p>Service fragmentation has the potential to confuse service users, require unnecessary transitions through the care journey, and restricts attainment of the best possible service.</p> <p>User perception of old, tired accommodation is that this will impact on the quality of service provision.</p>

<p><b>Potential Scope</b></p> <p>What is needed to overcome these problems</p>	<p>Increase in number of home care clients to, at least, Scotland average levels.</p> <p>Increase in provision of intensive care at home to, at least, Scotland average levels.</p> <p>Shift the Balance of Care in Stirling by 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.</p> <p>Develop intermediate care services to provide rehabilitation and reablement services.</p> <p>Provide sufficient daytime hours of respite for carers in Stirling to place it in the top quartile of Local Authority providers in Scotland.</p> <p>Centralise services to reduce the number of disjointed transitions through the care journey.</p> <p>Improve the condition of facilities used to provide services.</p>
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Investment Objective	Improve access to care
<p><b>Existing Arrangement</b></p> <p>The status quo</p>	<p>There are at least 12 different locations from which services are based and / or accessed; which includes separated accommodation for health care beds and social care residential beds, and 5 separate locations to access GP services.</p> <p>The AEDET review of existing premises suggests that they present difficulties re physical access to service delivery points.</p> <p>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.</p> <p>Stirling Council's Capacity Planning paper indicates that those waiting for social care assessments (prerequisite to accessing services) is steady increasing from 281 in Jan 2009 to 426 in Jan 2010 (note: an increased budget allocation of £780k was provided in 2010/11 to reduce the number of those waiting).</p>
<p><b>Business Need</b></p> <p>Problems with the status quo</p>	<p>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.</p> <p>Physical access to service providers can require several journeys which also increases the problems of accessibility to older properties.</p> <p>Access to the current model of care can lead to a more institutionalised placement when more user focussed intermediate care would be more suitable.</p> <p>There are currently delays in accessing social care services for older people and whilst extra funding was allocated in 2010/11 to alleviate this problem this may not be sustainable and increases in unmet demand would be inevitable.</p> <p>Access to care through the current system is inflexible to user needs and, therefore, more flexible solutions are required.</p>
<p><b>Potential Scope</b></p> <p>What is needed to overcome these problems</p>	<p>Centralise services to reduce number of physical access points and create seamless link between health &amp; social care beds.</p> <p>Improve accessibility of facilities used to provide services.</p> <p>Shift the focus from long term care in care homes to short stay intermediate care, enabling older people to be independent or cared for at home.</p> <p>Shift the Balance of Care in Stirling by 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.</p> <p>Make effective use of resources to ensure that those waiting for social care assessment is reduced to a reasonable operational level.</p>

<b>Investment Objective</b>	<b>Improve care pathways, capacity and flow management</b>
<p><b>Existing Arrangement</b> The status quo</p>	<p>There are 96 community hospital beds currently provided at Bannockburn Hospital (planned to move to the maternity block at Stirling Community Hospital in Spring 2012).</p> <p>There are four separate care homes across Stirling providing 75 beds.</p> <p>The five separate GP practices across Stirling City have a combined list size of over 26,000 patients.</p> <p>The above facilities are generally run at capacity.</p> <p>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).</p> <p>The 'Balance of Care Indicator' (as discussed earlier) for Stirling of 19% seems to suggest a greater reliance on institutional residential care than population needs.</p> <p>Between 2009 and 2010 delayed discharge levels from Acute Hospital (of more than 6 weeks) had increased from a zero for the first nine months of the year to 3 by February 2010. This can be directly attributable to a lack of appropriate Care at Home and specialist Dementia Care Home beds.</p> <p>The AEDET review of existing premises suggests problems with the functionality of the available accommodation.</p>
<p><b>Business Need</b> Problems with the status quo</p>	<p>Financial constraints are already impacting on the current provision of beds and will, therefore, be unlikely to cope with an increased demand for beds.</p> <p>Also, this accommodation is unsuitable for modern service provision and patient expectations. It will therefore need to be replaced at some point in the near future.</p> <p>Flow of patients from Forth Valley Royal Hospital into available beds is compromised due to lack of availability of single beds, very few male beds, and ability to move patients from one ward area to another, for example to rehabilitation in the gym due to isolated ward locations on the existing site.</p> <p>Flow of patients from health beds to social care or own homes is compromised. Delays in discharge are very low, however, a lack of integration between models of care mean that more people than necessary are discharged to care homes rather than their own homes. This has increased recently which appears to be a direct response to keeping delayed discharges low.</p> <p>Increased future demand for services, particularly for those over 65 years old will put increasing pressure on existing services to cope with that demand.</p> <p>The functional suitability difficulties associated with old, outdated accommodation restricts the effectiveness of care pathways and flow management.</p>
<p><b>Potential Scope</b> What is needed to overcome these problems</p>	<p>Reduce reliance on institutional care and demand for health &amp; social care beds to ensure capacity continues to meet demand.</p> <p>Provide more suitable and flexible bed provision so that use for health and social care purposes can be interchangeable.</p> <p>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 different bed usages; such as dementia care home beds.</p>

Investment Objective	Maximise flexible, responsive and preventative care - at home, with support for carers
<p><b>Existing Arrangement</b> The status quo</p>	<p>Stirling Council's Capacity Planning paper (for the Delivery of Social Care Services to Older People) indicates that:</p> <ul style="list-style-type: none"> <li>• The number of home care clients is 54.7, which is lower than the Scottish average of 68.2.</li> <li>• Provision of intensive (10+ hours per week) care at home is 9.4 (per 1000 population) which is significantly lower than the Scottish average of 17</li> <li>• Whilst the number of residential Care Home places per 1000 population for Stirling is the same as the Scotland average, the 'Balance of Care Indicator' for Stirling is much lower (19%) than the Scotland average (32%), thus confirming a greater reliance on institutional residential care.</li> <li>• There is limited use of reablement / rehabilitative approaches</li> <li>• Overnight respite provision in Stirling has reduced since 2006/07 but the figures for 2008/09 of 300 nights per 1000 population over 65 is the same as the Scottish average</li> <li>• However, daytime hours of respite for Stirling of 503 hours is much lower than other authorities (ranked 26th)</li> </ul> <p>The 'Balance of Care Indicator' (as discussed earlier) for Stirling of 19% seems to suggest a greater reliance on institutional residential care than population needs.</p>
<p><b>Business Need</b> Problems with the status quo</p>	<p>The current model for Older People's Care does not 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.</p> <p>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.</p>
<p><b>Potential Scope</b> What is needed to overcome these problems</p>	<p>Increase the number of home care clients to, at least, Scotland average levels.</p> <p>Increase provision of intensive care at home to, at least, Scotland average levels.</p> <p>Shift the Balance of Care in Stirling by 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.</p> <p>Develop intermediate care services to provide rehabilitation and reablement services.</p> <p>Provide sufficient daytime hours of respite for carers in Stirling to place it in the top quartile of Local Authority providers in Scotland.</p>

Investment Objective	Make best use of available resources
<b>Existing Arrangement</b> The status quo	<p>The 'Balance of Care Indicator' (as discussed earlier) for Stirling of 19% seems to suggest a greater reliance on institutional residential care than population needs.</p> <p>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).</p> <p>Spend per capita on Older People's Services in 2008/09 was £1,278 which is 10.5% below the Scottish average.</p> <p>It is estimated that an extra £2.438m would be required to meet the Scottish average for older people's service levels.</p>
<b>Business Need</b> Problems with the status quo	<p>Current facilities are run at capacity and the current model of Older People's Care already needs additional funding to attain Scottish average service levels. Meeting projected increased future demand for services will be unsustainable from current financial resources.</p> <p>More expensive interventions from both health &amp; local authority provision are having to be utilised due to the lack of support for self-care and independent living at home</p>
<b>Potential Scope</b> What is needed to overcome these problems	<p>Introduce a new model of older people's care that:</p> <ul style="list-style-type: none"> <li>• Shifts the Balance of Care in Stirling by 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.</li> <li>• Provides the flexibility to deliver better services and deliver all the investment objectives described herein.</li> <li>• Is able to cope with the projected increase in demand for services.</li> <li>• And, is affordable for all partner organisations.</li> </ul>

Investment Objective	Improve quality & effectiveness of accommodation used to support service delivery
<b>Existing Arrangement</b> The status quo	<p>An AEDET assessment has been carried out on all properties associated with this project which produced an overall average score of 2.84</p>
<b>Business Need</b> Problems with the status quo	<p>The main issues and problems highlighted within these assessments is summarised within the 'Existing Property Arrangements' section of this Initial Agreement.</p>
<b>Potential Scope</b> What is needed to overcome these problems	<p>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 or "Very Good" for all existing accommodation.</p>

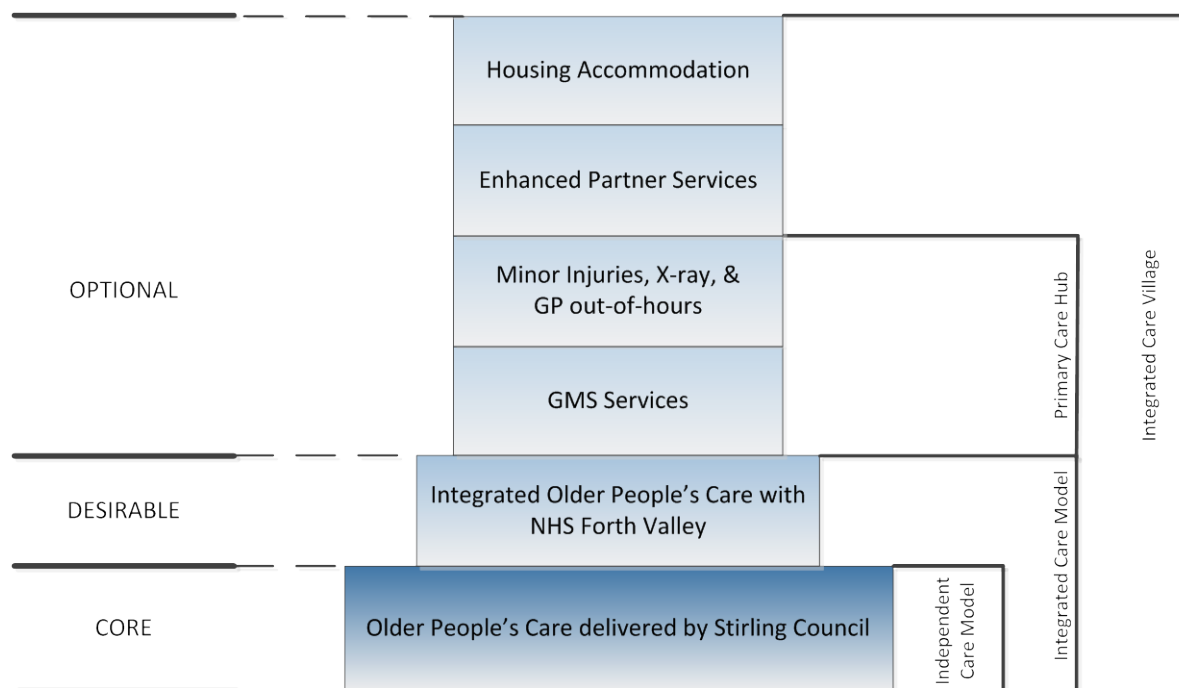
<b>Investment Objective:</b>	<b>Improve safety of health &amp; social care, advice, support &amp; accommodation</b>
<p><b>Existing Arrangement</b> The status quo</p>	<p>There is a lack of single beds in the existing NHS accommodation. The AEDET review of existing premises highlights the outdated accommodation which is not always maintained to modern statutory compliance and health &amp; safety standards.</p>
<p><b>Business Need</b> Problems with the status quo</p>	<p>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:</p> <ul style="list-style-type: none"> <li>• Lower fire safety standards</li> <li>• Need for backlog maintenance</li> <li>• HAI concerns</li> <li>• Trips and falls</li> <li>• Etc,</li> </ul>
<p><b>Potential Scope</b> What is needed to overcome these problems</p>	<p>Increase number of single bed use to reduce risk of infection transmission Improve AEDET score for facilities used in providing services</p>

## 4. Potential Business Scope and Key Service Requirements

### 4.1. Potential Business Scope and Key Service Requirements

The potential scope and the key service requirements have been assessed in terms of a continuum of business needs, ranging from 'core' minimum requirement, to 'core plus desirable' (intermediate requirement) to 'core plus desirable plus optional' (maximum requirement). Core is considered to be the things that are essential to meet existing and known needs; desirable are the things that are considered on a cost/benefit basis; and optional are the things that are being explored and will be considered if they are of exceptionally low cost but likely to deliver high benefits.

At this stage, the 'core' business scope for this scheme is the provision of older people's care services delivered by Stirling Council. However, in order to provide an improved model of care that seeks to achieve the investment objectives described previously, an integrated approach to service delivery with NHS Forth Valley is required. The Business Scope continues to grow in a layered approach as both desirable and optional elements are added and other partner organisations are introduced. The following diagram outlines the build-up of this scheme as it progresses through the continuum of business needs:



As the Business Scope grows more opportunities become possible for further service partners to be introduced to enable enhanced service provision and the creation of a Care Village approach. This could include opportunities to develop additional community support through Forth Valley College, local charities and the voluntary sector to deliver enhanced services as part of the Care Village model



The following table outlines the do nothing, minimum, intermediate and maximum service scope (range / volume of service provision) that could be delivered from the potential Business Scope described above:

	<b>Do Nothing</b>	<b>Minimum</b>	<b>Intermediate</b>	<b>Maximum</b>
<b>Service Scope</b>	Current Catchment Area & Range of Services	Reduced service scope based on reduced catchment area and/or range of services	Improved service scope due to proposed new service model	Increased service scope based on increase in catchment area and/or range of services

The potential business and service scope described above will be tested later in this Initial Agreement as part of 'Step 3 - Exploring the way forward'.

The key service requirements needed to deliver the business and service scopes is based on the proposed new model of care which has the following key components:

### **Model of Care for Older People's Care**

Stirling Council has developed a new model of care for older people which was submitted for approval to the Joint Executive Committee (involving Stirling Council and NHS Forth Valley) in June 2011. Its title is 'Reshaping Older People's Care: Right Service, Right Place, Right Time. Appendix 3 of that paper provides a summary of this model of care and should be referenced to attain greater detail of the proposed model of care. It describes the model of care in four stages (prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care) and the following provides an overview of the proposals contained within:

In the main, people choose to be a support 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.

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. We call these 'short-term therapeutic interventions', designed to support the older person to return to family, social and cultural life as quickly as possible and where necessary, provide support to maintain normality for individuals.

The care journey continues through a range of therapeutic interventions where intensity and professional support will increase and decrease as crisis or events demand. This model is therefore both responsive and focused on the individual's outcomes in relation to their ability and potential. The key point though is that care and support is available when it is needed, where it is needed and for the length of time it is needed and then withdraws.

As care needs increase the journey may flow into more regular care support. This could be at home, 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.

When the only option is longer-term care home placement, this service will be specific to the care needs and focused on outcomes while delivering best value in relation to quality and cost. This style of care is likely to support those with greater needs than is currently the case.

The integrated model for Older People's Care, as described above, is based on a joint health and social care approach whereby patients discharged from acute health or those referred to a care home are managed largely through intermediate care beds and not health beds, fewer people are admitted to care homes, and more people are supported at home. Beds will be used on a flexible basis between both organisations with current modelling expecting a reduction in overall bed numbers from 171 to 130 - 135 (initially anticipated that occupancy will be 50% health & 50% social care, however, over time it is likely that the shift will lower in terms of health specific beds and increase in terms of intermediate care / respite beds. This approach will allow flexibility between health and social care models and allow flexibility for delivery of care out with the care village model. It is thus envisaged that there will be a reduced number of health specific beds with remaining beds integrated or social care beds. The utility of beds will provide optimum flexibility to adapt to the demands or care required. The level of health input to those in integrated or intermediate care beds will be defined by patient need and managed accordingly through partnership arrangements.

### **The Care Village Concept**

The concept of a 'Care Village' for Stirling is aimed at developing the flexibility of care provision needed and introducing economies of scale both now and in the future. The 'Business Scope' diagram reviewed earlier outlines the range of services expected to form the Care Village for this scheme. This concept is well founded in establishments elsewhere which provides access to a full range of health and social care services, and in some cases housing on the same site.

### **GMS Services**

GMS services will generally continue as currently provided but with enhanced service delivery expected as a direct consequence of the close proximity of services within the Care Village concept. This enhanced approach to service delivery is likely to result from improved collaboration and communication between GP practices and with primary and social care teams and closer working with specialist geriatricians and others such as Allied Health Professionals, Mental Health Services and Children's Services.

The role of the GPs in achieving the shift in the balance of care required to implement other care models, in particular that for older people, is not to be underestimated and will be greatly enhanced by the proposed development.

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

The majority of existing NHS based community hospital services on the Stirling Community Hospital site (not including those specifically related to older people's care described above) will be unaffected by the integrated older people's care model and are not, therefore, included as part of this scheme. As the Business Scope for the project grows, however, these existing community hospital services will look to become fully integrated into the Care Village concept.

As part of NHS Forth Valley's full implementation of its Integrated 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 wider scope of the Care Village concept.

### **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 Initial Agreement Forth Valley College has explored the potential for vocational training and social enterprise for the provision of common services in hospitality and salon services on the Care Village site. The College are particularly interested in delivering vocational training in a community setting. Following from the successes demonstrated at Forth Valley College's Raploch Community Campus where the model is delivering school meals, a bistro and salon service; a similar approach within the Care Village would offer opportunities for employment, vocational training and learner placement, whilst delivering an excellent service for staff and residents.

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 wider health and wellbeing of staff and residents within the community setting will have great significance. The college will explore the role of sport and recreational services, using existing facilities across the Care Village, to create opportunities to develop leisure activity in all zones of the Care Village.

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.

### **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 private Housing with Care accommodation, has

the potential to provide a viable part-solution to this problem. Note, Housing with Care accommodation, in this context, is 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.

Housing accommodation is described as an 'Optional' inclusion in the Business Scope for this scheme and will, as such, only be included if it can demonstrate exceptionally good value for money i.e. if they are of exceptionally low cost but likely to deliver high benefits.

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.

As this remains an optional inclusion in the scheme, its potential can be investigated further in parallel with the development of the scheme until such time as either this option is rejected or it becomes an integral part of the preferred way forward.

### **Extra Care Services**

The inclusion in this scheme of housing accommodation introduces the possibility of including 'extra care' housing, but this will be dependent on the outcome from the development of the preferred way forward for this scheme.

The term 'extra care' housing is used to describe developments that comprise self-contained homes with design features and support services available to enable self-care and independent living but, in addition, the resident is likely to enter into some kind of formal 'extra care' arrangement with health & social care services.

This once again remains an optional inclusion in the scheme and is part-linked to the inclusion of housing accommodation in the scheme. It should be noted that a recent discussion paper based on a longitudinal study, titled 'The Cost Effectiveness of Extra Care' suggests that Extra Care is initially more expensive than the cost of providing home care. This is partly due to the support of unmet needs but other research also indicates that on entry to a scheme, there is often a shift from informal care to formal care, along with its associated costs. It concludes by suggesting that the limited cost effectiveness of this approach should not negate the non-financial benefits of introducing such a model of support.

## 5. Benefits, Risks, Constraints and Dependencies

### 5.1. 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:

<b>Investment Objective:</b> Increase integration & communication between health & social care services and delivery to service users			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
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	High	Medium	Quantitative
Shared use of partner resources	Low	Short & 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

<b>Investment Objective:</b> Improve user experience of local health & social care service provision			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
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	High	Medium term	Quantitative & resource releasing
Meeting service user preferences is more cost effective	High	Medium term	Cash & 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

<b>Investment Objective:</b> Improve access to care			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
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
Reduced travel time and costs for service users	Medium	Medium term	Qualitative & cost saving for patients

<b>Investment Objective:</b> Improve care pathways, capacity and flow management			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
More people treated on a scheduled rather than unscheduled basis	High	Medium & longer term	Quantitative
More referrals for treatment with diagnosis already established	Medium	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	High	Medium term	Quantitative & cash releasing to NHS & Council
Services users don't have to stay in hospital longer than necessary	High	Medium term	Quantitative

<b>Investment Objective:</b> Maximise flexible, responsive and preventative care - at home, with support for carers			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
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

<b>Investment Objective:</b> Make best use of available resources			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
Affordable service delivery	High	Short, medium & longer term	Quantitative
Service capacity meets service demands	High	Medium & longer term	Quantitative
Meeting service user preferences is more cost effective	High	Medium term	Quantitative
Service model is more flexible to future changes in demand	Medium	Medium term	Qualitative
Reduction in overall number of beds	High	Medium term	Cash & resource releasing to NHS & Council
Reduced demand for more expensive care pathways	High	Medium to longer term	Cash releasing to NHS & Council

<b>Investment Objective:</b> Improve quality & effectiveness of accommodation used to support service delivery			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
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
<b>Investment Objective:</b> Improve safety of health & social care, advice, support & accommodation			
<b>Benefit</b>	<b>Relative Value</b>	<b>Relative Timescale</b>	<b>Type</b>
Reduced risk of HAI incidents	High	Medium term	Qualitative
Reduced risk of harm from property related incidents	High	Medium term	Qualitative

## 5.2. Main 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. This section takes an early view of the key risks that could impact on the successful delivery of the project and sets out what actions the partner organisations can take to ensure risk is minimised and managed. These risks will then be reviewed in more detail at the Outline Business Case stage and the process of risk management will continue throughout the life of the project and then transfer to the operational management of the organisation. The following table sets out the high level early stage assessment of risks associated with the programme.



Risk No.	Risk Description	Consequence	Likelihood	Risk Level	Proposed Mitigation
1.	Partner Organisations are unable to agree preferred way forward	5	2	Medium	Continue with partnership approach to the development of the Initial Agreement & engage stakeholders in key decision points
2.	Project becomes unaffordable to one or all organisations	5	3	High	Prepare indicative costs at an early stage in the project and confirm expected contribution from each partner organisation and their confirmed acceptance of such costs. Then prepare more detailed costings as the project continues.
3.	The funding support for the hub revenue financed model is not available to Stirling Council or other partner organisations which affects their affordability issues	4	4	High	Under current arrangements for the funding of hub DBFM projects, direct funding is not available for the non NHS component of the unitary payment for facilities. Alternative sources of finance will therefore need to be explored for that element of the unitary payment, including a case to the Scottish Executive re the holistic health and well-being benefits to the Stirling community of implementing this integrated and partnership model of health & care and thus funding of the scheme. Further to this each partner to review alternatives in terms of implementation, procurement and scope with a view to delivery of the project within available resources.
4.	Organisations can't agree to work in partnership towards delivering the new Older People's Care model, particularly the manner in which resources and the flexible use of beds are allocated between organisations.	5	3	High	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.
5.	Capacity planning used as the basis to formulate the proposed service model is inaccurate	4	3	Medium	Detailed work has already been carried out on the capacity planning model but this should be regularly reviewed and sensitivity tested to ensure that it remains consistent with the developing scheme
6.	The sale proceeds from disposal of surplus land at Stirling	3	4	Medium	An assessment of land value is currently being sought and will

	Community Hospital can not be used to support this scheme, or, the proceeds are insignificant to the funding of the scheme				<p>be factored into appropriate cost calculations.</p> <p>Confirmation from the Scottish Government needs to be sought at the earliest opportunity to gain commitment that these sale proceeds can be used to support this scheme.</p> <p>Alternatively, an assessment needs to be made re whether the scheme remains viable without this funding.</p>
Risk No.	Risk Description	Consequence	Likelihood	Risk Level	Proposed Mitigation
7.	Centralisation of services is perceived as a reduction in access to care and will create a large, impersonal, institutional facility	3	2	Low	Public consultation needs to be carefully managed to ensure that the benefits of this scheme are at the forefront of the message portrayed. This will need to begin upon approval of this Initial Agreement
8.	Stakeholder / public expectations are unduly raised following announcement of the preferred way forward prior to formal approval of the project	2	3	Low	Confirm what approval process needs to be followed by each organisation prior to announcement of the scheme
9.	The Stirling community consider the development of the Care Village as a 'closed shop' and only for those residing within the new residential housing community	3	2	Low	Even though most referrals will be via the health & care system and would thus reduced the likelihood of this occurring, public perception will still need to be managed through appropriate community consultation. It also needs to make it very clear that this project is for the benefit of the full Stirling community and that residents living outside the Care Village campus will receive the same level of service as those within.
10.	Unmet demand for services increases due to better services being made available	4	3	Medium	The capacity planning model has taken into account increases in future demand for services, particularly relating to population growth and longer living expectations. This will need to be reviewed at each stage of the approval process and sensitivity testing included on further unmet demand

11.	It becomes difficult to identify and quantify workforce and professional development needs across all partner organisations so that Forth Valley college (and existing providers) can plan effectively to meet new level / range of demand	2	3	Low	This needs to be built into the project work plan and progressed in a collaborative way
Risk No.	Risk Description	Consequence	Likelihood	Risk Level	Proposed Mitigation
12.	Delays in implementation of parts of the project mean that the full service model can not be implemented	4	3	Medium	Once the preferred way forward is confirmed then a detailed programme for implementation needs to be developed. The strategy towards implementing the service model can then begin.
13.	The design of any new facilities does not meet with expectations	4	2	Low	Consultation on user requirements for the new facilities has already commenced and will continue once the preferred way forward is confirmed. Also, a design brief needs to be created for the scheme to accompany the Initial Agreement
14.	Planning restrictions do not allow the full development of the Care Village as planned	4	2	Low	Once the preferred way forward and design brief are confirmed consultation with planning authorities will need to commence.
15.	Procurement plans do not appropriately consider and reflect on the complex VAT implications and the ability of organisations to reclaim their VAT	4	3	Medium	Ensure that VAT experts are consulted at OBC stage when considering the financial / affordability implications of the preferred option
16.	Procurement and contractual risks are inherent in the procurement of the new facilities	3	3	Medium	Early involvement of suppliers (HubCo & commercial investors) will minimise this risk and ensure the right balance of risk transfer between parties.

## 5.3. Constraints

### 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 identifies 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 can not 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 this scheme is unlikely to be made available. Alternative sources of funding are being sought, such as the possible sale proceeds from surplus land on the Stirling Community Hospital site. Funding commitment to this source has not yet been granted and, therefore, remains a constraint on the affordability of the scheme.

### 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. It is unclear at this stage whether this mechanism will be available to cover all parts of this scheme or just the health based portion.

The current capacity planning model suggests that there will be no increase in the workforce cost 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 demonstration of the affordability of this scheme will continue to be tested fully throughout the different approval stages of this project which will include the development of a fully detailed revenue model within the next OBC stage.

### Site Availability Constraints

The current assumption is that the existing Stirling Community Hospital site will be used to create the Care Village model. As discussed above, this creates a health & social care purpose to the land sale receipts and increases the possibility of retaining these receipts for this scheme. If either the land or the sale receipts become unavailable then alternative solutions may need to be sought and the preferred way forward adjusted to reflect a more suitable integrated older people care facility rather than the more ambitious and beneficial Care Village concept. Alternative sites have not been sought at this stage.

## 5.4. Dependencies

The above constraints have discussed the potential dependency on the sale receipts from the surplus land at Stirling Community Hospital for the scheme to be financially viable.

The development of an integrated approach to older people's care is dependent upon the continued collaboration between Stirling Council and NHS Forth Valley. Without this collaboration each organisation would need to progress with its own individual schemes and the Care Village would not be possible.

The Care Village concept is also dependent upon the collaboration and inclusion of other partner organisations, such as the local GP practices, the primary care hub development, the other community hospital services already on site, and possibly the additional housing accommodation. It is these latter 'optional' elements that are needed to create the Care Village concept and without them the scheme would become the integrated older people's care accommodation. 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.

## 6. Critical Success Factors for the project

In addition to the Investment Objectives set out in the previous section of this Initial Agreement, 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	Project related CSF's
Strategic fit and business objectives	<p>Fits with the strategic intention to shift the balance of care from acute to primary care and from institutional care to home care</p> <p>It is also in line with Stirling Council's Single Outcome Agreement, in particular the theme of 'Making Stirling a place where improved well-being adds life to years, not just years to life'.</p> <p>It also fits with NHSScotland's Quality Strategy agenda and forms part of NHS Forth Valley's Integrated Healthcare Strategy and associated Property &amp; Asset Management Strategy</p>
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

## 7. The Long List of Options

### 7.1. Determining the Long List

The following table sets out the approach used by the Care Village Partnership Group for identifying and assessing a broad range of relevant options (the long list) for investment. It used a number of 'categories of choice' formulated around the who, the what, the when, the where and the how, to generate possible solutions and thus the long list of options.

The five categories of choice used were:

- Scoping options:  
What services are included in the scheme and what is the service coverage?  
Due to the complexity of scope for this project the scoping options were split into:
  - Business Scope: the type of service included
  - Service Scope: the functional size / catchment range of services delivered
- Service Solution options:  
How will the service be delivered?
- Service Delivery options:  
Who will deliver the service?
- Implementation options:  
When and how will the service be implemented?
- Funding options:  
How will the scheme be funded?

The options developed against each of these five categories of choice are described in the following tables:

Category of Choice	Range	Brief Description
<b>Business Scope:</b>	Do Nothing	Retain services as current arrangements
	Core	Older People's Social Care Services only (excluding NHS services)
	Desirable	Integrated Older Peoples Care Services (Council & NHS services)
	Optional	Plus General Medical Services
	Optional	Plus minor injuries, x-ray, & GP out-of-hours
	Optional	Plus enhanced partner services (e.g. Forth Valley College, Voluntary Sector, local Charities, etc)
	Optional	Plus housing accommodation
<b>Service Scope:</b>	Do Nothing	Current Catchment Area & Range of Services
	Minimum	Reduced service scope based on reduced catchment area and/or range of services
	Intermediate	Improved service scope due to proposed new service model
	Maximum	Increased service scope based on increase in catchment area and/or range of services
<b>Service Solution Options:</b>	Do Nothing	As existing - no further development of the service model
	Minimum	Further development of the service model via co-location
	Intermediate	Further development of an integrated service model between health & social care
	Maximum	Further development of an integrated service model between all service providers
<b>Service Delivery Options:</b>	Do Nothing	Existing service delivery arrangements
	Minimum	Part existing service team, part reduced outsourced service team
	Intermediate	Part existing service team, part increased outsourced service team
	Maximum	Outsource majority of public sector team but retain GMS providers
<b>Implementation Options</b>	Do Nothing	Retain existing arrangements
	Minimum	Retain NHS estate & new build for all other accommodation <ul style="list-style-type: none"> <li>Phased approach</li> <li>Completed at same time</li> </ul>
	Intermediate	Part retained NHS estate & new build for all other accommodation <ul style="list-style-type: none"> <li>Phased approach</li> <li>Completed at same time</li> </ul>
	Maximum	All new build <ul style="list-style-type: none"> <li>Phased approach</li> <li>Completed at same time</li> </ul>
<b>Funding Options</b>		From within existing funding limits
		Public Capital
		Supported by Stirling Hospital land sale receipts
		Private finance (Hub)
		Other commercial finance

## 7.2. Drafting and Assessing the Long List

Using the Options Framework approach, the following actions were undertaken:

- The options within the first category of choice (Business and Service Scope) were assessed in terms of how well each option met each of the investment objectives and

critical success factors (CSFs) and then upon review whether each option was 'preferred', 'possible (to take forward)' or 'discounted'.

- The 'preferred' option for the delivery of the first category of choice (Business and Service Scope) was considered in relation to the next category of choice (Service Solution) and again options were identified either as the preferred choice or as possible to take forward or discounted.
- The process was repeated for all other categories of choice.

The detailed assessment of how well the options for each category of choice met the investment objectives and the critical success factors were reviewed by the Care Village Partnership Group in a workshop environment and the conclusions made as to whether options were 'preferred', 'possible' or 'discounted' are summarised in the tables that follow. Supporting opinion given of the main advantages and disadvantages of each option is also highlighted:

Category of Choice: Business Scope		
Brief Description	Advantages / Disadvantages	Recommendation
Retain services as current arrangements	<b>Advantages:</b> Very few advantages other than reassurance of status quo <b>Disadvantages:</b> It does not deliver main policy objectives or maximise opportunities to use resources jointly. It can not achieve the main investment objectives. Safety / compliance issues with status quo	Discounted
Older People's Social Care Services only (excluding NHS services)	<b>Advantages:</b> First step towards delivering future demand. Moving from fragmented delivery model which lacks efficiency <b>Disadvantages:</b> Doesn't maximise potential from integration. Less likely to move to next step of full integration	Possible
Integrated Older Peoples Care Services (Council & NHS services)	<b>Advantages:</b> Optimises efficiency, meets policy initiatives, and provides smoother pathway to care. Achieves investment objectives <b>Disadvantages:</b> Focuses on one sector of population and thus narrower range of integration. Difficult to only do this. Risk of attaining partner acceptability. Fails to make best use of existing services on hospital site	Preferred
Plus GMS Services	<b>Advantages:</b> Strengthens care team and links with services already on site. Better links to primary care team. Reduces distance to service. Overcomes restrictions from existing properties in delivering future GMS model. Improves recruitment & retention of GP's. Examples already of how GMS inclusion supports better collaboration etc <b>Disadvantages:</b> Additional complexities to including independent contractors.	Preferred
Plus minor injuries, x-ray, & GP out-of-hours	<b>Advantages:</b> Supports public expectations of local access to these services. Flexibility of extended use of accommodation. Enhances project as a resources and widens range of	Preferred



	<p>available services. Supports rationalisation plans for site</p> <p><b>Disadvantages:</b></p> <p>Further complexity to delivery of scheme &amp; cost implications</p>	
Plus enhanced partner services (e.g. Forth Valley College, Voluntary Sector, local Charities, etc)	<p><b>Advantages:</b></p> <p>Creates centre of excellence and allows flexibility and sustainability of future workforce structure across all groups. Creates supportive infrastructure. More able to provide holistic approach to service delivery &amp; anticipatory care</p> <p><b>Disadvantages:</b></p> <p>Further complexity to delivery of scheme. Large number of partners needing to agree approach, way forward etc</p>	Preferred
Plus housing accommodation	<p><b>Advantages:</b></p> <p>Reinforces village concept. Ability to design accommodation for focussed tenants. Delivers unmet demand for focussed housing. Creates 'sense of place'. Creates community environment. Location of site is a factor to this. (these issues could be design dependent)</p> <p><b>Disadvantages:</b></p> <p>Further complexity to delivery of scheme. Increased disruption. Could raise car parking issues. Would need to be dependent on good design solution</p>	Preferred
<b>Category of Choice: Service Scope</b>		
Brief Description	Advantages / Disadvantages	Recommendation
Current Catchment Area & Range of Services	<p><b>Advantages:</b></p> <p>Short term comfort of continued deliverability</p> <p><b>Disadvantages:</b></p> <p>Unaffordable, unable to cope with growing demand, can not achieve investment objectives</p>	Discounted
Reduced service scope based on reduced catchment area and/or range of services	<p><b>Advantages:</b></p> <p>Achieves financial restrictions within narrow range of service definition</p> <p><b>Disadvantages:</b></p> <p>Not equitable, causes problems elsewhere, not strategic approach</p>	Discounted
Improved service scope due to proposed new service model	<p><b>Advantages:</b></p> <p>Optimises efficiency, meets policy initiatives, and able to cope with future increased demand for services. Achieves investment objectives. Creates a unique beacon status from innovative service solution, uniqueness</p> <p><b>Disadvantages:</b></p> <p>Will require substantial change management</p>	Preferred
Increased service scope based on increase in catchment area and/or range of services	<p><b>Advantages:</b></p> <p>Further economies of scale. Creates a super centre</p> <p><b>Disadvantages:</b></p> <p>Creates a super centre</p>	Possible
<b>Category of Choice: Service Solution</b>		
Brief Description	Advantages / Disadvantages	Recommendation
Independent service provision via non-centralised model	<p><b>Advantages:</b></p> <p>Short term comfort of continued deliverability</p> <p><b>Disadvantages:</b></p> <p>Unaffordable, unable to cope with growing demand, can not achieve investment objectives</p>	Discounted
Independent service provision via co-location model	<p><b>Advantages:</b></p> <p>Provides platform for future integration. Better opportunities for interaction and communication</p>	Discounted

	<b>Disadvantages:</b> Separation of older people care model	
Seamless integration of Older People's health & social care services via centralised model	<b>Advantages:</b> Step change in effectiveness of service provision. Delivers national policy drivers. Reduces risk of implications of not doing this <b>Disadvantages:</b> Major cultural change therefore risk to ongoing political & financial support from partners	Preferred
Seamless integration of all health & social care services via centralised model	<b>Advantages:</b> Potential for economies of scale, <b>Disadvantages:</b> Bring all services together just for sake of it is not demonstrable service improvement. Overly complex & difficult to achieve. Would be dependent on wider political change	Discounted
<b>Category of Choice: Service Delivery</b>		
Brief Description	Advantages / Disadvantages	Recommendation
Retain existing service providers	<b>Advantages:</b> Team already established providing effective, good quality services <b>Disadvantages:</b> Doesn't take advantage of future opportunities for organisational change and potential amalgamation	Preferred
Part existing service team, part reduced outsourced service team	<b>Advantages:</b> More control over service providers' ability to deliver new service model <b>Disadvantages:</b> No evidence that reducing outsourced services will provide better services	Possible
Part existing service team, part increased outsourced service team	<b>Advantages:</b> Potential to provide better value for money <b>Disadvantages:</b> Reduced control over service provision and no evidence that increased outsourced services will provide better services	Possible
Outsource majority of public sector team but retain GMS providers	<b>Advantages:</b> Seamless delivery of services from user perspective <b>Disadvantages:</b> Major reliance on one private organisation providing all services - high risk. Lack of flexibility. Against NHS principles	Discounted
<b>Category of Choice: Implementation</b>		
Brief Description	Advantages / Disadvantages	Recommendation
Retain existing arrangements	<b>Advantages:</b> Properties already available <b>Disadvantages:</b> Properties not capable of efficiently and effectively supporting new service model	Discounted
Retain NHS estate & new build for all other accommodation <ul style="list-style-type: none"> <li>Phased approach</li> <li>Completed at same time</li> </ul>	<b>Advantages:</b> Implementation of partner accommodation needs can proceed without delay from NHS progress <b>Disadvantages:</b> NHS accommodation is compromised in its ability to deliver its commitment to the new service model. Would create split between NHS and Social Services accommodation	Discounted
Part retained NHS estate & new build for all other accommodation	<b>Advantages:</b> Implementation of partner accommodation needs can	Possible

<ul style="list-style-type: none"> <li>• Phased approach</li> <li>• Completed at same time</li> </ul>	<p>proceed without delay from NHS progress.</p> <p>Smaller resource commitment from NHS portion and potential to maximise potential from retained estate</p> <p><b>Disadvantages:</b></p> <p>Potential for disjointed development of scheme and ability to maximise benefits from scheme against site rationalisation plans for site</p>	
<p>All new build</p> <ul style="list-style-type: none"> <li>• Phased approach</li> <li>• Completed at same time</li> </ul>	<p><b>Advantages:</b></p> <p>Creates full, co-ordinated approach to future plans for Care Village concept and delivery of older peoples care model</p> <p><b>Disadvantages:</b></p> <p>More expensive and potentially less affordable</p>	Preferred
<b>Category of Choice: Funding</b>		
Brief Description	Advantages / Disadvantages	Recommendation
From within existing funding limits	<p><b>Advantages:</b></p> <p>Long term revenue implications would not be an issue</p> <p><b>Disadvantages:</b></p> <p>Scheme development works can not be supported from within existing funding limits</p>	Discounted
Public Capital	<p><b>Advantages:</b></p> <p>Long term revenue implications would not be an issue</p> <p><b>Disadvantages:</b></p> <p>Scheme development works can not be supported from available public capital</p>	Discounted
Supported by Stirling Hospital land sale receipts	<p><b>Advantages:</b></p> <p>Land sale receipts would help with the affordability of the scheme</p> <p><b>Disadvantages:</b></p> <p>Sale receipts may be insignificant in terms of overall affordability</p>	Possible
HubCo finance	<p><b>Advantages:</b></p> <p>NHS revenue implications can be supported by NHSScotland funding support for this procurement process and should include GP premises too.</p> <p><b>Disadvantages:</b></p> <p>Not sure if similar funding support is available to Councils. Revenue model may be more expensive than Council can seek elsewhere</p>	Possible
Other commercial finance	<p><b>Advantages:</b></p> <p>May be able to find more economically attractive finance elsewhere (i.e. outside of HubCo mechanism), therefore, particularly more attractive of Council</p> <p><b>Disadvantages:</b></p> <p>Not available to the NHS. Would create two financial partners supporting development of different parts of the scheme.</p>	Possible

### 7.3. The Preferred Way Forward

The following table represents the main outcome from the workshop in which a potential way forward is recommended for approval by the Joint Executive Group. It is based on the appraisal of the main options (long list) for each category of choice as described above. The potential way forward, or Reference Project, is made up of each preferred option for each category of choice as identified in the workshop. A description of how the 'Reference Project' has been built up is outlined in the following table. The table also identifies alternative options which are either more or less ambitious than the Reference Project. These are built up of a combination of 'preferred' and 'possible' options. A Do Minimum option has also been included for reference purposes.

	Do minimum	Least ambitious	Less ambitious	Reference Project (The Preferred Way Forward)	More ambitious
Scope	Older peoples 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 peoples 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 peoples 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 peoples 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 peoples health and social care services for the Stirling <b>and a wider catchment area</b> including prevention, short term therapeutic intervention, long term continuing care and palliative and end of life care
				General Medical Services	General Medical Services
				Minor injuries, Diagnostic & Treatment and Out of Hours GP Service	<b>Extended</b> minor injuries, Diagnostic & Treatment and Out of Hours GP Service
			Enhanced Partner Services – FV College, charities and voluntary sector	Enhanced Partner Services – FV College, charities and voluntary sector	<b>Extended and enhanced</b> Partner Services – FV College, charities and voluntary sector
			Housing	Housing	<b>Extended</b> Housing
Service Solution	As existing – no further development of the Integrated Service Model	Further development of the Service Model by co-location and integration of Social Services	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 for only Social Services	Development of a Care Village – excluding health services	Development of a Care Village – integration and co-location of existing health and social care services in Stirling	Development of a Care Village – integration and co-location of existing health and social care services
Implementation	No change	Existing social care services co-located on a single site in Stirling	Single development	Single development	Single development for health & social care services - & phased housing
Funding	As existing	Stirling Council Capital through Prudential borrowing	Stirling Council Capital through Prudential borrowing + commercially funded housing	Hubco revenue solution + commercially funded housing	Hubco revenue solution + commercially funded housing

The Reference Project and alternative options as identified in the above table are recommended for further examination at the Outline Business Case stage for this scheme.

## 8. Commercial, Financial and Management Cases

The Scottish Capital Investment Manual requires the Initial Agreement to include a brief outline reference to other elements of the Five Case Model i.e. the Commercial Case, the Financial Case and the Management Case.

### 8.1. Commercial Case

The purpose of the Commercial Case is to set out the planned approach that the project partners will be taking to ensure there is a competitive market for the supply of services and facilities. This in turn will determine whether or not a commercially beneficial deal can be done and achieve the best value for money for the project.

Health Boards have signed up to exclusivity for all schemes in excess of £750k to be offered to Hubco in the first instance and only if value for money cannot be established do Health Boards have the option to consider alternative procurement options. This initiative offers a flexible financing and procurement route for community healthcare projects which may otherwise not happen because of the decline in available capital. A portfolio of healthcare projects to the value £200 million is earmarked for development through hub over the next five years.

East Central Hubco which incorporates the Forth Valley area is now operational and the Amber Blue consortium, comprising of Robertson Group (Holdings) Ltd, Amber Infrastructure and FES, has been selected to deliver public sector infrastructure projects for the East Central Scotland partners.

For Stirling Council and the GMS accommodation there are two other procurement routes available; these are the use of a third party developer and associated funding or, for Stirling Council in particular, the potential to raise their own funding to support a traditional procurement route.

The hub initiative offers a flexible financing and procurement route for community based projects which may otherwise not happen because of the decline in available capital and is available both to NHS Forth Valley, Stirling Council, and other local public sector organisations.

The Scottish Government have committed to providing revenue funding support to health, education, transport and lifelong learning sectors that are delivered via hub revenue financed models.

The potential advantages to the public sector partners of hub over more traditional procurement methods are:

- Faster and more efficient procurement timescales
- Savings on costs through partnering arrangements, standardised processes and documentation - an estimated 3% saving on procurement costs, 2% on capital costs and a further 2% reduction in costs through risk transfer to the private sector.

Whilst East Central Hubco is expected to be the preferred provider for developing the capital projects associated with this Initial Agreement, it will be required to demonstrate value for money for each project, through an open book approach, benchmarking and/or market testing. This will include comparisons against the other funding routes identified within options in the Economic Case

The East Central HubCo can deliver projects through one of the following options:

- Design and Build contract (or build only for projects which have already reached design development) under a capital cost option;
- Design, Build, Finance and Manage under a revenue cost option (land retained model); or
- Lease Plus model for a revenue cost option under which the land is owned by hubco.

The second option of Design, Build, Finance and Manage is likely to be the most suitable for this project.

The alternative use of a third party developer by Stirling Council will depend on the commercial viability and value for money offered by such an approach. The financial appeal of such a route may, however, need to be considered alongside the contractual difficulties associated with commercial developments on NHS land and the complications associated with two separate developers working on the same Care Village development.

Third party development via commercial finance is seen as the only viable route for the housing developments but it will be relatively straight forward to separate this element of the overall scheme from the remaining parts. The type and content of housing included in such a development has still to be confirmed but will need to be fully co-ordinated with the main components of the Care Village project.

A full development plan for the site is needed to ensure a co-ordinated approach to the scheme.

## **8.2. Outline Financial Case**

The purpose of the Financial Case is to set out clearly the financial impact of the investment proposals. Given that the Initial Agreement is an early stage of the overall development of a business case for the project, the SCIM guidance states that these costs need only be indicative and can be expressed as a range of costs.

### **Indicative Capital Costs**

Indicative capital costs for each of the short-listed options are provided in the tables that follow. These capital costs are estimates which are generally based on average prices for buildings similar to those in this scheme and are arrived at by applying an approximate “all in £ rate per sq.m” to the total building area of each project. The following broad assumptions apply to these costs:

Shortlisted Options	Indicative Capital Costs (£m)
<b>Preferred Way Forward</b> (Full integration of Health & Social Care services & enhanced partner services through the development of a Care Village)	£44 - 55m
<b>Less Ambitious 1</b> (Older People's Social Care Services plus enhanced partner services & housing accommodation)	£29 - 37m
<b>Less Ambitious 2</b> (Older People's Social Care Services only)	£29 - 37m
<b>More Ambitious</b> (Full integration of Health & Social services but with 50% more beds)	£58 - 71m
<b>Do Minimum</b> (Upgrade of existing properties at some future stage)	£18 - 24m

The broad assumptions made in calculating the above costs are:

- 1st quarter 2012 cost basis, therefore, exclude future cost inflation.
- An allowance of 30% for optimism bias has been included.
- VAT is included at 20% to all costs (no consideration has been given to VAT recoverable amounts).
- Capital receipts for surplus land at Stirling Community Hospital and for the Bannockburn Hospital site have not been included in the above calculations as the receipt may need to be returned to the Scottish Government. The currently value of the surplus land is approximately £5 million, dependent on site conditions and final use.
- There are assumed to be no land purchase costs as the current assumed site is Stirling Community Hospital.
- Provision of new housing accommodation is excluded.

### Property Related Revenue Costs

The property related revenue / recurring costs associated with this scheme are:

- Hard Facilities Management costs – buildings and engineering maintenance costs.
- Soft Facilities Management costs - including cleaning, catering, grounds maintenance and security.
- Utilities costs including gas, electricity, water and rates.
- Capital charges etc (for publicly procured / financed projects only).

- Lifecycle maintenance costs – replacing building and engineering elements during the life of the buildings

It is expected that these property related revenue costs will be largely offset by the savings from similar costs that are currently incurred in existing buildings which will be replaced by the scheme. Therefore, at this early stage it has been assumed that will be no overall increase in property related revenue costs. However, there is potential for some revenue increases associated with these costs which will mainly be as a result of increases in the floor area of the proposed buildings compared to the existing buildings. This increase in size is required to support the Care Village concept and for coping with the forecast increasing activity arising from increasing populations. These costs will be examined in more detail for the Outline Business Case.

### **Indicative Unitary Charge**

If, as expected, the preferred way forward is procured through a revenue solution by way of East Central Hubco then 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 table that follows shows the indicative unitary charge payable by the partners and is based on the Preferred Way Forward i.e. Full integration of Health & Social Care services & enhanced partner services through the development of a Care Village.



		Indicative Unitary Charge (£m) based on:	
Accommodation	Capital Cost Estimate (£m)	Low capital cost estimate £m	High capital cost estimate £m
Council Elderly Care Accommodation	£20 to £24	£2.00	£2.40
NHS Elderly Care Accommodation	£13 to £16	£1.30	£1.60
Primary Care Accommodation	£3 to £3.5	£0.30	£0.35
GP Accommodation	£9 to £11	-£0.90	£1.10
Enhanced Partner Services Accommodation	£0.50	£0.05	£0.05
<b>TOTAL:</b>	<b>£45 - 55</b>	<b>£4.55</b>	<b>£5.50</b>

### Non-property related revenue costs

Within Stirling Council's paper, *'Reshaping Older People's Care'*, published on 30 June 2011, it outlines that social care services for people over 65 costs around £18m per annum. Almost 50% of this amount is spent on over 85's, and this is the age group expected to increase by the biggest proportion – by around almost 40% in 10 years. Applying the projected increases in these age bands to the existing levels and patterns of spend would result in an estimated increase from £18m to £23.5m – an increase of £5.5m in 10 years (based on the existing service model).

The proposed new service model will be more cost effective on a per person basis but the projected increase in the elderly population will inevitably increase the overall cost in the long run. Initial estimates show that by year 10 the cost of the new service model could be £21.3m, which is £2.2m less than the traditional model of service delivery but still higher than the current level of spend by £3.3m.

The following table provides a year on year estimate of these projected service costs:

Service Costs:	Spend Year 1	Spend Year 2	Spend Year 5	Spend Year 10
Traditional Model	£18.1m	£18.7m	£20.7m	£23.5m
Proposed Model	£18.1m	£18.3m	£18.8m	£21.3m
Difference	£0m	-£0.4m	-£1.9m	£2.2m

It needs to be acknowledged that these costs are only indicative at this stage.

The partnership approach to the new service model is likely to affect how resources are deployed between health and social care. It is anticipated that the proposed new service model will result in shorter stays in hospital and increased preventative activity resulting in reduced need and demand for beds. Overall, across the health and social care economy in

Stirling, this preventative model is expected to result in less care per head of population and, therefore, reduced costs. However, this will be counteracted somewhat by the increase in people served due to population increases, plus potentially more expensive but shorter healthcare intervention. Such a shift in resources from health funding towards more appropriate community based intervention could help to support this model.

Although there is confidence in the philosophy and broad commissioning approach to the proposed new service model, there are many areas to be examined and developed in further detail. For example, the overall levels of spend, capacity projections, balance of service provision, service levels, and associated costs, will all need to be examined in more detail at the outline business case stage for this scheme.

### **Affordability**

This Initial Agreement has been prepared on the broad assumption that the project is procured through a hubco 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.
- Additional cost components for soft FM, services, utilities costs and equipment costs (not included in the overall construction cost)

To allow for an assessment of the potential contribution from SG to NHS Forth Valley, an estimate of the constituent parts of the Unitary Charge has been calculated based on other hubco funded projects and is shown in the table that follows.

Element of Unitary charge	Percentage of Unitary Charge
Construction costs (subject to the agreed scope of the project)	83%
Private sector development costs (subject to an agreed cap)	
Financing interest and financing fees (at prevailing Financial Close rates)	
SPV running costs during the construction phase (subject to an agreed cap)	
SPV running costs during the operational phase (subject to an agreed cap)	
lifecycle maintenance costs	9%
Hard FM (facilities management) costs	11%
<b>Total:</b>	<b>100%</b>

On the basis of the above constituent parts of the Unitary Charge, the value of the support from the SG has been estimated to be approximately 85% of the overall unitary charge.

The table that follows shows the estimated gross unitary charge and the net unitary charge after Scottish Government support of 85%.

Shortlisted Options	Capital Cost Range (£millions)		Gross Unitary Charge based on capital cost range (£000)		Net Unitary Charge after SG support of 85%* see below (£000)	
	Min	Max	Min	Max	Min	Max
<b>Preferred Way Forward</b> (Full integration of Health & Social Care services & enhanced partner services through the development of a Care Village)	£45	£55	£4,550	£5,500	£683	£825
<b>Less Ambitious 1</b> (Older People's Social Care Services plus enhanced partner services & housing accommodation)	£29	£37	£2,900	£3,650	£435	£548
<b>Less Ambitious 2</b> (Older People's Social Care Services only)	£29	£37	£2,900	£3,650	£435	£548
<b>More Ambitious</b> (Full integration of Health & Social services but with 50% more beds)	£59	£71	£5,850	£7,100	£878	£1,065
<b>Do Minimum</b> (Upgrade of existing properties at some future stage)	£19	£24	NA	NA	NA	NA

The overall cost of the scheme can be further reduced by taking into account the savings on hard FM costs associated with the existing buildings that will close as a result of the scheme. These savings in hard FM costs are estimated to be approximately £400k. A detailed breakdown of the cost of the preferred way forward, taking into account the hard FM savings on existing buildings is shown in the table that follows.

Accommodation	Capital Cost Range (£m)		Unitary Charge (£000) based on:		85% SG Support based on High & Low Capital Cost estimates* see below		Revenue Savings on existing hard FM (£000)	Net Cost of the project to partners £000* see below	
	Low	High	Low capital cost estimate	High capital cost estimate	Min (£000)	Max (£000)		Min	Max
Council Elderly Care Accommm.	£20	£24	£2,000	£2,400	-£1700*	-£2040*	-£80	£220	£280
NHS Elderly Care Accommm.	£13	£16	£1,300	£1,600	-£1,105	-£1,360	-£250	-£55	-£10
Primary Care Accommm.	£3	£4	£300	£350	-£255	-£298	£0	£45	£52
GP Accommm.	£9	£11	£900	£1,100	-£765	-£935	-£110	£25	£55
Enhanced Partner Services Accommm.	£0.50	£0.50	£50	£50	£0	£0	£0	£50	£50
<b>TOTAL:</b>	<b>£45</b>	<b>£55</b>	<b>£4,550</b>	<b>£5,500</b>	<b>-£3,868</b>	<b>-£4,675</b>	<b>-£440</b>	<b>£243</b>	<b>£385</b>

This Initial Agreement, has been prepared on the assumption that revenue support will be made available for the NHS Board elements of the project in accordance with Derek Feely's letter to NHS Boards of 22 March 2011. This support will enable a unique, first opportunity to demonstrate a successful joint venture between health & social care and deliver the Scottish Government's plans to integrate older people's health & social care.

**\* Although the table above illustrates revenue funding support for the Council element of the project, it must be highlighted that under current funding arrangements for hub DBFM projects there is no commitment that funding is available to support the local authority element of unitary payments. In the event that this support was not available, then the net cost of the project to the Council would increase to £1.920M - £2.320M. Further, alternative funding sources for that element of the project would require to be fully evaluated with a view to meeting the stated aims within the available resources. This would include a review of the phasing/timescales, procurement method and scope of the project.**

The following property related cost elements are normally out with the scope of the hub contract and are therefore excluded from the above table:

- Additional procurement support costs (funding support is likely to be available for approved schemes).
- Equipment costs not included in overall construction cost (which could be £2 - 3m) dependent upon reuse of existing equipment).
- Soft FM costs, including cleaning, catering, grounds maintenance and security (currently assumed to be cost neutral).

- Utilities costs including gas, electricity, water and rates (currently assumed to be cost neutral).
- Provision of new housing accommodation (currently assumed to be cost neutral).

As part of the value for money assessment process required at the Outline Business Case stage, a detailed model of anticipated project costs and financial flows will be prepared. This model will aim to confirm projections of the various cost components of the project, including contributions to the total unitary charge payment from the relevant parties.

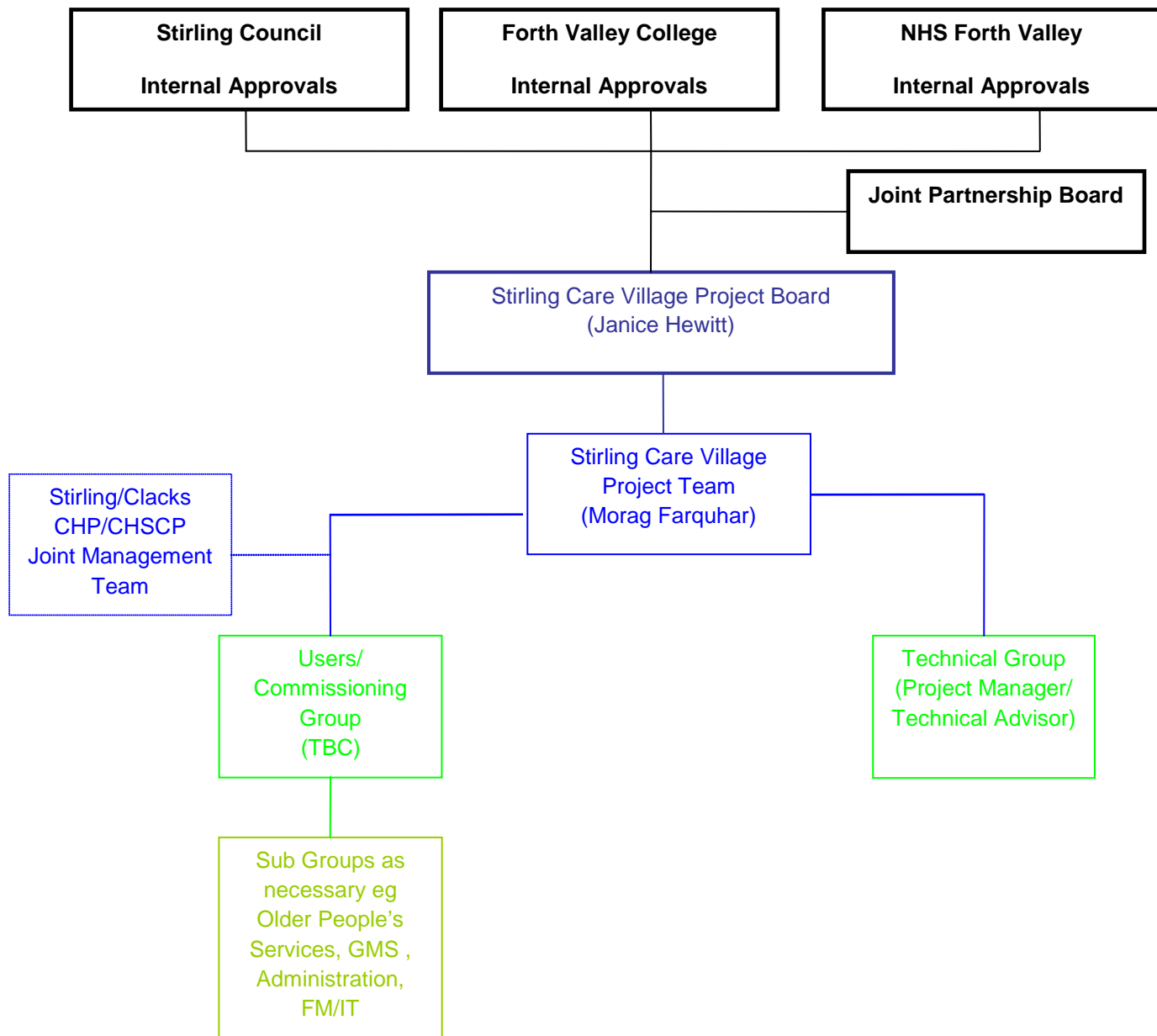
### 8.3. Management Case

The purpose of the Management Case is to describe how the organisation will ensure the project will be managed effectively and the investment objectives and benefits will be delivered successfully.

#### **Project Governance**

It is proposed that this work be managed as a project by the 'Stirling Care Village Project Board, to be chaired by the Assistant Chief Executive for Care Health and Well-being. The Project Board will report (via the Assistant Chief Executive) to the partner organisations' internal governance structures as well as to the Joint Partnership Board (which includes Elected Members and the chair of the NHS Board), and externally to the Scottish Government.

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



Further detail regarding the governance structure is included in Appendix B.

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

### Risk Management

The Programme Board has already identified the key high level risks associated with this project and these are set out in this Initial Agreement. This will form the basis of a more

detailed risk register which will be regularly reviewed by the Programme Board and will be continually updated during the life of the project.

### **Benefits Realisation**

As with risk management, benefits realisation will also require active management if the benefits envisaged from this project as set out in this Initial Agreement are to be fully realised. The benefits of each Investment Objective have already been considered as part of this Initial Agreement and will form the basis of a benefits realisation plan that will be established and overseen by the Programme Board as part of the outline business case. This plan will clearly describe each benefit including the success measure and will also show who has the accountability for its realisation.

### **Stakeholder Engagement**

Consultation events have taken place with senior management team, staff and key service users / stakeholders on service user needs, recommended improvements and the proposed older people's service model. A summary of consultations is as follows:

- Kaizen event for Older People's Service in November 2010 involving key stakeholders including older people and carers.
- Staff consultation event (January 2011).
- NHS Forth Valley's Joint Management Team and Nurse, Palliative, AHP consultants, the General Managers of Acute Services and the CHP were consulted on the models of care.
- Strategic Forum for Care, Health and Wellbeing (February 2011, April 2011).
- Key stakeholder review and challenge event on Investment Objectives, Critical Success Factors, Option long-list to short-list, and identification of the preferred way forward (see Appendix A for list of attendees).

The Project Board will have ongoing responsibility for the active management of communication with and involvement of stakeholders during the life of the programme.

## Project Timetable

The indicative timetable for implementation of the project is set out in the table below:

Milestone	Date
Submit Initial Agreement for internal partner organisation approval	January - March 2012
Approval of IA by Scottish Government Capital Investment Group	June 2012
Development of Outline Business Case (OBC)	July - December 2012
Appointment of HubCo	August 2012
Submission of OBC for internal Board approval	January - February 2013
Approval of OBC by Scottish Government Capital Investment Group	March 2013
Development of Full Business Case (FBC)	April - November 2013
Submission of FBC for internal Board approval	December 2013
Approval of FBC by Scottish Government Capital Investment Group	March 2014
Construction Phase	April 2014 - March 2016
Commissioning	April 2016
Services and facilities operational	May - June 2016



## **Appendix A**

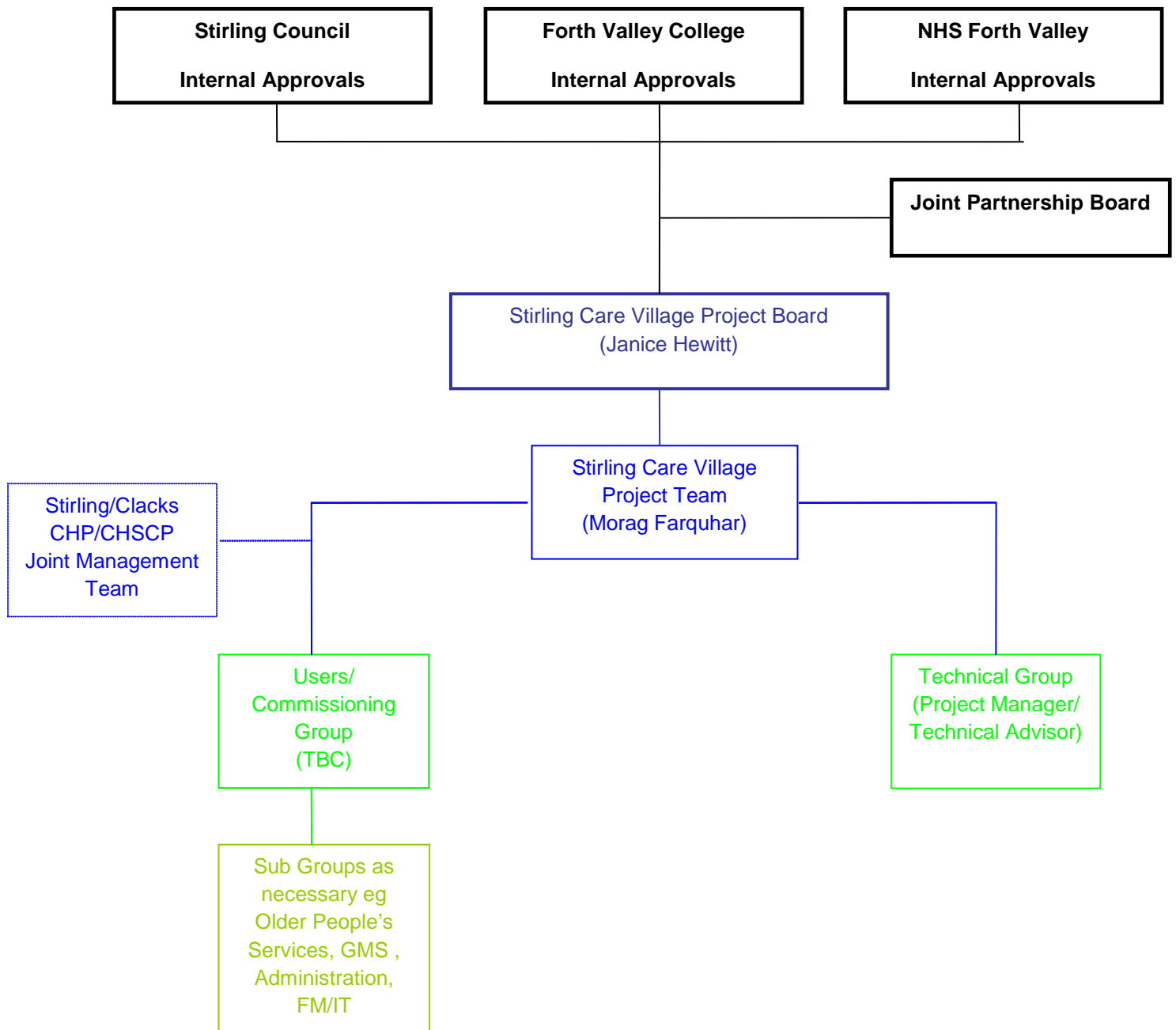
### **List of Attendees at the Initial Agreement workshop event on 12 January 2012**

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## **Appendix B**

### **Governance Structure**

## 1. Organisation Chart



## **2. Remit & Membership of Groups**

### **Project Board**

#### **Remit**

In line with PRINCE 2 methodology, a Project Board will be established to direct the project and will include the following three key roles: Executive, Senior User(s) and Senior Supplier

Taking account of the scope and importance of the project, it is recommended that Project Board members are drawn from senior management levels and will 'manage by exception'. Members will be provided with regular progress reports prepared by the Project Director and will be asked for joint decision making at key points in the project. Exception reports will be submitted to the Board when it is forecast that agreed tolerance levels, for cost or key project milestones will be exceeded. The Project Board will be responsible for signing off the detailed governance arrangements as outlined in this document and for the delegation of authority on behalf of each organisation to the Project Director and setting the latter's operational parameters.

It is envisaged that key milestones will be:

- New Project Request/formal engagement with the hubco
- Outline Business Case
- Completion of preparation of documents for tender
- Completion of process of appointment of construction and FM contractors plus supply chain
- Full Business Case
- Contract close
- Construction Practical Completion and handover phase

Given the nature of the project and the number of stakeholder organisations, a key task for the Project Board will be to establish and agree the joint and several responsibilities of the partners, for example, who will enter into the contract with the hubco, who will own the completed facilities, who will pay the annual charge, how will costs be shared. It is anticipated that exploration of these issues will be delegated to the Project Director/Project Team who will then make recommendations to the Project Board for approval and onward submission to the internal governance committees of the partners.

It will also be for the Project Board, via the Project Team, to ensure that communications within and external to the stakeholder organisations are conducted as appropriate.

#### **Membership :**

Executive (Chair)	J. Hewitt, Assistant Chief Executive, Stirling Council
Senior User	D. Cilliers, Joint Head of Social Services, Stirling/ Clackmannanshire Councils
	K. O'Neill, General Manager, Stirling and Clackmannanshire Community Health Partnership, NHS Forth Valley
	H. Ritchie, Forth Valley College

Senior Supplier            T. Steele, Director of Strategic Projects & Property, NHS Forth Valley  
                                     R. Gil, Head of Corporate Projects

In attendance:

Project Director            Morag Farquhar, Programme Director, NHS Forth Valley

Other members to be confirmed, to include senior representative of Finance, Human Resources, Communications.

## **Project Team**

The Project Team will require to contain the following disciplines:

- Project Management experience
- Service providers
- Technical experience
- Facilities management
- Financial
- Legal
- HR

The requirement for the level of in-house expertise, particularly in relation to technical, legal and financial input will depend on the level of external advice commissioned to support the project

## **Remit**

The Project Team will have the authority to and be responsible for driving the project and delivering outputs and will:-

- Provide support and advice to the Project Director on a range of issues including the development of the detailed service brief, design, construction and commissioning of the new facility.
- Assist, where appropriate, in the evaluation of competitive bids from potential professional and technical advisors, building contractors/ developers and equipment suppliers/procurement managers. Advise the Project Director on recommendations to be made to the Project Board in relation to their appointments.
- Ensure the engagement of all internal and external stakeholders and that communications are undertaken appropriately as directed by the Project Board..Assist the Project Director to develop formal proposals for the Project Board, including in regard to the procurement/ownership issues arising from the multi-organisational nature of the project – who will contract with the hubco, payment sharing etc.
- Agree room data, equipment schedules, budgets, building and services specifications and service and building commissioning programmes.
- Agreement of all legal and contractual arrangements through negotiation with “SubHubco”
- Appoint and manage the input of technical, financial and legal advisers and other external advice that may be required as necessary
- To consider any human resources issues and to take the appropriate HR and legal advice

- Support and assist the Project Director in relation to the development of the Business Cases for the project.
- Monitor the project in terms of cost and time and assist the Project Director in identifying potential variances and action to keep the project on time and to cost.
- Be satisfied that appropriate steps are being taken if problems are identified with the progress of the project.
- Oversee delivery of the benefits realisation plan defined in the Business Cases.
- Oversee the commissioning of services, including any changes to service models, and equipment.
- Oversee the development and implementation of detailed operational policies which embrace the principles set out in the Business Cases.
- Demonstrate a visible commitment to the project, ensuring that the project is actively promoted.

A core element of the work of the Project Team, potentially requiring a sub group, will be the relationship with the hub company and their Supply Chain and have a key responsibility for the execution of procurement contracts and delivery of the construction project:

- Checking, implementing and monitoring of the contracts.
- Developing and monitoring the overall programme for the project.
- Developing the Business Cases in liaison with internal and external stakeholders.
- Developing the design, ensuring compliance with technical standards and user requirements.
- Ensuring that statutory consents are secured.
- Provision of cost plans at agreed stages within the programme
- Monitoring expenditure against the cost plan and taking corrective action where variances are within tolerances and seeking direction/approval where they are not.
- Monitoring construction progress against the agreed programme and taking corrective action where variances are within tolerances and seeking direction/approval where they are not.
- Overseeing risk management and maintenance of the project Risk Register
- Delivery of the construction contract to programme, within budget and to the required standard
- Managing the process for Client Change Requests during the construction period

### **Membership: to be confirmed**

It is envisaged that the make up and role of the Project Team or that the level of involvement of the individual members will change over the life of the project. The initial aim will be to set up a robust project team to progress through the stage up to and including contract close and construction commencement. The make-up of the project team should then be reviewed at this stage for the period through construction and revised again once the operational stage of the project is reached.

### **Users/Commissioning Group**

#### **Remit**

In the early stages of the project, the Users Group will represent the interests of all those providing services/utilising accommodation within the Care Village in the planning and design stages of the project. This will include:

- Finalising the clinical/service brief
- Agreeing Schedules of Accommodation
- Agreeing the general layout
- Agreeing the detailed layout
- Contributing to the development of the Business Cases
- Contributing to the requirements of Room Data Sheets
- Contributing to the generation of the Services Specification

Sub Groups will be established as necessary to achieve the required outputs from the Group in these stages.

The Users Group and Sub Groups will be relatively short life groups, ie in operation until the completion and approval of the Full Business Case and members will thereafter be involved in the commissioning process, and making appropriate plans for the operation and use of the building, ensuring that users understand the nature of the services specification and payment/deductions mechanisms

At the appropriate time, therefore, the Group will plan and develop operational policies and procedures and any change to clinical or care models along with the preparation and implementation of the commissioning plan/programme.

Sub groups will be established as necessary to achieve the required outputs from the commissioning process eg in relation to administration, facilities management etc.

**Membership: to be confirmed**

## **Technical Group**

### **Remit**

The Technical Group will meet on a regular basis as required during the design development, construction and commissioning phases to ensure that all aspects of the development are fully compliant. This will include the development of the Technical Brief for the project and review of hubco proposals to ensure that they meet requirements.

The Technical Group will also provide support for the Project Manager and Director in finalising the legal and financial elements of the DBFM contract as required.

The Group will include representation from Estates Maintenance, Risk Management (Fire Safety, Security, Infection Control, Manual Handling), ICT/E-Health, Telecoms, Support Services (Domestic Services, Catering, Waste). Each organisation will work together to ensure that the requirements of each are met without undue duplication of effort or detriment to others.

**Membership: to be confirmed**



### **3. Roles of Key Individuals**

#### **Executive**

The Executive is the key decision maker and is ultimately responsible for ensuring that the project meets business needs/interests and gives value for money. The Executive will act as Chair of the Project Board

The Executive is responsible for the following:-

- Overseeing development of a viable business case
- Ensuring a coherent organisation structure and plans are in place
- Agreeing key milestones and ensuring that key stages are reported and approved prior to progressing to the next stage
- Monitoring and controlling progress of the business change at a strategic level and within pre-agreed parameters
- Referring serious problems upwards to top management
- Formally closing the project and ensuring lessons learnt are documented
- Ensuring that post project review takes place

The Executive will be supported by the Senior User and Senior Supplier

#### **Senior User(s)**

The Senior User(s) represent the interests of all those that will use the Final 'product(s)' .

The Senior User is responsible for the following:-

- Providing user resources
- Ensuring the project produces products that meet user requirements
- Ensuring that the products provide the expected user benefits

#### **Senior Supplier**

The Senior Supplier has to achieve the results required by the Senior User and is accountable for the quality of all products delivered by the supplier(s).

The Senior Supplier is responsible for the following:-

- Ensuring that proposals for designing and developing and using the products are realistic
- Achieve the results required by the Senior User within the cost and time parameters

The role represents the interests of those designing, developing, facilitating, procuring and implementing. The role must have the authority to commit or acquire the required supplier resources.

#### **Remit**

- Overall direction and management of the project
- The success of the project
- Has responsibility and authority for the project set by corporate or programme management

- Approves all major plans
- Authorises any major deviations from agreed plans
- Signs off completion of stages/authorises the start of the next stage
- Ensures that resources are committed
- Arbitrates on conflicts/negotiates solutions to problems
- Approves the appointment and responsibilities of the Project Director
- Ensures the project remains on course to deliver the products of the required quality to meet the business case
- Project assurance – monitoring the projects performance and products independently of the Project Director

## **Project Director**

### **Remit**

The role of the Project Director is key to the successful outcome of the project.

The Project Director will:-

- Manage the stakeholders' interests in the project, including the co-ordination of user's interests and the production and agreement of operational policies and commissioning programmes.
- Monitor the project to minimise any planning, design, construction and commissioning time and cost overruns. Provide regular progress reports and exception reports when required.
- Ensure that a specification is prepared for the role of Project Manager and that an individual or practice is appointed to perform this role that is demonstrably capable of performing it.
- Ensure that services are delivered according to the service brief/output specification, project commissioning programme and service costs identified in the Business Cases.
- Ensure that competitive arrangements are put in place for procuring professional and technical advisors deemed necessary. Recommend the appointment of individuals/practices to the Project Board or approve their appointment where allowed by delegated financial limits.
- Ensure that competitive arrangements are put in place for procurement of contractors (construction and FM) by the hubco and that the stakeholders interests are represented in the selection process.
- Ensure that a process is put in place for engaging stakeholders in the development of the service brief, design and commissioning plan for the new facility and its services.
- Ensure that the new facility and its proposed services remain affordable in the context of the business case
- Ensure that arrangements are in place for controlling and accounting for the use of the facilities for services provided by third parties.
- Act as the point of contact in all dealings with advisors, contractors, and other external organisations involved in the project and provide all decisions and directions on behalf of the Project Board, including the preparation of all reports to the Project Board.
- Be aware of the business objectives and corporate management structure as it relates to the project.
- Ensure that adequate communications channels exist between the project and stakeholders (internal and external)

- Ensure that procedures are in place to involve service providers, and service users, where appropriate, at all phases of the commissioning and mobilisation of services to be provided from the facility.
- Liaise with and formally report to the Scottish Government on contract progress.
- Ensure that the project is completed and handed over in a managed way.
- Ensure that the post project evaluation is planned and implemented and that appropriate processes are put in place for the on-going management of the services element of the contract.
- Demonstrate commitment to the project and promote the benefits which it will bring.
- Ensure that actions are taken to manage the risks to the project as identified in the risk register and any subsequent update.

## **Project Manager**

### **Remit**

The Project Manager is responsible for:-

- Liaising with the Project Director to plan and design the project.
- The day to day management of the project, including execution of a wide range of the Project Director's responsibilities and co-ordination of the Project.
- Ensuring that the project is delivered in accordance with agreed timescales and resources.
- Effective co-ordination of the project and any interdependencies
- Managing and resolving risks and other issues.
- Managing the project's budget, monitoring expenditure and costs.
- Ensuring that the delivery of products/services meets project requirements within time, budget and quality parameters.
- Managing communications with stakeholders.
- Regularly reporting progress to the Project Director.

## **Appendix C**

### **Draft Design Statement**

**DRAFT**

## **STIRLING CARE VILLAGE DESIGN STATEMENT**



**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. 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 inpatient/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 at the main entrance(s) 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 buildings there is a need to ensure DDA compliance including wheelchair user accessibility – 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.

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.



Stratheden  
Hospital,  
Waterford  
Health  
Park,  
David Walker  
Gardens

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

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

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, Maggie's Cancer Caring Centre London

## 1.6 Key Spaces

### 1.6.1 Reception/Waiting

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. 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 and sufficient area to be allocated for wheelchairs and prams in waiting areas.

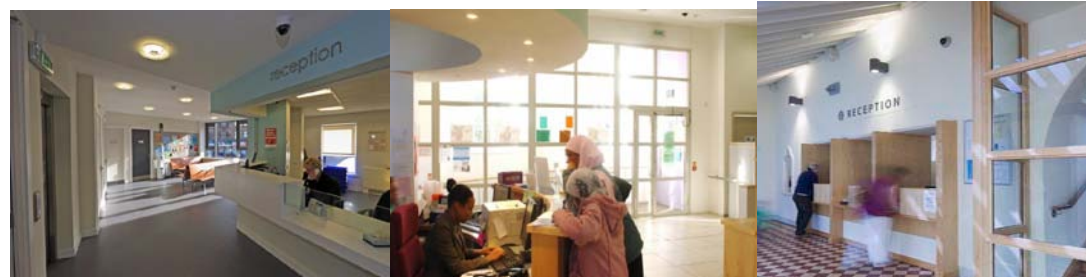
Reception areas should allow for confidential discussion when required – if necessary separate rooms/areas should be provided for this.

The design should protect confidentiality between staff and public areas.

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 distractions to be provided such as views to outside, internal/external artwork to alleviate stress.



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



### 1.6.2 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,  
Firhill Respite Centre,  
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. Inpatients to be provided with a choice of day space including a 'quiet room' without television or other entertainment.



David Walker Gardens, As above, Maggie's Cancer Caring Centre, Highlands

### 2.3.4 Staff Areas

Rest areas to be adequate in number and size, Rest areas 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. Rest areas to have access to natural daylight and pleasant views.

Access to external areas to be provided  
Changing areas to be provided.



Girvan Community Hospital, Plein Street Centre for Health, 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 and not be perceived as a ‘ghetto’ for the ill or for older people.

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 whilst 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 ‘inpatients’ 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 Strategic Projects & Property

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 Local 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.

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An Initial Agreement for a Care Village in Stirling

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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.	