NHS Ayrshire & Arran

Full Business Case for the Acute Mental Health and North Ayrshire Community Hospital

10 March 2014

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Follow us on Twitter @NHSaaa

Find us on Facebook at www.facebook.com/nhsaaa

All our publications are available in other formats

Visit our website: www.nhsaaa.net

Document Control

Programme ID	Acute Mental Health and North Ayrshire Community Hospital
Document Owner	Derek Lindsay Director of Finance NHS Ayrshire & Arran
Phone number	01292 513326
E-mail	Derek.Lindsay@aapct.scot.nhs.uk
Document Name	NHS Ayrshire & Arran **Acute Mental Health and North Ayrshire Community Hospital** Full Business Case
FBC Date	22 April 2014

Document history			
Version	**Date**	**Issued to**	**Comments**
1	20/02/14	Steering Group	
2	21/02/14	Programme Board	
3	27/02/14	Capital Planning Management Group	
4	27/02/14	Corporate Management Team	
5	27/02/14	Performance Governance Committee	

Table of Contents

Table of Appendices

Executive Summary

Executive Summary

Context

This Full Business Case (FBC) sets out proposals for the proposed Acute Mental Health Facility and North Ayrshire Community Hospital ("the Development") on the site of the Ayrshire Central Hospital campus in Irvine, North Ayrshire and the refurbishment of Elderly Mental Health wards at Ailsa Hospital, Ayr. The new build accommodation on the Ayrshire Central Hospital site will provide 206 beds within mental health and older people wards plus a range of clinical support accommodation.

The Outline Business Case Addendum (OBC) was approved by the Scottish Government Health and Social Care Directorate (SGHSCD) Capital Investment Group (CIG) on 31 May 2012.

The new build element at Ayrshire Central Hospital will be procured through the NPD model with a capital value of £46.661m. The refurbishment work at Ailsa Hospital will be procured through traditional public capital investment at a cost of £5.794m and associated fees/equipment costs of £2.246m met from the Board Capital Allocation.

The OBC developed the Initial Agreements for the Community Hospital and Acute Mental Health Services, approved by the Scottish Government in May 2008 and June 2009 respectively. The FBC confirms the need for investment, established within the OBC, building on national strategies (including "2020 Vision", "NHS Quality Strategy" and "Reshaping Care for Older People", "Mental Health Strategy") to establish the case for change.

The Development will complete the NHS Board's programme of Community Hospital investments under the Hub and Spoke model in the Estates Development Strategy.

The proposed programme will promote service and health improvement, better use of resources, as well as providing state of the art facilities to best meet the needs and aspirations of patients, staff and local communities.

As outlined within the OBC the current arrangements in place for acute mental health and older people's services present significant barriers to ensuring that these requirements are met. This impacts adversely on the patient experience, causes delays in treatment and resources to be used ineffectively. This new development will remove such barriers and thus contribute to improved patient experience.

The Acute Mental Health and North Ayrshire Community Hospital programme provides for the future investment required to ensure that these services are delivered in facilities which are in the right place and configured to best manage patient flow in the assessment and treatment of patients. As such they provide the capital solution required to most effectively support the delivery of the programme.

Case for Change

The case for change is explicit, the requirement for new build and refurbished premises will not only remove the many constraints on the quality of care due to environmental limitations but also acts as a catalyst in the quality improvement of services and service user outcomes and is based on the following key drivers:

- Responding to and managing future demographic change & epidemiology – providing facilities that will meet changing population rates within NHS Ayrshire & Arran;
- Provision of person centred, safe and effective care as well as care which is equitable, efficient and timely. This respects individuals' needs and values and ensures receipt of healthcare in an appropriate, clean and safe environment;
- Workforce, ensuring the right staff in the right place at the right time; and
- Enable the improvement of service models and ensure that NHS Ayrshire & Arran realise our clinical and investment objectives.

Future Service & Workforce requirements

For FBC all models of care have been further refined and detailed capacity planning exercises have been undertaken to determine revised requirements for the Development.

Similarly detailed workforce planning was undertaken in particular on medical, nursing, Allied Health Professionals and support services to establish the workforce requirements for the development. This took into account new ways of working, required nurse to bed ratios; application of workforce tools (within ward areas); professional judgement and the impact of single bedrooms and ward configuration. The outcome for workforce planning will be considered through the NHS Ayrshire & Arran Clinical Developments prioritisation. processes with no risk to the programme.

Confirmation of the preferred option

Following an extensive, robust option appraisal process involving many stakeholders including the public, the NHS Board approved, on November 2008, the preferred option for New build and refurbishment at Ayrshire Central Hospital and Refurbishment at Ailsa. This decision remains valid.

Financial Case

The Development is a strategically important capital investment to the NHS Board valued at £54.701m which will provide the means to deliver national and local priorities consistent with the Board's vision, objectives and clinical strategies, with an overall recurring revenue saving of around £0.2 m.

Management Case

The FBC sets out the project management arrangements including the governance arrangements, key roles, responsibilities and overall project milestones.

An overview of the change management philosophy, impact of change and change management plan is also provided. An extensive benefits realisation plan has been completed and maintained. A Risk Management Strategy has been developed and implemented across all elements of the programme.

NHS Ayrshire & Arran have worked with Scottish Futures Trust (SFT) and completed all Key Stage Reviews (KSRs) to date which have provided assurance in meeting all Scottish Government Health and Social Care Directorate (SGHSCD) requirements with regards to the programme.

This ensures there is a robust process in place for monitoring the delivery of benefits which will be used as part of the post project evaluation.

1. Introduction

1.1 Purpose

1.1.1 The purpose of this document is to present the Full Business Case (FBC) to support the proposed investment to provide a new Acute Mental Health Facility and North Ayrshire Community Hospital on the site of the Ayrshire Central Hospital campus in Irvine, North Ayrshire.

The programme will be facilitated through a mix of new build and refurbished accommodation. The new build element at Ayrshire Central Hospital will be procured through the Non Profit Distributing (NPD) model with a capital value of £46.661m. The refurbishment work at Ailsa Hospital will be procured through traditional public capital investment at a cost of £5.794m, and associated fees/equipment costs of £2.246m met from the Board's capital allocation.

1.1.2 The FBC develops the two Initial Agreements for the Community Hospital and Acute Mental Health Services, approved by the Scottish Government in May 2008 and June 2009.

1.1.3 An OBC for the Acute Mental Health and North Ayrshire Community Hospital was approved by the Scottish Government Health and Social Care Directorates in May 2012. The approval letter can be found in Appendix A.

1.1.4 The remainder of this section of the FBC provides an overview of:

- The context for the proposed investment;
- Compliance with NHS Scotland Capital Investment Guidance;
- Developments since OBC;
- Programme Governance Arrangements and Team Structure; and
- The structure and content of the FBC.

1.2 Context for the proposed investment

1.2.1 This FBC presents the context of the Board's strategy for improving the management and delivery of acute mental health and community hospital care across NHS Ayrshire and Arran.

1.2.2 The Acute Mental Health and North Ayrshire Community Hospital programme is closely aligned to service improvements which are currently supported through the following Policies and Strategies:

- Community Hospitals Strategy Refresh (2012);
- Building for Better Care (current Programme);
- NHS Ayrshire & Arran Primary Care Strategy 'Your Health: We're In It Together' (2009);
- The Healthcare Quality Strategy for NHS Scotland (2010);
- Dementia Strategy (2012);
- Mental Health Strategy for 2012-2017;
- Suicide Prevention Strategy 2013-16;
- Public Bodies (Joint Working) (Scotland) Bill (2013) (Health & Social Care Integration);
- Reshaping Care for Older People – Ten Year Vision for Joint Services (2010);
- 2020 Vision for Health and Social Care;
- Towards a Mentally Flourishing Ayrshire & Arran (2011); and
- Changing Scotland's Relationship with Alcohol (2009).

These policies and strategies are described in more detail in section 3.

1.2.3 The programme for the Development provides for the future investment to ensure that care is delivered in facilities which are in the right place and configured to a defined standard which fully meets Governance requirements.

The NHS Board recognises that workforce is a key element and has used its workforce planning and clinical prioritisation process to consider the workforce requirements out with the overarching programme investment.

1.2.4 The challenging financial outlook for the public sector for the foreseeable future will require fundamental change in the way NHS services are provided and new ways of working to achieve the Board's clinical strategies.

1.2.5 The financial case for the investment envisages significant improvements in the use of existing resources, which have contributed to the overall revenue saving, and offers the following benefits:-

- new and improved clinical pathways and outcomes;
- improved use of the estate and efficient use of resources;
- efficient clinical management and patient flows;
- improved bed utilisation and safer environment for staff and patients; and
- community benefits.

1.2.6 The foundation for these improvements has been derived from:

- significant staff participation in clinical review of processes and procedures, supported by the LEAN Continuous Improvement Programmes and Patient Safety Programmes;
- general agreement on change in admission policy from 'admit to assess' approach towards 'assess to admit' philosophy;
- improvements in workforce utilisation (right staff to be available in the right place at the right time); and
- co-location of services, general environmental improvements in terms of a more productive and motivated workforce.

1.3 Compliance with National Capital Investment Guidance

1.3.1 The FBC is consistent with the requirements of the Scottish Government Health Directorates Capital Investment Manual (SCIM) from 1st April 2009.

1.3.2 The FBC demonstrates that the investment benefits, costs and risks are identified and have been assessed and evaluated in a systematic way. It ensures that NHS Ayrshire and Arran's Board can demonstrate convincingly that the investment is economically sound and financially viable.

1.4 Developments since OBC

1.4.1 Procurement process

- Establishment of dedicated Programme Office;
- Public Consultation Exercise carried out to support the Planning Permission in Principle Application from 14 May to 3 August 2012;
- Planning Permission in Principal Approval was received on 28 January 2013 (Appendix B);
- OJEU was issued on 14 January 2013;
- A Bidders briefing day was held on 1 February 2013;
- A Short listing process was then undertaken and three Bidders were selected for the next stage of Procurement;
- Invitation To Participate in Dialogue (ITPD) Documents were issued on 5 April 2013;
- Competitive Dialogue process undertaken with three Bidders over a eight month period from April to November 2013;
- Invitation to Submit Final Tenders documents were issued on 20 November 2013;
- Evaluation process was undertaken and the outcome endorsed by the Programme Board on 5 February 2014, and subsequently approved by NHS Ayrshire & Arran;
- Various Key Stage Reviews with SFT up to and including Pre Preferred Bidder appointment which was on 14 February 2014; and
- Preferred Bidder letter issued on 18 February 2014.

Further developments following approval of the OBC include:

- There has been alternative provision of the Child and Adolescent Mental Health and the Learning Disability clinical consulting areas (outpatient activity) from the OBC, within on site accommodation
- Refresh of the bed modelling exercise using latest activity data and population projections indicated planned bed numbers remain extant;
- Extensive stakeholder group involvement;
- Detailed Analysis of the refurbishment of Ailsa Elderly Mental Health and revised the specification;
- Further refinement of clinical models of care and consideration of emergent legislation, policy, strategy and local guidelines; and
- Detailed Workforce Modelling for all clinical and non clinical workforce groups associated with the development.

1.5 Programme Governance Arrangements and Team Structure

1.5.1 A summary of the programme governance structure is provided in Figure 1 and the programme team in Figure 2 below. This is further described in the Management Case section.

Figure 1: Governance structure

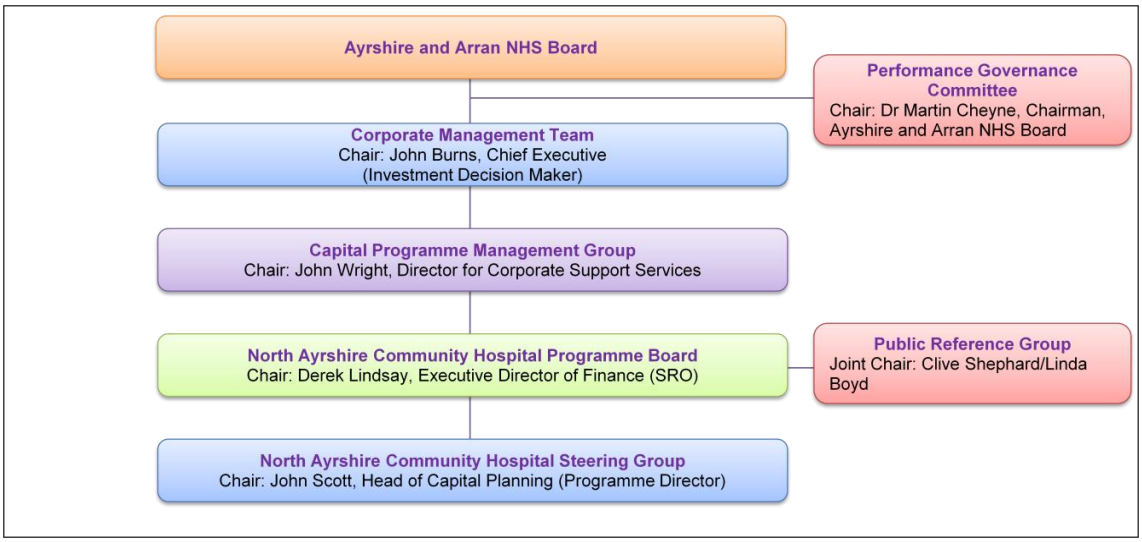
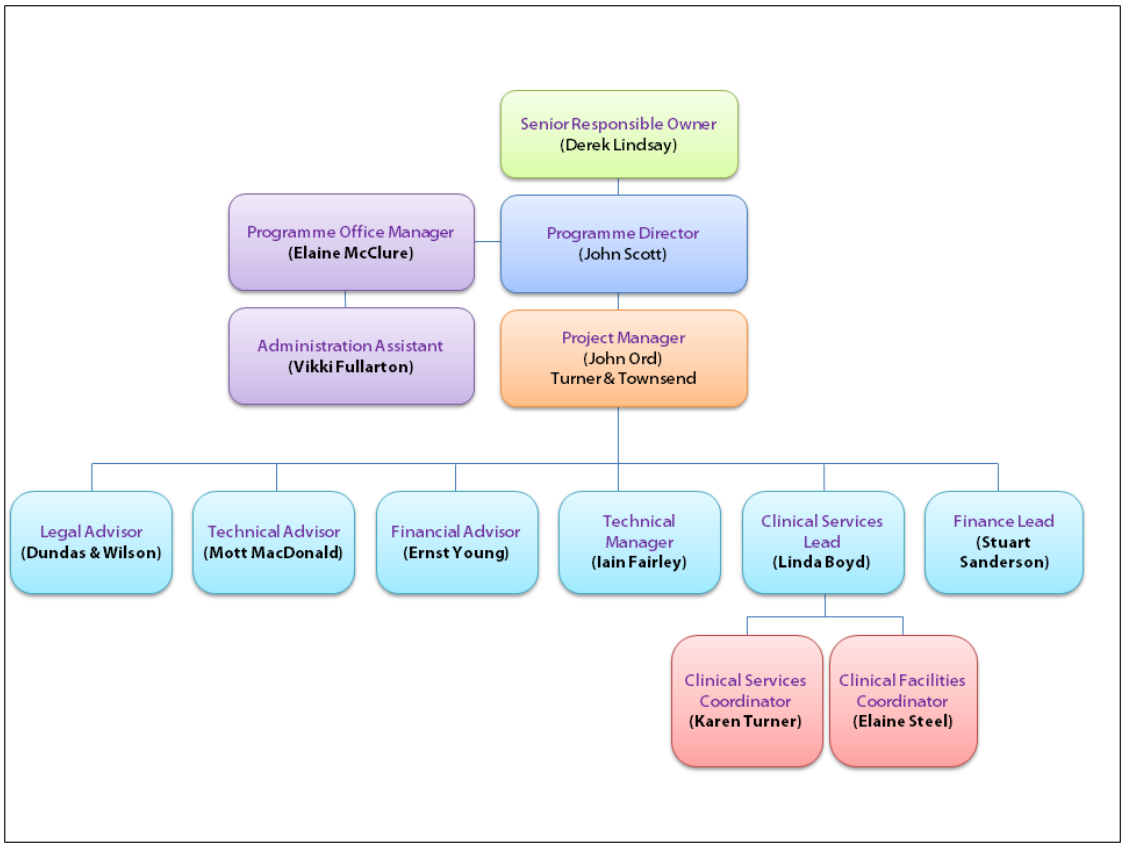


Figure 2: Programme Team structure



1.5.2 The North Ayrshire Community Hospital Programme Board is chaired by the Senior Responsible Owner who is in turn supported by an NHS Programme Director. There is also a supporting Steering Group which includes representation from stakeholder services (clinical and non-clinical).

1.5.3 The membership of the Programme Board and Steering Group is set out in Appendix C.

1.6 Structure of the Full Business Case Document

1.6.1 The structure and content of the FBC is outlined below in Figure 3. This structure reflects the '5 Case' approach as reflected in current Scottish Government Health Directorates SCIM guidance and accepted best practice in Business Case development and presentation.

Figure 3: Summary of the Full Business Case

The Strategic Case	**Section 2 - Profile of NHS Ayrshire and Arran**: provides an overview of the Board along with its purpose, commitments and values.
	Section 3 - Strategic Context: review of the case for change outlined at OBC highlighting any changes to the strategic drivers for the programme.
	Section 4 - Business Case Objectives and Scope: reviewing the business case objectives and scope outlined at OBC.
	Section 5 - Future Service Model: provides analysis of the revised bed modelling work.
	Section 6 - Workforce Planning: provides analysis of the workforce planning, including details of the approach, requirements and how the workforce change will be managed.
	Section 7 - Benefits, Risks, Constraints and Dependencies: reviews the OBC benefits and risks and updates the constraints and dependencies presented.
The Economic Case	**Section 8 – Economic Case** • Option Appraisal: reviews key variables from the option appraisal work undertaken as part of the OBC for the detailed FBC plans; • Financial Appraisal: reaffirms the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) results from the OBC financial appraisal; and • Preferred Option: reconfirms the preferred option outcome from the OBC.
The Commercial Case	**Section 9 - Negotiated Deal & Contractual Arrangement**: describes the key commercial details of the agreed contract between the Board and Project Company (Project Co) through the construction and commissioning and operation of the new facilities.
The Financial Case	**Section 10 - Financial Case**: presents a profile of the capital and revenue costs of the preferred option and the associated projected impact on the Board's income and expenditure account and balance sheet.
The Management Case	**Section 11 - Project Management & Project Implementation Timetable**: describes how the Board intends to manage the various phases of the project and sets out the proposed timetable and key milestones.

1.6.2 Appendices to the FBC are contained within a separate volume.

1.7 Further information

For further information about this Full Business Case please contact:

Derek Lindsay (Senior Responsible Owner)
Executive Director of Finance
NHS Ayrshire & Arran
Greenan House
Ailsa Hospital
Dalmellington Road
Ayr KA6 6AB

Tel: 01292 513326

or

John Scott (Programme Director)
Head of Capital Planning
NHS Ayrshire & Arran
Brunston House
Ailsa Hospital
Dalmellington Road
Ayr
KA6 6AB

Tel: 01292 513811

The Strategic Case

2.0 Profile of NHS Ayrshire & Arran

2.1 Overview

2.1.1 NHS Ayrshire and Arran covers an area of 2,500 square miles and serves a population of some 368,000, which is 7.3% of the population of Scotland. The majority of the population live in urban areas, of which Ayr (population 46,431), Kilmarnock (population 43,588) and Irvine (33,090) are the largest in the region.

2.1.2 The population varies from rural in the south, old coal mining areas in the east and industrial towns in the north. There are considerable health inequalities throughout Ayrshire and Arran – particularly in east and north Ayrshire, with an increasing number of areas of high deprivation.

2.1.3 The Board provides a range of acute, community and primary care services from a variety of locations across Ayrshire and Arran. Main sites are shown in the Figure 4 below.

Figure 4: Location of main sites in Ayrshire and Arran

2.2 NHS Ayrshire & Arran – purpose, commitment and values

2.2.1 In May 2013, NHS Ayrshire & Arran approved new purpose, commitment and values statements. These are set out within this section:

Figure 5: NHS Ayrshire & Arran purpose

"Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran"

2.2.2 The commitments are set out in the table below.

Figure 6: NHS Ayrshire & Arran commitments

Commitments	Detail
To our service users and communities	We will work together with you and your family to: • Promote and improve your health; • Improve your safety, outcomes and quality of experience while in our care; and • Live up to our customer care commitments.
To our workforce	We will work with our workforce to create an open, fair and just culture where: • We are all valued, respected and developed to be our best; • We are all informed, involved, listened to and treated fairly and consistently; and • We are all safe and are supported to improve our health and wellbeing.
To our partners	We will work together with partners to: • Improve health, prevent disease and reduce inequalities;

	• Join up our service delivery to improve outcomes; and • Make best use of our resources.

2.2.3 The values established are, “caring, safe and respectful” further details are set out in the table below.

Figure 7: NHS Ayrshire & Arran Values

Caring, Safe, Respectful	• I will show concern for others and care about the health, safety, and wellbeing of everyone I come into contact with; • I will do my job well, striving to learn and do things better, while taking responsibility for the quality, safety, and effectiveness of my actions; and • I will see everyone as an individual, be open, approachable, and treat everyone with dignity and respect.

2.3 The Development – in this context

2.3.1 Within Ayrshire & Arran, the localities of North, East and South Ayrshire have significant demographic variance and health needs. Our values require equity of health outcomes for all residents of Ayrshire & Arran. The Development in this context can deliver significant improvements in health, social care and community benefit outcomes for the residents of North Ayrshire. From an Ayrshire wide perspective the delivery of specialist mental health care in purpose built and refurbished premises will address all current constraints to provide safe, effective and quality clinical care.

3.0 Strategic context

3.1 Overview

3.1.1 The programme set out within this FBC is presented within the context of the Boards wider programme for improving the management and delivery of acute mental health and older peoples care across NHS Ayrshire and Arran.

3.1.2 The strategic context for this programme remains consistent. Planning of the proposed new development has been taken forward in line with all relevant national policy, local strategy and NHS guidance including but not limited to:

- Community Hospitals Strategy Refresh (2012);
- Building for Better Care (current Programme);
- NHS Ayrshire & Arran Primary Care Strategy 'Your Health: We're In It Together' (2009);
- The Healthcare Quality Strategy for NHS Scotland (2010);
- Dementia Strategy (2012);
- Mental Health Strategy for 2012-2017;
- Suicide Prevention Strategy 2013-16;
- Public Bodies (Joint Working) (Scotland) Bill (2013) (Health & Social Care Integration);
- Reshaping Care for Older People – Ten Year Vision for Joint Services (2010);
- 2020 Vision for Health and Social Care;
- Towards a Mentally Flourishing Ayrshire & Arran (2011); and
- Changing Scotland's Relationship with Alcohol (2009).

The relevant context for each of these strategies is summarised below.

3.2 Community Hospitals Strategy Refresh (April 2012) Developing Community Hospitals – a Strategy for Scotland', originally published in 2006

3.2.1 The Scottish Government's commitment to integrating adult health and social care, and the 'Intermediate Care Framework', will have significant impact on the care provided within and associated with the community hospital, especially the links with care home and home care support. These agendas will require local teams to 'knit' community hospitals into the fabric of local care and support services, ensuring improved outcomes for patients. The development of a community hospital within North Ayrshire will support delivery of this integrated vision.

3.3 Building for Better Care (current Programme)

3.3.1 Both the Acute Mental Health and North Ayrshire Community Hospital and Future Delivery of Front Door Services within Ayrshire & Arran (Building for Better Care) are key strategic programmes which are essentially linked. This link can be demonstrated for example by the Emergency Care Quality Improvement Programme which has particular focus on:-

- recovery of the four hour A&E waiting time target;
- recognises that Public consultations tell us that, given the option, people want to stay in their own homes for as long as possible;
- that prolonged hospital stays are not good for patients especially frail elderly patients; and
- some admissions to Acute Hospitals could be avoided, if services and support should be available closer to people's home, in their own communities or in community hospitals.

A key element of these programmes is the in-patient provision at the Acute Mental Health and North Ayrshire Community Hospital which will contribute to improved rehabilitation, recovery and re-enablement and integration with local community based services ensure that return home is as soon as possible.

3.4 NHS Ayrshire & Arran Primary Care Strategy 'Your Health: We're In It Together' approved in December 2009

3.4.1 In December 2009, the Board approved the Primary Care Strategy 'Your Health: We're In It Together'. The strategy envisages a strong local health service supporting people in their day to day lives to get the best from their health. The overall theme is one of partnership between the individual and the community with the NHS and its public sector partners. The new service model is based on shifting the balance of care, substituting traditional service models with more services delivered in the community and in community hospitals and is very much in keeping with the Board's overall strategic drive for service integration and continuity.

3.5 NHS Quality Strategy

3.5.1 The NHS Quality Strategy outlines six dimensions of Quality and is informed by what the people of Scotland said they want from their healthcare system (Caring, Compassionate, Communication, Collaboration, Clean environment, Continuity of care and Clinical excellence). From this, three Quality Ambitions were developed:

- **Safe** - There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times;
- **Person-Centred** - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making; and
- **Effective** - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

3.5.2 The Healthcare Quality Strategy for Scotland continues to be a central policy driver. The vision that this sets out for world-leading, safe, effective and person-centred healthcare services provides the context for all strategic and operational decision making within our organisation. NHS Ayrshire & Arran continue to progress our patient safety work as part of the Scottish Patient Safety Programme (SPSP) and endeavour to improve our services through our quality improvement activity.

3.5.3 Implementation of this overarching strategy prioritises the integration of services and existing strategies with the opportunities for working cohesively and effectively with the full range of primary and community care services to focus on improved quality of care, significantly improving health and wellbeing and ensuring improved pathways of care resulted in improved outcomes.

3.5.4 The development of the Acute Mental Health and Community Hospital was recognised as a focal point for the delivery of holistic, integrated services from a wide variety of care providers, but dovetailed essentially with the proposals within Building for Better Care to ensure the whole NHS estate addresses the differing needs and presentations with the specific aim of maintaining individuals in communities, close to home and when admission cannot be prevented.

3.6 Dementia Strategy (2012)

3.6.1 This Strategy recognises that estimates suggest that the number of people with dementia is set to increase significantly, with some projections indicating that there will be a 85% increase in over 85's within the next 20 years. NHS Ayrshire & Arran have responded to this anticipated growth in demand through detailed bed modelling and confirm inpatient services will be able to respond to demand when older people require an inpatient stay for either physical or mental health reasons. The Strategy also describes and refers to best practice in dementia design and dementia care and all aspects of this have been incorporated into our specification for the new development.

3.7 Mental Health Strategy for 2012-2017 and the National Suicide Reduction Strategy (Dec 2013)

3.7.1 The Mental Health strategy implementation is well embedded within Ayrshire and reviewed by the bi-annual Scottish Government Implementation visits. The development of the hospital is cognisant of the strategy commitments with a special focus on opportunities for Peer Support Workers, reduction of self harm and efficient use of inpatient estate adequately supported by community services especially Crisis Services. This is fully described in;
"Mental Health Strategy Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, NHS Ayrshire & Arran will develop an indicator or indicators of quality in community services".

3.7.2 The National Suicide Reduction Strategy 2013-16, requires a focus on inpatient safety, therefore building on the Scottish Patient Safety Programme and learning from the National Enquiry into Suicide & Homicide as well as from national and local significant incident reviews, the design requirements have incorporated this theme as a priority.

3.8 Health & Social Care Integration

3.8.1 Since the formal publication of the Public Bodies (Joint Working) (Scotland) Bill in May 2013 NHS Ayrshire and Arran and East, North and South Ayrshire Councils have agreed and approved their joint approach to integration in the creation of a Health and Social Care Partnership in each of the three local authority areas using the "body corporate" model. This includes the decision in relation to the incorporation of community hospitals including the Development.

3.8.2 The aim of the partnerships is to reduce health inequalities, improve the quality of health and social care services in each area, and to enhance the experience of patients and service users. This will be done by developing a culture which is about giving people much more choice and control, so that they can live safe, healthy lives in the community.

3.8.3 Leadership arrangements are being put in place with the appointment of a Director of Health and Social Care within each partnership, who will report jointly to the Chief Executive of NHS Ayrshire & Arran and the Chief Executive of the relevant council.

3.8.4 The health board and councils are already discussing how the partnerships will work in practice. The initial priority is to integrate services to improve outcomes for older people. However local planning will cover:

- "traditional" primary care and community services – for example, district nursing;
- services based in community facilities – for example, community hospitals;
- specialist services – for example, mental health and learning disabilities; and
- Alignment of allied health professions and children's services.

3.9 Reshaping Care for Older People – Ten Year Vision for Joint Services

3.9.1 Reshaping Care for Older People - Ten Year Vision for Joint Services sets out a high level vision, future direction of travel, as well as specific areas for action, to show how the Ayrshire services will work together to develop new models of care and support to reshape services and improve outcomes for older people, their families and carers.

3.9.2 A joint Older People's Needs Assessment was carried out to provide a comprehensive overview of the issues relating to the demographic change and issues associated with the Ayrshire & Arran's ageing population. This highlighted key factors in relation to:

- Demographic change - e.g. projecting one older person for every 2 working age people;
- Life circumstances – given increase in "solo living" services and activities focusing on overcoming social isolation and developing personal support mechanisms will become increasingly important for older people;
- Lifestyle factors – e.g. 'Future' older people, have not tended to adopt healthy lifestyles;
- Health status – rising trend in long term conditions with diagnosis earlier and patients managed better for longer;
- Use of health and social care services – e.g. Around 1 in 50 emergency admission patients have had three or more previous emergency admissions; and
- Equity and healthy ageing - Those most in need of care and services are least likely to access them.

3.9.3 In response to the needs highlighted a range of changes to services have been planned around the following themes:

- Preventative and anticipatory care e.g. an increasing proportion of older people with high level needs cared for at home in relation to the proportion in long stay hospitals or care homes;
- Sustaining independence e.g. best use is made of Telehealth and Telecare to support people within their homes;
- Effective care at times of transition e.g. home care services have a 're-enablement' focus which means encouraging confidence and independence for people who have been ill or injured;
- Care homes e.g. a change in the way that care home places are used, with a reduction in long stay care home places and an increase in the number of beds used for respite and step up/step down care; and clinicians are available to offer support to staff and residents in Care Homes; and
- Hospitals e.g. reduced 'automatic admission' to hospital for older people who attend A&E as there are safe alternatives at home. Linked to Building for Better Care Programme and this development.

3.10 The 2020 vision for health and social care

3.10.1 The 2020 vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. NHS Ayrshire & Arran will have a healthcare system where NHS Ayrshire & Arran have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment and shorter lengths of stay will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community as quickly as safely possible.

3.11 Towards a Mentally Flourishing Ayrshire & Arran (2011) (TMFAA)

3.11.1 This strategy emphasises the benefits for the population in terms of health and social outcomes by improving mental wellbeing for all. The opportunity for this Development to influence wellbeing is an important contributory factor.

3.12 Changing Scotland's Relationship with Alcohol (2009)

3.12.1 The interventions and the new model of care for Recovery that the new Addiction unit will deliver are in line with key elements of 'Changing Scotland's relationship with alcohol: A framework for action (2009)' and the 'Road to recovery: A new approach to tackling Scotland's drug problem (2008)'. In addition the new Addiction unit will support the delivery of East, North and South Ayrshire's Alcohol and Drug Partnerships (ADP's) Alcohol and Drug Strategies (2011 – 2015). The Addiction unit is also an essential component in supporting the delivery of the ADP's 'Recovery Orientated System Of Care' for individuals with alcohol and drug problems.

3.13 Conclusion

3.13.1 Following the submission of the OBC in December 2011 the Scottish Government has retained or initiated a range of policy initiatives which will change the way healthcare services are provided in Scotland, making them more responsive to patients' needs.

3.13.2 NHS Ayrshire and Arran have embraced the spirit of this national policy approach within its local development plans by shaping the way healthcare services will be provided in the future. This Acute Mental Health and Community Hospital development is at the heart of these proposals and represents a key part of the overall system for delivering high quality care to the local population.

3.13.3 NHS Ayrshire and Arran recognises the financial challenges it will face in the future and the need to ensure that the proposals can be delivered in an affordable manner whilst still delivering the key objectives of the programme.

4.0 Business Case Objectives and Scope

4.1 Overview

4.1.1 This section of the FBC sets out the business case objectives and the agreed scope of the service requires for the programme.

4.1.2 The analysis contained within this section includes:

- Confirmation of the Key Investment Objectives;
- Confirmation of the scope of the project;
- Summary of existing arrangements and the agreed service requirements;
- Issues associated with existing arrangements; and
- Conclusion.

4.2 Key Investment Objectives

4.2.1 The key investments objectives relate to the overall programme as outlined in the OBC. These remain relevant but have been refreshed for the FBC. They are shown below in Figure 8.

Figure 8: Key Investment Objectives

Key Investment Objectives
Clinical Quality: To ensure that the proposed Development provides the infrastructure for clinical services that are clinically safe, secure, effective and sustainable for at least 25 years.
Environmental Quality: To provide high quality internal & external public progression to private environments which meets the therapeutic needs and expressed expectations of patients, relatives, carers and staff. The Development will meet all relevant building standards and will provide 100% single rooms, mixed and single sex social and therapeutic accommodation as specified.
Strategic Fit/Sustainability: To provide a flexible, adaptable and sustainable property that can respond to the inevitable changes in future service demand.
Affordability/Value for Money: To provide a development that is affordable both in terms of capital and revenue.
Effectiveness and Efficiency: Maximise the use of all available resources – property, staff and financial to meet or exceed performance requirements and improve efficiency. Enable the recruitment and retention of high quality skilled staff to support the delivery of high quality patient care.
Access: To maximise access, when required, to inpatient and community services for the local population

4.2.2 As per SCIM guidance, the Investment Objectives have been reviewed to ensure they remain valid.

4.3 Project Scope

4.3.1 The proposed scope of services contained in this FBC representing The Acute Mental Health and North Ayrshire Community Hospital programme at Ayrshire Central Hospital and the refurbishment of Elderly Mental Health Wards at Ailsa Hospital include:

For the Ayrshire Central Hospital site:

4.3.2

- A main entrance with reception area, waiting space, security accommodation, administration office, cashiers area, café, retail outlet, toilets, spiritual care area and other supporting space as scheduled;
- An in-patient ambulance entrance to support the discrete admission/transferring in and out of patients on trolleys/chairs (avoiding main public thoroughfares);
- A Facilities Management entrance to support services including loading bay, goods handling area, mail room and porter's area;
- An outpatient clinic/consultation area supporting the full range of mental health and psychology-related outpatient/ consulting activity on the site (it is noted that "general out-patient consulting" will continue to occur within the existing outpatient department although there will also be a cross-over in activity terms between the two areas to ensure long-term flexibility);
- An ECT area with treatment and recovery spaces that will also be used as flexible clinical accommodation for Allied Health Professional (AHP) services and potentially other services when not required for ECT (functions changing on a sessional basis);
- A pharmacy/dispensary area which provides the base for two main elements of pharmacy service provision to the development:
    - An in-patient clinical pharmacy service to all wards on site;
    - The supply of medicines to wards and to patients on pass and on discharge from the hospital;

- A Mental Health tribunal/meeting area that is easily accessible from the main “core” of the development that will also double as meeting/out-patient group rooms when not being utilised for tribunals and that will also ideally be combined with out-patient group area to create a larger more flexible meeting area suite; and

- A staff library.

Inpatient Services

Acute Mental Health services:

In-patient ward areas arranged in clinically appropriate “clusters” around shared re-enablement and rehabilitation Centres including

- 3 x 20 bedded Adult Acute Mental Health beds in wards;
- 8 bed Intensive Psychiatric Care Unit (IPCU); and
- 8 bed Forensic Rehabilitation Unit that has the potential to become a low secure unit in future without any requirement for building work/conversion.

Mental Health Rehabilitation & Addictions Rehabilitation services:

- 30 bedded Rehabilitation unit comprised of 3 x 10 bedded sub-units; and
- 10 Addiction Rehabilitation beds with day patient attendance.

Elderly Services:

- 15 Elderly Organic Assessment (e.g. Dementia) Mental health beds;
- 15 Elderly Functional Assessment Mental Health beds;
- 30 Older people Assessment and Rehabilitation beds; and
- 30 Older people Continuing Care beds.

For the Ailsa Hospital site:

4.3.3 Ailsa Hospital in Ayr will be retained, vacated wards /departments being reused for other clinical and non clinical services. However, interior and exterior refurbishment work is required to improve the clinical functionality for the Organic Continuing Care and Assessment and the Functional Continuing Care and Assessment Patients.

Figure 9: Current Elderly Mental Health Wards at Ailsa Hospital

Ward name	Speciality
Iona/Lewis	Organic Continuing Care
Jura	Organic Continuing Care
Dunure	Organic Assessment
Clonbeith	Functional Continuing Care
Croy	Functional Assessment and Resource Centre

This work is specified and includes:

Internal

- The conversion of 16 en-suites shower rooms across 5 wards into fully dual accessible “wet room type” en-suites that are in line with those specified for the new build development;
- The creation of a distinct accessible bathroom in Iona ward;
- The creation of a distinct sluice room (dirty utility: bedpan disposal and urine test) in Lewis;
- The installation of appropriate durable, anti-slip floor coverings in all wards areas that do not currently have them;
- The creation of an accessible bathroom in Croy ward;
- The creation of additional clinical equipment storage; and
- The construction of simple conservatory areas on all wards where appropriate.

External

A condition survey has been carried out on the buildings listed above. In general the survey concludes that the overall building fabric retains its integrity, is generally in a fair condition and that any defects are rectifiable. The following works have been identified:

- Overclad the existing fascia and soffits with an insulated fascia system;
- Repair external walls and apply an insulated render system;
- Remove entrance canopies and make good;
- Replace all window head and cill flashings; and
- Minor roof repairs.

Mechanical & Electrical

A condition survey has been carried out on all mechanical plant and electrical systems for the buildings listed above. In general the survey concludes that the mechanical plant and systems have been well maintained and are in good condition. Electrical systems will require some minor upgrading, but in general are well maintained and in good condition. The following mechanical & electrical works have been identified:

- Replace existing water booster set;
- Replace Low Temperature Hot Water pipework insulation;
- Replace existing ventilation diffusers & grills;
- Strip out existing main low voltage switchboard - 25 years; and
- Replacing existing light fitting with energy efficient light fittings.

The works noted above is a excerpt from a larger brief and fully priced scope of works for the wards at Ailsa, also included within the works are:

- New Nurse Call and Staff Alarm system; and
- Controlled Door access system.

4.4 Summary of Existing Arrangements

4.4.1 The existing arrangements for the services within scope were fully detailed within the OBC; a summary is set out below.

Ailsa Hospital, Ayr

4.4.2 The mainly Victorian estate at Ailsa Hospital offers no flexibility on configuration, ward sizes etc, and the physically disparate spread of wards does not support an integrated approach to care delivery. In particular the Intensive Psychiatric Care Unit (IPCU) is of such unsuitable accommodation it fails environmental audit and other standards. It constrains the Millan principles demanded by mental health legislation and houses an unsuitable mix of forensic and acutely unwell patients.

4.4.3 Ailsa Hospital currently as the following:

- For South Locality
    - One Adult Acute Inpatient ward; and
    - Six ward/departments for Elderly Mental Health (as above).
- For all Ayrshire & Arran
    - Four adult slow stream rehabilitation (continuing care) wards;
    - One adult rehabilitation ward;
    - One Intensive psychiatric care unit;
    - A recreation therapy service that provides drop-in support, a programme of social activity and outings for inpatients and is provided by qualified nursing staff. Additional activity is provided by other professional groups such as Occupational Therapy working with other local educational establishments;
    - An industrial therapy unit which provides access to French polishing, picture framing, woodwork, joinery, gardening and dressmaking. The unit also supports service users' work placement on the campus within the hairdressers, coffee shop, recreation therapy and hotel services. The majority of people using the services live in the community and attend as work placements;
    - Occupational Therapy and Physiotherapy Departments; and
    - ECT suite – Millan Suite.

University Hospital Crosshouse

4.4.4 The two adult acute mental health inpatient wards for North and East Locality, ECT and Millan suite accommodation are located within University Hospital Crosshouse a District General Hospital opened in the 1980's. The wards are of the same configuration as the upper floor surgical and medical wards.

The wards are accessed from the main hospital circulation at first floor with 6 bedded bedrooms at first floor level and single occupancy bedrooms/offices and some day spaces at the rear at ground floor level with no access to outdoors.

There is no opportunity for patients to benefit from off ward clinical therapy or recreational facilities or to access outdoor areas in a safe, secure, dedicated landscaped space with privacy or dignity.

A rear corridor to ECT and Millan Suite has no direct observation from the wards and has an offset link to a limited access entrance with FM only roadway. This area is immediately outside the east ward and is often used for essential temporary storage or as builders' compounds and as a thoroughfare to a medical records storage shed. This area has a few paving slabs creating an unobserved, unsecure area with a picnic bench and has no garden or landscaping.

Isolated from the main mental health provision at Ailsa Hospital and of note the IPCU, these wards require additional staffing and are reliant on General Hospital or other police support in times of crisis.

4.4.5 These wards also require to accommodate the following patients in the same accommodation as acutely unwell adults:

- Adolescent patients when there is not a bed available in the regional child and adolescent unit in Glasgow;
- Inpatient detoxification in collaboration with Addiction Services; and
- Perinatal mental health patients (mother only, with conditions such as antenatal depression/postnatal depression) when there is not a bed available in the regional unit.

Ayrshire Central Hospital, Irvine

4.4.6 Ayrshire Central Hospital, a former fever hospital, consists of isolated Pavilion style wards and currently provides Physical Rehabilitation/Stroke services in two refurbished wards and an adjacent rehabilitation centre which will be retained. In addition it has two assessment wards for elderly mental health services, an older people rehabilitation ward and a continuing care ward for older people (currently decanted) which will be re provided in the new Development.

4.4.7 In the Board's Estates Strategy, the existing Pavilions which will be replaced by this Development are listed as Estate Code category C (below acceptable standards) for functional suitability and category 3 (adequate) for space utilisation.

4.4.8 Figure 10 illustrates the existing and confirmed bed numbers for the new Development:

Figure 10: Beds at OBC stage, existing and planned Bed Numbers

Speciality/Hospital	Beds in use at OBC	Existing Beds @ Feb 2014	Number of beds in new development
Mental Health			
Acute Mental Health+Detox Crosshouse Hospital	92	40 4*	3x20 beds= 60
Acute Mental Health Ailsa Hospital		20	
Slow stream Mental Health Rehabilitation (continuing care) Ailsa Hospital	30	29**	3x10 beds=30
Faster Stream Mental Health Rehab Ailsa Hospital	12	12**	
Forensic Rehabilitation/low secure Ailsa	10	10**	8
Intensive Psychiatric Care Unit Ailsa Hospital	7	7	8
Elderly Mental Health Organic Ayrshire Central Hospital	18	15	15
Elderly Mental Health Functional Ayrshire Central Hospital	18	15	15
Addictions Rehabilitation- Loudon House Ailsa Hospital	12	12*	10
Sub Total Mental Health	199	164	146
Older People			
Rehabilitation – Ayrshire Central	30	30	30
Continuing Care –Ayrshire Central	60	30	30
Sub Total Older People	90	60	60
	289	224	206
*On trajectory to achieve planned bed numbers within 2014 and ** early 2015 before planned occupation date in 2016			

The reduction in Older Peoples and Elderly Mental Health beds are supported by both the Older Peoples Strategy and the Mind your Health Strategy.

4.5 Issues associated with existing arrangements

4.5.1 Older people's and adult inpatient Mental health services at all existing sites are currently delivered in disparate buildings not fit for purpose which constrains the effectiveness, safety and efficiency of care.

Fragmentation

4.5.2 Older Peoples Services on Ayrshire Central Hospital site are delivered from a number of unconnected stand alone buildings and mental health services are in numerous buildings and sites over 20 miles apart in three directions.

Physical location

4.5.3 Mental Health services are delivered from split sites, a former Victorian asylum and two wards within a District General Hospital. There are clinical risks issues in relation to poor observation, ligature challenges, restricted external space and poor recreational facilities. Furthermore, whilst the main provision is Ailsa hospital in Ayr, the majority of the demand for mental health services comes from North and East Ayrshire.

Staffing

4.5.4 The environmental deficits of the current wards and departments have constrained the models of care provided. For instance, elements of containment and loss of opportunity for recovery and rehabilitation have emerged in the current delivery models due to these constraints.

Staff ability to work flexibly across these sites is significantly restrained and at times of unplanned events is a risk to safe and effective care.

NHS Ayrshire & Arran's commitment to improved models of care requires staff to have developed skills and practice which support and underpin these new models. Patient safety is enhanced with the clinical staff and managers' current participation in the Scottish Patient Safety Programme. Nevertheless, this requires a greater focus on staff's knowledge, practices and competencies.

Facilities

4.5.5 The design of the wards does not facilitate effective patient observation; the lack of single room accommodation and inadequate toilet facilities fail to promote dignity and privacy in the delivery of patient care and the facilities for the provision of rehabilitation are poor. There are clinical risk issues in relation to poor observation, inadequate accommodation, and infection control, lack of suitable enclosed external space, ligature risk and poor recreational facilities.

The Case for Change

4.5.6 The case for change outlined within the OBC remains valid and is based on the following key drivers outlined below:

Shifting the balance of care

4.5.7 In 2008, NHS Ayrshire & Arran agreed the future strategic direction for Acute Services and identified the need for the development of a clear, complementary vision for the future provision of local Community and Primary Care Services that would radically shift the balance of care, to provide an even greater proportion of healthcare in primary and community care settings.

Tackling inequalities

4.5.8 Inequalities in health remain a feature with those in the most disadvantaged communities having significantly more co-morbidity and higher mortality rates than the Scottish average. The gap is also increasing between those in the worst and best performing areas. Many of the worst data zones exist in North and East Ayrshire. The Development and its services will be very well placed to participate in the wider multiagency planning to tackle these inequalities.

Improving health and wellbeing

4.5.9 The development of a community hospital based in North Ayrshire is entirely in accordance with the Board's strategic vision for service change and improvement. There are already successful community hospitals in operation in Cumnock, East Ayrshire and Girvan in South Ayrshire, where staff are working together to deliver integrated, effective and efficient services for local patients. The Development will provide a geographical and organisational hub for local health service delivery in the north of the area, enabling residents to benefit from convenient, accessible services. The Development will benefit local patients living in urban settings such as Irvine and the Three Towns area of Ardrossan, Saltcoats and Stevenson in addition to those in rural communities.

The development of the community hospital in North Ayrshire also supports the Board's commitment to retaining healthcare services on the Ayrshire Central Hospital site, which was given in the NHS Ayrshire & Arran Local Health Plan, 2004-07, and retained to the present day.

The improvement of health and wellbeing for those using mental health services will be significantly improved through the planned specification of a model which enhances Recovery.

Responding to and managing future demographic change

4.5.10 The population in Ayrshire and Arran is changing; a slight reduction in the size of the overall population is expected between 2013 and 2035 (2.6%). However an analysis of the structure of the population suggests a growing ageing population with a 15.4% reduction in the working age population (those aged 16- 65). Overall the over 65 age group is expected to make up 29.7% of the population by 2035 compared to 20.7% currently. This data reflects the general trends in dependency within Scotland as shown in sources such as the Census.

The number of dependents per 100 population is projected to increase by 13.4% by 2035, of which the most significant increase is in the number of dependent pensioners, which will increase by 28.7%.

As well as an increase in the older population, the proportion of elderly people living alone is likely to increase dramatically by 2035. It is expected that 68% of the over 75 population will be living alone.

These population changes and living conditions have considerable importance when planning future services. To utilise health resources efficiently trends in the level of future patient demand for services need to be considered.

Epidemiology

4.5.11 The changes in population described above are already, and will continue to, impact on the pattern of illness and disease within Ayrshire and Arran. For health services to be effective there should be a balance of care between the prevention, diagnosis and treatment of illness and disease.

It is widely accepted that, with an increasingly elderly population, the challenge for the 21st century will be the management of chronic disease and dementia. In Scotland, findings from the 2011 Census highlighted that 54% of over 65s reported an illness or condition that limits the activities of daily living.

This figure increased to 75% in the over 85s, thereby reinforcing the link between an increasingly elderly population and the burden of chronic disease and dementia.

Long term conditions including dementia and severe and enduring mental illness are acknowledged to consume a high proportion of available healthcare resources e.g. estimated to account for 80% of all GP consultations, are twice as likely to be admitted to hospital, stay in hospital disproportionately longer and account for 60% of hospital bed days.

Whilst the Board can expect an increasing demand for healthcare from an ageing population, its effects are being exacerbated by the fact that our older people are on average less healthy than the average across Scotland. This is partially offset by the fact that generally, life expectancy in Ayrshire and Arran is improving, although at a slower rate than the Scottish average.

Provision of person centred, safe and effective care

4.5.12 The NHS Scotland Quality Strategy makes a specific reference to the need to respect individual needs and values and which demonstrate compassion, continuity, and clear communication and shared decision-making.

Furthermore it stresses that there be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Additionally it emphasises that the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

As outlined within the OBC the current arrangements in place for acute mental health and older people's services present significant barriers to ensuring that these requirements are met. This impacts adversely on the patient experience, causes delays in treatment and resources to be used ineffectively. This new development will remove such barriers and thus contribute to improved patient experience.

Workforce

4.5.13 The overall vision for the workforce is to ensure the right staff are available in the right place with the right skills and competences to deliver high quality care and services.

In order to realise this vision the workforce needs to be aligned with both service and financial plans to ensure affordability and sustainability over the long term.

The redesign and configuration of services emerging from this development is anticipated to provide the leverage of ensuring long term sustainability of services provided via reviewing roles, responsibilities and skill mix. The opportunity gained by the provision of inpatient care from a purpose built development is already resulting in increased applications for posts with candidates and increasingly citing this reason for applying.

There will be the potential to further develop new multi specialty team approaches and develop advanced practice roles. These factors are expected to help make NHS Ayrshire & Arran a more desirable employment destination and thus contribute to a reduction in the need to use temporary staffing solutions such as Medical Locums and Bank/Agency Nursing.

Workforce Planning is discussed at section 6.0.

Current configuration and nature of acute mental health and community hospital services.

4.5.14 The configuration and nature of acute mental health and older peoples services demonstrates a number of problems which mean that services are not currently delivered optimally. These include:

- Unsatisfactory integration with other services – The integration of older peoples services with Acute Secondary Care at University Hospital Crosshouse is a feature of the "Front Door" Business Case. These services require synergy to ensure adequate throughput and length of stay to ensure bed availability where and when it is needed;

- Fragmentation – Mental Health Services are fragmented over a number of sites and have limited access to AHP services and Facilities;

- Operational challenges – Unnecessary journeys and split site specialities require additional programmed time for travel and attending patients. Ensuring the right staff are in the right place when demand changes is logistically difficult especially when this occurs at short notice or out of hours when public transport is limited; and

- Physical issues – Restrictions on patients due to lack of dementia design, availability of a safe and secure environment results in unnecessary constraints such as increased observation and increased adverse events.

Whilst interior decor improvements have gone someway to improve the overall ambiance of some wards they remain institutional, constrain rehabilitation have limited or no facility to outdoor space, have no flexibility, are not welcoming nor create a sense of wellbeing, calmness or safety. Many areas do not benefit for sufficient natural sunlight and in the main are no longer compliant with current health planning guidance.

4.6 Conclusion

4.6.1 From the above analysis it is evident that the existing models of care are constrained in a number of significant ways. The changes in the structure of the population, combined with the likely future health profile, are likely to result in increased but changing demand for healthcare. It is therefore extremely unlikely that, in its current form, the model of healthcare provision in Ayrshire and Arran could continue to effectively meet the needs of the local population over the medium to long term without this Development.

4.6.2 In summary NHS Ayrshire & Arran face considerable challenges including increased pressure on budgets, increased expectations from our service users and our communities, together with the rising demands coming from demographic change. National and local strategies are fully considered and are at the heart of our business case.

4.6.3 The NHS Quality Strategy aims to put people at the heart of the health service. Related policies on Recovery, rehabilitation, re-enablement, self-management and person-centred care work to achieve the same set of outcomes as self-directed support models led by local authorities in partnership.

4.6.4 The implications of not providing a new Acute Mental Health and Community hospital are significant, in terms of outcomes for patients there remains a likelihood of adverse and significant adverse events, delayed or missed health outcomes through extended length of stay. Operational challenges particularly around managing difficult or unsafe behaviours will continue to create demand and stress on clinical staff which is difficult to address effectively or economically.

5.0 Future Service Model

5.1 Overview

5.1.1 This section of the FBC reconfirms the Model of Care developed as part of the OBC and the bed modelling presented.

5.2 Proposed Model of Care

5.2.1 Mental health promotion, the prevention and treatment of mental illness and promotion of physical wellbeing amongst those who have a mental health problem are integral components of NHS Ayrshire & Arran's Mental Health Services (MHS) proposed model of care.

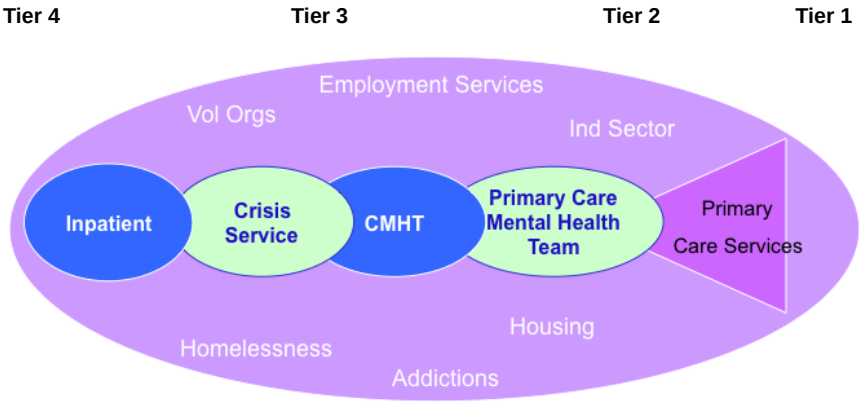
5.2.2 The Scottish Government has described its vision for Scotland where 'our flourishing mental health and mental wellbeing contributes to a healthier, wealthier, fairer, smarter, greener and safer Scotland.'

5.2.3 It also reinforces the commitments of the Mental Health Strategy (2013-17) that patient safety and efficient use of the Mental Health estate is priority.

5.2.4 Following the strategic review of local mental health services, a tiered model of care was introduced and is illustrated in Figure 11 below.

Figure 11: Multidisciplinary/multiagency services directly Interfacing with the New development

Figure 12: Tiered Model of Care – Mental Health Services



5.2.5 The 4 tier model (Figure 12), illustrates the relationship of the components of a mental health system with each other in terms of likely population need. Many more people will need the services of tier 1 compared to tier 4. The inter-linkages between the service components represents the new service models' capacity to function as an integrated network. By ensuring a whole system approach to supporting mental health, wellbeing and recovery, the majority of patients requiring a service will be seen and supported in their local community.

5.2.6 On those occasions where in-patient admission is the best option for the patient, NHS Ayrshire & Arran aims to provide an effective high-quality inpatient experience. It is essential that in-patient care is embedded as part of the integrated mental healthcare network. The new development will ensure a world class inpatient setting that is fit for purpose, meets all regulatory standards and provides a therapeutic environment. The design will be based on single sex single rooms with en-suite facilities, to provide maximum flexibility.

5.2.7 Ensuring a focus on recovery from the point of admission, inpatient care in the new development will be provided in a safe and supportive and engaging environment where choice features along with active rehabilitation, re-enablement and Recovery.

5.2.8 Admission to an acute inpatient ward will be limited to those whose care and treatment needs are assessed to necessitate an inpatient stay, and after a comprehensive assessment of all community and home based options.

5.2.9 The new model of care will focus on Recovery and rehabilitation from the point of admission, to eliminate stays beyond what is clinically required and to have inpatient services that enable recovery and enhance personal well being whilst also reducing levels of institutionalisation and stigma.

5.2.10 Discharge planning will begin at admission and be supported by a network of community based services and social, third and independent sector services, ensuring people are able to take advantage of a range of services to meet their individual needs. Accessing social, leisure and employment opportunities will be a distinct part of every discharge plan.

5.2.11 The Intensive Psychiatric Care Unit (IPCU) will be part of the development for people who, due to risk to self and/or others, require to be in a secure therapeutic environment with safe and secure access to outdoor space.

5.2.12 The model of rehabilitation for patients requiring more intensive support will be significantly improved within the new development. Patients will be supported in an environment which enables a graduated recovery, building on their strengths in managing their activities of daily living. Easy access to the activity areas and safe external grounds will promote quicker recovery and improved opportunities to engage with the community. As an outcome patient length of stay in rehabilitation will reduce and this will further impact on the improved wellbeing of patients.

5.2.13 In line with the recently published National Dementia Strategy, inpatient services for older people will be included in the development in homely settings incorporating dementia friendly design recommendations compiled by the Dementia Services Development Centre. An older people's liaison service is now in place to support people with dementia.The Audit Tool designed by Dementia Services Development Centre at the University of Stirling has been central to the design specification within the design development.

5.2.14 Low secure /forensic rehabilitation care will be designed to support safe medium term in-patient care and step down support. This will be closely supported by the Community Forensic Team and form part of an integrated community service approach to Forensic Care.

5.2.15 Palliative and end of life care will be developed albeit for infrequent use, as a core element of support provided by inpatient services, community based services and primary care teams, in consultation with partners from the Local Authorities and the voluntary sector.

5.2.16 Priority for future adaptability and flexibility has been specified on a tiered level Commencing with single room provision giving day to day flexibility of room allocation, next is ability to subdivide wards areas to have single sex areas in bedroom wings and sitting/social areas. The next level is achieved by mitigating ward adjacency and concept of swing beds that on day to day basis can be managed by the neighbouring ward to meet demand and activity variations efficiently. Further flexibility has been incorporated by having a very common but high specification for common room types to allow ward speciality to change if required with no or minor cost to adjust. More substantive change can be accommodated by a design which allows 'add on' areas or additional wards to be accommodated.

5.3 Bed modelling exercise

5.3.1 The development has been the subject of extensive and involved bed and capacity modelling exercises that have been reapplied since OBC and remain extant. These take into consideration a wide range of factors related to future activity and models of care as shown in Figure 10, Existing and confirmed bed numbers for the new Development, and Figure 9, Current Elderly Mental Health Wards at Ailsa Hospital. A copy of the report was submitted with the OBC and is available on request.

5.4 Future capacity requirements

5.4.1 It is imperative that bed capacity is regularly reassessed to account for unpredictable change; change in future strategy and policy; gains from enhanced partnership working and from updated data and trends in bed utilisation. A prioritised review of Elderly Mental Health beds at Ailsa Hospital in advance of refurbishment will be undertaken as bed utilisation has changed more substantially than projected and anticipated.

5.5 Conclusion

5.5.1 This section summarises the proposed model of care for services along with the results of the bed modelling exercise which show the associated physical capacity required to support the service to be provided within the scope of the FBC.

6.0 Workforce Planning

6.1 Overview

6.1.1 This section of the FBC describes the approach taken in relation to workforce planning and how the workforce requirements of the new service model were evaluated and modelled. Specifically the section sets out the methodology employed and the way in which all stakeholders were involved in the development of the workforce plan.

6.1.2 Consideration is given to how the new model will be introduced and how these changes will be managed in the lead up to the opening of the new Development.

6.2 Developing the workforce plan

6.2.1 Using the revised Scottish Government Workforce Planning Guidance 6 step methodology (CEL 32, 2011) as a framework methodology a multi disciplinary Workforce Planning Group was formed to develop an overarching workforce plan for every aspect of service impacted by the new development and took into consideration all non clinical and clinical services and also a range of corporate support departments. It had at its foundation the planned model of care and the new way services will be provided. Each service however was expected to interface their contribution to this workforce plan with that of their own service work plans to ensure synergy, impact analysis and corporate planning for the impact of such a large scale development on a new site and other sections or localities impacted by this relocation.

6.2.2 To develop the models the Workforce Planning Group undertook a series of workshops and analysis meetings cumulating in the development of integrated workforce plans cognisant of the dependencies and interdependencies of services. Comparing these against current staffing profiles resulted in the final workforce plans.

6.2.3 The first workshop identified all services which may be impacted and introduced the concept of integrated workforce planning. The models of care and the specification and requirements for the hospital as well as the exemplar design were described in detail to ensure a very clear understanding of the anticipated benefits and stakeholders in the development.

6.2.4 This informed position then allowed the independence or interdependence of services to be assessed using criteria to ensure the linking of services in the next phases. Skills were varied and this approach allowed both facilitation, coaching and cross fertilisation of risks, issues and solutions.

6.2.5 Issues such as TUPE were explored and confirmed as fully mitigated due to clarity around hard and soft FM and existing implementation in advance.

6.2.6 Due Governance was incorporated by ensuring the components of the workforce plan remained in the ownership of the respective Directorate and from there via their Directorate partnership fora to ensure dovetailing to assurance plans for staff governance standards. Accredited and approved Workforce tools, where available, were used and triangulated or adapted by those services which currently do not have approved tools available.

6.2.7 Leadership was achieved via co chairing of the group by the Senior Manager aligned to the North Ayrshire Community Hospital Programme Board and the Employee Director supported by Workforce Futures and Human Resources. The group reported to the Programme Board, but also to the Board's Workforce Planning Programme Board as one of its priorities.

Outcome

6.2.8 Workforce capacity was broadly identified as being sufficient with skill mix and minor adjustments within teams to progress to implementation. In Clinical services where an increase in workforce was identified it has been agreed that these will be progressed through the Boards clinical developments prioritisation mechanism with no risk to the Programme Budget. It has also been agreed that these workforce figures will continue to be refined and tested at periodic intervals and will report this via the programme boards.

6.3 Management of workforce change

6.3.1 Workforce Planning and Workforce Change in relation to the new Development is a critical success factor and has a dedicated work stream led by the Clinical Services Lead for the Programme and the Employee Director.

6.3.2 Changes in workforce have already taken into account the reduction of bed numbers from pre submission of OBC to date by 22% and in anticipation of the further reduction to the planned 206 beds. The proposed workforce plan also considers the specification for the new development (such as single bedrooms and impact of layout on walking distances.)

6.3.3 A major change programme is also required to plan and support the transition of services from three current sites. The impact of this on staff for role development, skill mix changes and shift pattern changes and location of base will be assessed and managed through the Framework for Managing Workforce change Policy in partnership with staff side colleagues.

6.3.4 The Model of care is being implemented where practical for instance in those areas where it is limited by environmental constraints mentioned earlier, this will give the opportunity to regularly refresh the workforce plan as the model is delivered, refined or improved. It is a known risk that the model cannot be fully implemented until the new development opens.

6.3.5 As part of the overall Programme a commissioning plan is being developed, the transition plan for workforce moving to the new development or remaining on the Ailsa site in the refurbished wards will be incorporated into this supported by the Programme team but led by individual Directors for their areas.

6.3.6 The Programme Communication Plan has already incorporated this phase and will support the implementation through staff newsletters, road show meetings, small group and individual meetings.

6.4 Conclusion

6.4.1 Significant workforce change is required to secure the identified benefits of the programme, but importantly many of these required changes are now being actively implemented, through linked projects of work coupled with sound Governance of workforce planning at a programme and strategic level.

7.0 Benefits, Risks, Constraints and Dependencies

7.1 Overview

7.1.1 This section of the FBC:

- Sets out the main outcomes and anticipated benefits of the programme;
- Highlights the main risks of the programme;
- Key programme constraints;
- Key programme dependencies; and
- Conclusion.

7.2 Main outcomes and benefits

7.2.1 Since the OBC, further work has been undertaken to refresh and ensure the benefits remain valid and SMART. The Benefits Realisation plan is shown in Appendix D. Supporting this an overarching Benefits Realisation Process is described in the Management Case - Section 13.0.

The benefits action plan is a summary of the full benefits realisation process in one easy to use manageable document. Its format encapsulates the following recommended features:-

- Identify and make a record of the desired benefits developed with stakeholders;
- Identify the stakeholders that will be affected by each identified benefit;
- Identify the outcomes and enablers required for each benefit realisation;
- Determine how you will measure whether a particular benefit has been realised;
- Ideally, try taking a baseline measure before the project starts, and use this as a benchmark to determine realisation of the anticipated benefit;
- Allocate responsibility for delivery of these benefits;
- Prioritise the benefits so that the most important always has the most focus. This ensures that the project makes the greatest impact; and
- Identify dates for expected delivery of the benefits.

7.3 Main Risks

7.3.1 The current Risk Register contains 65 risks.

All risks, regardless of their duration, will follow the same process which can be outlined as follows:

- Identifying the risk;
- Assessing the risk;
- Documenting the risk;
- Managing and reporting the risk; and
- Closing the risk.

Each of these process steps is detailed in the risk management strategy.

Once the likelihood and impact of a risk has been rated, each risk will then have a single score which is calculated by multiplying the likelihood and impact ratings. This single score determines whether a risk is Red, Amber or Green (RAG). The table below outlines the scores and how these relate to the RAG rating of a risk.

Risk Rating

Once the likelihood and impact of a risk has been rated, each risk will then have a single score which is calculated by multiplying the likelihood and impact ratings. This single score determines whether a risk is Red, Amber or Green (RAG). The table below outlines the scores and how these relate to the RAG rating of a risk.

			Likelihood				
			Rare	Unlikely	Possible	Likely	Almost Certain
		Score	1	2	3	4	5
Impact	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

KEY

Risk rating	Combined score	Action/Treatment
HIGH	15 – 25	Poses a serious threat. Requires immediate action to reduce/mitigate the risk.
MEDIUM	9 – 12	Poses a threat and should be pro-actively managed to reduce/mitigate the risk.
LOW	1 – 8	Poses a low threat and should continue to be monitored.

The risks described below are the amber risks (as at February 2014) identified in the Risk Register which forms part of the risk management strategy outlined at Section 14.

Amber Risks

- **Securing senior debt finance** - Although there is strong evidence to suggest that there will be a good range of funders willing to commit to the project, the risk remains that in seeking value for money funding options, e.g. a funding competition, this may incur a delay to the project. Mitigation Strategy - An agreed strategy and programme will be agreed with the Preferred Bidder to plan and mitigate any prospect of delay;
- **Surplus land and property disposal** - disposal of the surplus land and property identified as part of the estates rationalisation, is not achieved. This may not realise the capital receipt anticipated for the land and property disposal, leading to a shortfall of assumed capital funding (for the non NPD elements of the programme). Mitigation Strategy – Master Planning and market analysis carried out on surplus land and property to promote interest;
- **Investment into the overall site infrastructure** - The site wide requirements for traffic management, way finding and creating a safe environment are not delivered through lack of investment in the overall site. This may result in an increase in the risk of accidents and incidents due to the increased traffic created by the NPD project during construction and operation.
  Mitigation Strategy - Business case identifying the risks, scope of works required, costs etc to be prepared and submitted to CPMG. Short term measures to be implemented;
- **Delivery of Service Continuity Plan** - the Service Continuity Plan is not delivered to time and cost. This includes the programme of decants, demolitions, service diversions, temporary car parking, site access etc. This may have the potential to delay the commencement of the project on site, with cost implications to the Board.
  Mitigation Strategy - The Service Continuity workstream is established to plan, manage and monitor all aspects of the Plan and report progress to the Steering Group, and Programme Board. The NPD Contract is ultimately not signed until all parties are content with the position reached including enabling works;

- **Bidders challenge to process** - unsuccessful bidders could challenge the processes adopted e.g. Evaluation leading to preferred bidder appointment. This may have the potential to delay the project.
  Mitigation Strategy - Prepare constructive feedback to unsuccessful Bidders. Provide evidenced examples of weak areas. Maintain all records and documentation;
- **Unforeseen or unidentified underground services** - unforeseen or unidentified services are discovered on site when construction work starts. This may require the services to be identified and diverted as necessary leading to a delay to the works programme.
  Mitigation Strategy - All necessary diversions shall be agreed and made prior to construction phase. Known site information shall be provided to bidders. Any impact on existing services to be considered; and
- **Failure to meet programme from Preferred Bidder appointment to Financial Close** - the present target date of 13th June 2014 for Financial Close may be delayed. This may result in a delay to the programme overall with consequential financial and reputational impact to the Board.
  Mitigation Strategy - Programme period could increase to 17 weeks if Preferred Bidder appointment is made earlier. This will enable comprehensive engagement in any design improvements and sign off during Preferred Bidder period. Tight control of project plan required and early planning permission application as critical path.

7.4 Key Programme Constraints

7.4.1 The programme constraints outlined at OBC remain valid:

- Final solution must be deliverable within the available capital and revenue resources;
- Preferred solution should provide sufficient flexibility for future changes in service requirements; and
- Service continuity must be maintained during construction / refurbishment.

7.5 Programme Dependencies

7.5.1 The key programme dependencies remain valid from the OBC and include:

- The availability of adequate numbers of appropriately trained staff;
- Timely and appropriately resourced access to Allied Health Professionals; and
- The need to deliver the necessary improvements in clinical quality.

7.6 Conclusion

7.6.1 The expected outcomes and benefits as well as the main risks, key programme constraints and dependencies from this development have been identified, developed, agreed and confirmed during the development of this FBC.

The Economic Case

8.0 Economic Case

8.1 Overview

8.1.1 This section of the FBC reviews the results from the detailed appraisal undertaken at OBC stage in order to determine if there are any significant changes in the key variables impacting on the outcome.

8.2 Review of OBC Option Appraisal Results

8.2.1 The results from the OBC economic analysis determined that Option 2 – New Build Ayrshire Central and Refurbishment at Ailsa was the preferred option from the shortlisted options:-

Figure 13: OBC option appraisal results

Option	Net Present Cost £000	Equivalent Annual Cost £000	Ranking
Do Minimum	14,665	293	Reference only
New build Ayrshire Central and refurbishment Ailsa	**38,717**	**794**	**1**
New build on adjacent greenfield site and refurbishment Ailsa	92,919	1,843	2

8.2.2 The key variables reviewed at FBC stage include:-

- Capital cost of new build work at Ayrshire Central;
- Capital cost of refurbishment work at Ailsa site;
- Capital cost of associated NPD fees and equipment costs;
- Overall running costs and net revenue impact; and
- Benefits associated with the preferred option.

8.2.3 Capital Cost of New Build at Ayrshire Central

The projected capital costs at OBC stage were assessed at £50.953m. The capital value of the new build works for the NPD contract has been set by the final tender from the Preferred Bidder at £46.661m. The Preferred bidder submission is within the terms of the Construction Cost Cap ("the cap"). This covers the construction costs eligible for revenue funding support including the cost of the building, IT infrastructure, Group 1(supply and installation) and Group 2 (installation only) equipment and private sector design fees post financial close. The cap was updated at Invitation to Submit Final Tender for inflation in accordance with the revenue funding conditions. The preferred bidder was announced at the end of February 2014 following a full evaluation of the bids received).

The SFT, in setting the cap, took account of progress on the NPD project including conclusion of the competitive dialogue process, results from review of draft tenders received and outcome from key stage reviews.

There has been no significant change in the capital value of the NPD new build works at Ayrshire Central between OBC and FBC stages.

8.2.4 Capital Cost of Refurbishment Work at Ailsa Site

The projected capital costs at OBC stage were assessed at £5.963m. The capital cost of the more detailed plans at FBC stage amounts to £5.794m for the upgrading/ reconfiguration of the five Elderly Mental Health wards remaining on the Ailsa site.

This work is scheduled to be undertaken over the two financial years 2016/17 and 2017/18 from traditional public capital funding using the Framework Scotland procurement route.

These timescales have been set to commence following the transfer of the Adult Acute Mental Health Services to the new build development in the summer 2016.

There has been no significant change in the capital cost of the refurbishment work at Ailsa between OBC and FBC stages

A further review of bed requirements will be undertaken in 2014 to reaffirm longer term clinical requirements and determine whether four of five wards require to be upgraded.

8.2.5 Capital Cost of Associated NPD Fees and Equipment

The projected capital costs at OBC stage were assessed at £1.2m for specialist Adviser Fees (mainly Technical, Legal and Financial to support the NPD contract) and £1.0m for equipping the new build development mainly moveable equipment group categories 2 and 3 (balance of equipment to transfer from current use or be procured under the Board's normal replacement programme).

The updated costs at FBC stage amount to £1.246m for specialist Adviser Fees.

The moveable equipment costs have remained at £1.0m. The Equipment procurement and management will feature as part of the Commissioning strategy and implementation phase with the overall programme budget monitoring supporting the mitigation of risk.

No significant change in these cost elements has taken place.

8.2.6 Annual Running Costs and Net Revenue Impact

The annual running costs of the new facilities covering all services (clinical and non-clinical) at OBC stage were assessed at £30.357m per annum with an annual net revenue saving to the NHS Board of £0.228m (after allowing for existing running costs and other revenue contributions of £30.585m per annum).

The updated annual running costs at FBC stage have been assessed at £29.587m per annum, with an annual net revenue saving to the NHS Board of £0.199m (after allowing for existing running costs and other revenue contributions of £29.786m per annum).

Therefore no significant change in running costs or net revenue impact has taken place between OBC and FBC stages. The Financial Case (section 10.0) sets out these figures in more detail.

8.2.7 Benefits Associated with the Preferred Option

Following stakeholder consultation, the key benefits identified at OBC stage for the development together with their relationship to the dimensions of the National Quality Strategy, are shown in the table below. These remain valid and are linked to the benefits realisation plan in sections 7 and the Benefits Realisation Process in section 13.

Figure 14: List of Identified Benefits

Benefit	Description	Quality Dimension
Improved quality of clinical care including standards and clinical outcomes, helping NHS Ayrshire & Arran's healthcare services	Although there is a shift to providing more services in the community, inpatient care remains an essential component of mental health services. This development will	Patient centred Safe Equitable Timely

Benefit	Description	Quality Dimension
to go from good to great	ensure that inpatient settings are fit for purpose, meet all regulatory standards and provide a therapeutic environment.	
Implementation of current and new models of health care and the wider clinical strategy	Developing new ways of working and recognising the changing needs of the population over the longer term, should enable optimal and efficient deployment of all types of resources.	Effective Efficient
Improved access to area wide and local health services for an increased proportion the people of Ayrshire and Arran	The relocation of Mental Health In-patient Services brings these services closer to the larger population clusters in Ayrshire, and significantly closer to the majority of those people who currently use these in-patient facilities. The development offers access to improved public transport services making it easily accessible.	Equitable Effective Efficient
Maximised opportunities for partnership working and wider public involvement / engagement	Service users, carers, the public and partner organisations have been involved in the development of this site. The grouping of services on one site maximises the opportunity for volunteer involvement and for co-location of interagency staff.	Patient Centred Efficient
Supporting an improved and safer working and clinical environment	The development should provide a safe service for all patients, carers, visitors and staff. Clinical risks will be assessed, managed and minimised. The provision of services should do no harm and aim to avoid preventable adverse events.	Safe
Delivering future flexibility and functionality	Current physical estate encompasses a wide range of buildings some over 100 years old. Many of these buildings are used to deliver services / fulfil functions which they were not designed for. The nature of the older buildings is such that they do not lend themselves to financially viable physical alteration and therefore service development and	Effective Efficient

Benefit	Description	Quality Dimension
	advancement is at risk of being repressed by these limitations. Moving to a new development which has “future-proofing” and flexibility as a key built in function will significantly reduce obstacles and barriers to progress.	
Making more efficient and effective use of resources	The consolidation of the majority of In-patient services on one site offers the opportunity to make more efficient use of resources in several ways. For Nursing and Medical Staff economies may be achieved through the increased flexibility of a larger staff group on a single site allowing opportunities for redeployment of staff on a shift by shift basis without reducing the number of staff on duty on site at any one time, further reducing the need for bank or overtime. Purpose built, fit for purpose modern buildings will allow for more efficient and effective cleaning regimes improving hygiene standards without increasing expenditure. Other services and partners will gain by reducing the need, time and expense currently encountered whilst delivering their services over multiple, geographically distant sites. For example the delivery of Social Work and associated services for Mental Health Adult Inpatients will be focused on a single site.	Effective Efficient
Supporting the delivery of all current national local and future strategies, policies and targets e.g. “having the right care in the right place at the right time”	The new development will take into account where applicable, the national, local and future strategies.	Effective
Assisting in the delivery/ provision of NHS Ayrshire & Arran published values	The sustainable future - mission, vision, values and objectives for NHS Ayrshire & Arran will drive continuous improvements in health and the quality of services, especially around patient safety,	Patient centred Effectiveness Sustainable Equitable

Benefit	Description	Quality Dimension
	person centredness and clinical effectiveness, while controlling costs within the development.	
Minimising the risk of healthcare acquired infections (HAI)	Services are currently provided in a variety of settings, many in older building, the fabric of which is deteriorating and is difficult and costly to maintain. Many of these buildings used for clinical care present significant challenges to housekeeping and cleanliness (High Ceilings, exposed pipework, unsealed floors etc). The provision of a new, purpose built development, built to modern standards, would allow for significant improvements in cleanliness standards. Current in-patient care is often delivered in multi occupant bedrooms, the new build would provide single bed accommodation for all patients, a standard which cannot be realistically or financially achieved within the current estate.	Safe
Supporting the aims and objectives of the Capital Plan/Estates Strategy and wider environmental agenda	The requirement to achieve a BREEAM Healthcare very good rating is integral to the business case process. The new development will reduce heating consumption/volume and carbon emissions.	Effective Efficient
Bringing an end to institutional living and ensuring that the mental health stigma associated with existing facilities does not transfer to the new development	The provision of modern accommodation and facilities coupled with a move from multiple occupancy to single occupancy will assist in completing the move away from institutional living. In tandem with national campaigns (See Me) the relocation of inpatient services to a new purpose built hospital will reduce stigma by allowing the focus of mental Health Care in Ayrshire to move away from Ailsa Hospital and the negative historical associations it has within Ayrshire.	Patient centred Safe

Benefit	Description	Quality Dimension
Improving physical and mental wellbeing	The new development will deliver better outcomes for patients through the improvement of physical and mental health and wellbeing. Co-location of services which support patient pathways will improve service access times and communication between services. This will enable earlier intervention and treatment within an integrated delivery structure.	Patient centred Equitable Effective Timely

These benefits have been reinforced by the further stakeholder consultation as part of the detailed planning and further work on benefit realisation at FBC stage.

As required by SFT Value for Money Guidance the Board has completed a Qualitative assessment of value for money. This confirmed that the project is considered viable, desirable and achievable. The detailed Value for Money Assessment is contained within Appendix E.

8.3 Conclusion

8.3.1 Following a robust option appraisal process involving a wide range of stakeholders at OBC stage, the NHS Board determined that its preferred option was Option 2 – New Build at Ayrshire Central using NPD and Refurbishment of retained wards at Ailsa Hospital using public capital funding.

8.3.2 This decision has been further reinforced by the detailed plans at FBC stage which have identified no significant change in the planned costs/benefits and validated the outcome.

8.3.3 The preferred option maximises the overall revenue savings to the NHS Board and provides the optimal value for money solution whilst also addressing key clinical requirements covering both local and national priorities.

8.3.4 Further supporting information is shown within the appendices in relation to: Final schedule of accommodation (Appendix F), drawings (Appendix G); and Equality Diversity Impact Assessment (Appendix H).

8.3.5 Subsequent sections of the FBC provide details on the financial case and the proposed procurement route for the work programme, as well as the supporting arrangements and project plan.

The Commercial Case

9.0 Negotiated Deal and Contractual Arrangements

9.1 Overview

9.1.1 This section describes the key commercial details of the agreed contract between NHS Ayrshire and Arran and the Preferred Bidder for the Development. The remainder of the Programme for Ailsa Refurbishment will be procured using Traditional Public Capital funds, ear marked for this purpose.

9.1.2 NHS Ayrshire & Arran received correspondence from the Acting Director-General Health & Social Care and Chief Executive NHS Scotland dated 15 July 2011. This advised that the programme would be supported through the programme of revenue financed investment through the Non Profit Distributing (NPD) model.

9.1.3 This section outlines the commercial transaction that Preferred Bidder and the Board will be asked to sign up to and serves to communicate the following:

- Agreed scope of services;
- Agreed risk allocation;
- Agreed payment mechanism;
- Key contractual clauses;
- Personnel implications (TUPE);
- Agreed Procurement Strategy;
- Agreed implementation timescales; and
- Conclusion.

9.2 Agreed scope of services

9.2.1 A description of the services to be included in the Acute Mental Health and North Ayrshire Community Hospital project is detailed in the Invitation to Submit Final Tender (ISFT) which is available on request.

9.2.2 The programme will be delivered by a Project Co (a non recourse vehicle funded from a combination of senior and subordinate debt underpinned by a 25 year service concession contract).

9.2.3 In essence Project Co will be responsible for providing all aspects of design, construction, ongoing facilities management (hard maintenance services and lifecycle replacement of components) and finance throughout the course of the project term other than a small number of exceptions as discussed below.

9.2.4 Soft facilities management services (such as domestic, catering, portering) are excluded from the Project Agreement with Project Co and these services will be provided by NHS Ayrshire & Arran.

9.2.5 Group 1 items of equipment, which are generally large items of permanently installed plant or equipment, will be supplied, installed, maintained and replaced by Project Co throughout the project term.

9.2.6 Group 2 items of equipment, which are items of equipment having implications in respect of space, construction and engineering services, will be supplied by NHS Ayrshire & Arran, installed by Project Co, and maintained by NHS Ayrshire & Arran.

9.2.7 Group 3 items of equipment are supplied, installed, maintained and replaced by NHS Ayrshire & Arran.

9.2.8 The responsibility and interface of equipment and soft FM in the operational development is a key consideration of the service provision. To facilitate this, an 'Equipment Responsibility Matrix' has been prepared, detailing all equipment by description, group reference, location and responsibility between NHS Ayrshire & Arran and Project Co in terms of supply, installation, maintenance and replacement over the course of the operational period. To facilitate joint working arrangements between NHS Ayrshire & Arran and the hard FM services provider an 'Interface Responsibility Matrix' will articulate responsibility at a practical operational level and supplements the Project Agreement.

9.3 Agreed Risk Allocation

9.3.1 This section provides details of how the associated risks have been apportioned between the Board and Project Co. It also outlines the process used for identifying, assessing and apportioning the programme specific risks.

9.3.2 The general principle is to ensure that the responsibility for risks should rest with "the party best able to manage them", subject to value for money.

9.3.3 The table below outlines the allocation of responsibility for key risk areas.

9.3.4 A key feature of the NPD model is the transfer of inherent construction and operational risk to the private sector that traditionally would be carried by the public sector. Figure 16 below outlines ownership of known key risks.

Figure 16: Ownership of known key risks

	Risk Description	**Allocation**		
		Public	**Private**	**Shared**
1.	Design risk		√	
2.	Construction and development risk		√	
3.	Transitional and implementation risk		√	
4.	Availability and performance risk		√	
5.	Operating risk			√
6.	Variability or revenue risks			√
7.	Termination risks			√
8.	Technology and obsolescence risks		√	
9.	Control risks	√		
10.	Residual value risks	√		
11.	Financing risks		√	
12.	Legislative risks			√
13.	Sustainability risks			√

9.3.5 Design risk sits with Project Co subject to the Project Agreement. For example, agreed derogations identified within the Authority's Construction Requirements and on-going Authority's Maintenance Obligations during operation may give Project Co relief on certain designed components.

9.3.6 Construction and development risk sits with Project Co subject to the Project Agreement. For example, a small number of delay and compensation events could entitle Project Co to compensation if the events materialised and this would be reflected in a revised Annual Service Payment calculation.

9.3.7 Transition and implementation risk sits with Project Co subject to compliance with the Authority's Requirements and agreed commissioning timetable.

9.3.8 Availability and performance risk sits with Project Co subject to the Project Agreement. For example, availability or performance failures that arise as a result of an excusing clause could give Project Co relief from payment deduction.

9.3.9 Operating risk is a shared risk subject to NHS Ayrshire & Arran and Project Co's responsibility under the Project Agreement and joint working arrangements within operational functionality.

9.3.10 Variability of revenue risk is a shared risk subject to adjustments of the Annual Service Payment under the Project Agreement. In addition NHS Ayrshire & Arran are responsible for a number of pass through utility costs such as energy usage and direct costs such as local authority business rates, all of which are subject to different factors such as indexation.

9.3.11 Termination risk is a shared risk within the Project Agreement with both parties being subject to events of default that can trigger termination. In addition NHS A&A have an additional right of voluntary termination subject to the Project Agreement.

9.3.12 Technology and obsolescence risk predominantly sits with Project Co however NHS Ayrshire & Arran could be exposed through specification and derogation within the Authority's Construction Requirements, obsolescence through service change during the period of functional operation and relevant or discriminatory changes in law under the Project Agreement.

9.3.13 Control risks sit with NHS Ayrshire & Arran subject to the Project Agreement.

9.3.14 Residual value risks sits with NHS Ayrshire & Arran.

9.3.15 Financing risks predominantly sit with Project Co subject to the Project Agreement: however relevant changes in law, compensation events that compensate Project Co and changes under the Project Agreement all may give rise to obligation on NHS Ayrshire & Arran to provide additional funding. Authority Voluntary Termination may also bring an element of reverse risk transfer due to aspects of the funding arrangement with the funder.

9.3.16 Legislative risks are shared subject to the Project Agreement. Whilst Project Co is responsible to comply with all laws and consents, the occurrence of relevant changes in law as defined in the Project Agreement can give rise to compensation to Project Co.

9.3.17 Sustainability risks are proportionately shared subject to the Project Agreement. Project Co is obliged to comply with the Authority's Requirements in terms of sustainable design and construction, which includes achieving a Building Research Establishment Environmental Assessment Methodology (BREEAM) overall score of 'Very Good', and an 'Excellent' level of performance for the credit pertaining to Reduction in CO_2 Emissions, which sets the Energy Performance Target for the Facilities. Project Co is further obligated to perform tests on completion to demonstrate that its design and construction meets the Authority's Energy Performance Target, and is also required to ensure that these standards are continually upheld by ensuring energy efficient operation of Plant in line with an agreed Energy Strategy, in part through maintenance and lifecycle of hard FM components. However, NHS Ayrshire & Arran ultimately carries the operational volume and price risk relating to the actual operating energy and Utilities consumption of the Facilities.

9.4 Agreed Payment Mechanism

9.4.1 The payment mechanism follows standard form drafting, with deductions from the annual service payment for availability and performance failures.

9.5 Key Contractual Clauses

9.5.1 The draft NPD Project Agreement reflects SFT's Standard Form Project Agreement, with additional project specific amendments made to the Project Agreement including amendments relating to lifecycle, TUPE, insurance, community benefits and the payment mechanism agreed by SFT.

9.5.2 During the Dialogue Period, the Preferred Bidder had the opportunity to discuss and propose further changes to the NPD Project Agreement. As a result of this process, a short table of comments was agreed to by NHS Ayrshire & Arran and approved by SFT. Following close of the Dialogue Period, only fine tuning and clarification issues are able to be considered by NHS Ayrshire & Arran and any issues not raised by the Preferred Bidder during the Dialogue Period are not able to be considered by NHS Ayrshire & Arran if they involved changes to the basic features of the Preferred Bidder's Final Tender submission or the Project which are likely to distort competition or have a discriminatory effect.

9.6 Personnel Implications (TUPE)

9.6.1 No staff will transfer and therefore the alternative standard contract provisions in relation to employee transfer (TUPE) will not come into effect.

9.7 Agreed Procurement Strategy

9.7.1 The procurement strategy for the Acute Mental Health and North Ayrshire Community Hospital project has followed the NPD procurement route.

9.7.2 NHS Ayrshire & Arran has made the following key appointments for the provision of advisor support for the Revenue Funded Accommodation Non-Profit Distributing (NPD) project. This team advise on the project from procurement of the Project Co through to completion of construction works and commissioning:

- Technical (Including all design disciplines);
- Legal; and
- Financial.

9.7.3 The preferred option is being procured through the Revenue Funded Accommodation Non-Profit Distributing (NPD) procurement route. The Board will appoint its advisors and the private sector Project Company that will design, finance, build, and operate (in regard to Hard Facilities Management) the new development.

9.7.4 To maximise the value of the development work already undertaken during the Frameworks Scotland and to achieve the programme timetable, the Board maintained the Healthcare Planner and Cost Advisor appointments. These appointments ensured the delivery of the Exemplar Design and associated costs for the OBC. The Programme Team ensured that this work aligned with the requirements and was adopted by the Technical Advisor when appointed.

9.7.5 The NPD model was developed and introduced as an alternative to, and has since superseded in Scotland, the traditional private finance initiative or Private Finance Initiative (PFI) and Public Private Project (PPP) models and is defined by the broad core principles of:

- Enhanced stakeholder involvement in the management of projects;
- No dividend bearing equity; and
- Capped private sector returns.

9.7.6 The NPD model retains the benefits of traditional PFI and PPP structures, such as:

- Optimum risk allocation;
- Whole-life costing;
- Maximised design efficiencies;
- Robust programming of lifecycle maintenance and facilities management;
- Performance-based payments to the private sector;
- Single point delivery system, reducing interface risk for the public sector client; and
- Improved service provision.

and also produces the following additional benefits:

- Capped returns ensure that a “normal” level of investment return is made by the private sector and that these returns are transparent;
- Excess profits or surpluses generated by the Project Company are returned at the discretion of the Public Interest Director; and
- The public interest is represented in the governance of the NPD structure, which increases transparency and accountability and facilitates a more pro-active and stable partnership between public and private sector parties.

9.7.7 Following appointment of Technical, Legal, and Financial Advisors the Project Team carried out the procurement of the private sector provider Project Company. A high level initial programme to Financial Close was compiled and is included at Appendix I. The key milestones were:

- Official Journal of the European Union (OJEU) Notice;
- Pre-Qualification Questionnaire (PQQ) and Memorandum of Information (MOI) ;
- Select Participants;
- Invitation to Participate in Dialogue (ITPD);
- Competitive Dialogue period;
- Invitation to Submit Final Tender (ISFT);
- Final Tender Submission;
- Evaluation of Tenders;
- Selection of Preferred Bidder (PB);
- Award of Contract; and
- Complete Full/ Final Business Case (FBC).

9.7.8 The selection process adhered to fair and equitable treatment of bidders to realise and select the most economically advantageous tender.

9.7.9 Annual Service Payments (Unitary Charge) to Project Co will only commence when the development is made operational and will be managed and regulated by means of the payment mechanism that will protect the Board (by deductions from payment) if there are failures in availability or performance.

9.7.10 In regard to the existing retained estate, refurbishment works are not appropriate to be included in and will not form part of the NPD procurement but will be procured separately as capital works.

9.8 Agreed Implementation Timescales

9.8.1 The Acute Mental Health and North Ayrshire Community Hospital OBC was approved by CIG at its meeting on May 2012.

9.8.2 The programme for delivery of the project is as follows:

Figure 16: Programme Delivery

Activity	Timescale
OBC Approval	31/05/2012
FBC Formal Consideration by NHS Board	31/03/2014
FBC Formal Consideration by CIG SGHSCD	22/04/2014
Pre-Financial Close KSR Approval	June 2014
Financial Close	13/06/2014
Start on site	July 2014
Final Business Case to NHS Ayrshire & Arran Board (in the form of an Addendum)	30/06/2014
Final Business Case to CIG SGHSCD (in the form of an Addendum)	26/08/2014
Completion/Handover	March 2016
Project Co FM Service Commencement	March 2016
Project Co FM Service Completion	March 2041

9.9 Conclusion

9.9.1 In January 2013 NHS Ayrshire & Arran published a contract notice on the Official Journal of the European Union (Ref: 2013/S012-015259). Pre qualification submissions were received in March 2013 from the following six applicants:

- Balfour Beatty;
- Eglinton Care;
- BAM;
- Interserve Kajima;
- Prospect Healthcare; and
- You in Mind.

Following a detailed review the Board shortlist three applicants to continue in the project:

- Balfour Beatty;
- Eglinton Care (named changed to Enhanced Care); and
- You in Mind.

A copy of the Evaluation Report on Short-Listing of Bidding Consortia approved by the Programme Board is included as Appendix J.

The Invitation To Participate in Dialogue was issued in April 2013.

During the dialogue period the structure of the You in Mind consortium changed. Kajima Partnerships Limited replaces Bilfinger Project Investments as a provider of 80% of the junior debt. The PQQ test was updated to reflect this change and the consortium continued to pass.

Following a detailed dialogue period the Invitation to Submit Final Tenders invited each bidder to submit final proposals on 16 December 2013.

A detailed evaluation was undertaken, this resulted in the selection of Balfour Beatty as the most economically advantageous tender.

The three Final Tender Legal Submissions were evaluated by Dundas & Wilson and they provided Final Legal Evaluation Reports to the Board in connection with each of the three submissions. Dundas & Wilson's recommendation to the Board was to award each of the three Bidders with a 'pass' for the purposes of the Final Tender Legal Submissions.

A copy of the Financial Evaluation of Final Tenders and selection of the Preferred Bidder approved by the Programme Board is included as Appendix K with details of the key elements of Preferred Bidder Funding Structure contained in Appendix L.

The Financial Case

10.0 The Financial Case

10.1 Overview

10.1.1 The financial case considers the overall affordability of the preferred option based on the overall Capital and Revenue costs and impact on NHS Board's Income and Expenditure Account and Balance Sheet.

10.2 Background

10.2.1 The Outline Business Case made the case for long lasting/sustainable improvements in clinical services to be introduced by the NHS Board in a cost effective manner. The Full Business Case confirms this position.

10.2.2 The investment in the Acute Mental Health and North Ayrshire Community Hospital will enable significant improvements in Mental Health and Other Services to be realised from new state-of-the-art facilities with 100% single room provision; introduced at no additional cost to the NHS Board through better use of existing resources and estate rationalisation measures in line with its Estates Development Strategy.

10.2.3 The foundation for this outcome remains the significant staff and stakeholder participation in the planning for the new hospital, the reduction in the bed requirements confirmed from the bed modelling as part of the move to more effective care in the community, improvements in clinical and other staff utilisation through a more productive workforce and the savings from the associated estate rationalisation.

10.3 Capital Costs and Funding

10.3.1 The Stage 1 Capital Costs at Outline Business Case were identified at £59.116m for the mixture of Non Profit Distribution (NPD) model for the new build elements (£50.953m capital value) / traditional public capital funding for improvement elements at Ailsa (£5.962m), plus fees and equipment (£2.2m).

10.3.2 The Stage 2 Capital Costs from the detailed plans at Full Business Case are projected at £54.701m (new build elements under the NPD capital value £46.661m as per Preferred Bidder / traditional public capital funding for premises improvement costs of £5.794m for services remaining at Ailsa site plus associated fees and equipment capital costs of £2.246m). Figure 17 details the Capital Costs Summary.

Figure 17: Capital Costs Summary

Element	NPD New Build Capital Value (£)	SGHSCD Improvement Works Public Capital Funding (£)	NHSAA Fees/ Equipment Public Capital Funding (£)	Total (£)
Building Costs: New Build ACH	46,661,000	-	-	46,661,000
Building Costs: Improvement Work Ailsa	-	4,828,333	-	4,828,333
Furniture and Equipment	-	-	833,333	833,333
Advisor Fees (Legal/Financial/Technical etc)	-	-	1,246,000	1,246,000
VAT	-	965,667	166,667	1,132,333
Non Value Adding Elements	-	-	-	-
Total	46,661,000	**5,794,000**	**2,246,000**	**54,701,000**

10.3.3 The key elements of the NPD funding structure (Appendix L), analysis of final tenders received from three bidding consortia (Appendix K) and terms of award to Preferred Bidder, are contained within Appendix M together with a letter from Ernst Young LLP, the Board's Financial Advisers, outlining the work they have conducted to ensure the Board has met all due diligence requirements (Appendix N). This result has been achieved following an extensive period of competitive dialogue with the three bidding consortia. Details on the associated Annual Services Payment / Unitary Charge are highlighted in section 10.5.

10.3.4 Traditional public capital funding of £5.794m is to be provided by Scottish Government to cover the cost of improvements the following wards / departments remaining at Ailsa Hospital :-

Figure 18 : Capital costs of improvements to premises for services remaining at Ailsa site

Ward/Department	Cost of refurbishment works (£)	Fee costs including Planning Approval (£)	VAT costs net of relief (£)	Optimism Bias (4%) (£)	Total Capital Costs (£)
Iona/Lewis	643,559	130,133	133,538	32,178	939,408
Jura	841,512	190,376	174,614	42,076	1,248,578
Dunure	625,000	126,625	129,688	31,250	912,563
Clonbeith	748,000	172,702	155,210	37,400	1,113,312
Croy/Resource Centre	564,000	118,136	118,440	28,200	828,776
Decant	459,850	123,665	98,868	68,978	751,361
Total	**3,881,921**	**861,637**	**810,358**	**240,082**	**5,793,998**

10.3.5 Most of the capital resources to cover these costs of improvements and the source for the public capital funding from SGHSCD, is provided by the following capital receipts from the planned estate rationalisation measures in the Board's Asset Disposal Programme:-

Figure 19: Summary of capital receipts

Location	2012/13 (£)	2013/14 (£)	2014/15 (£)	2015/16 (£)	2016/17 (£)	2017/18 (£)	Total (£)
ACH Surplus Land	-	150,000	-	1,000,000	1,500,000	1,350,000	4,000,000
Seafield Hospital	-	-	500,000	-	-	-	500,000
Holmhead Hospital	-	-	-	-	-	80,000	80,000
Strathdoon House	-	-	450,000	-	-	-	450,000
Hartfield House	435,000	-	-	-	-	-	435,000
Nightingale House	-	-	250,000	-	-	-	250,000
Westmount	-	245,000	-	-	-	-	245,000
Davidson Cottage Hospital	-	-	50,000	-	-	-	50,000
Patna Clinic	40,000	-	-	-	-	-	40,000
Crosshouse Clinic	-	23,000	-	-	-	-	23,000
Total	**475,000**	**418,000**	**1,250,000**	**1,000,000**	**1,500,000**	**1,430,000**	**6,073,000**

10.3.6 An additional benefit from the Development investments is significant elements of backlog maintenance costs at Ayrshire Central will be avoided through the new build and demolition programmes. This will reduce the total backlog of £19m by around £6.8m (36%).

10.4 Capital Investment Plan

10.4.1 A copy of the Board's latest Capital Investment Plan (CIP) approved as part of the Local Delivery Plan is included at Appendix O.

10.4.2 This covers the planned Development investments and the projected capital receipts from the asset disposal programme.

10.4.3 The CIP identifies the projected cash flow for the premises improvements / fee elements subject to public capital funding. These projections have been agreed with SGHSCD as part of the approval of the Local Delivery Plan.

10.4.4 The CIP also highlights that the NHS Board will this year complete a programme of enabling works at the Ayrshire Central site to facilitate the investment. This programme has included capital investments totalling just over £17m over the last five years. A summary of the main service improvements already effected is highlighted in Figure 20 below :-

Figure 20: Capital investment on Ayrshire Central site over the period 2009/10 to 2013/14

Details	**Capital Cost** ***(£000)***	
New Dental Department	531	(complete 09/10)
External refurbishment - Horseshoe Building	2,586	(complete 09/10)
New Kitchen/Dining Room	3,254	(complete 09/10)
New Sexual Health Premises	1,525	(complete 09/10)
Extension to Outpatient Department	1,436	(complete 10/11)
New Central Decontamination Unit (CDU)	5,294	(complete 10/11)
Refurbishment work to Pavilions 10/11	178	(complete 10/11)
Site Continuity Plan - CAMHS/LDS	647	(complete 13/14)
Site Continuity Plan – Car Park / Roads	300	(14/15 to 16/17)
Site Continuity Plan – Other elements	1,357	(complete 13/14)
Total	**£17,108**	

10.5 NPD Annual Service Payment (Unitary Charge)

10.5.1 A monthly service payment (unitary charge) will be paid for the provision of facilities, which will be met by the NHS Board from the revenue budget. The Board will be responsible for meeting the Hard Facilities Management Services and 50% of the lifecycle maintenance elements. The Scottish Government will meet the remaining elements of the annual service payment via revenue support funding.

10.5.2 The cost of service payments for the first full year of operation split between the element funded by the Board and the element funded by Scottish Government is highlighted in Figure 21 below. The Board funded element is subject to an annual indexation adjustment. There are also a number of pass through costs mainly relating to utilities which are funded by the Board.

Figure 21: Funding of Annual Cost of Service Payments

	2016/17 **£000**
Board Funded (Hard FM/50% Lifecycle)	511
SGHSCD Funded (balance)	4,594
Total Annual Service Payment	5,105

10.6 Revenue impact on Income & Expenditure Account and Affordability

10.6.1 The projected recurring revenue implications resulting from this investment is highlighted in Figure 22 below :-

Figure 22: Recurring Revenue Implications

Summary		**OBC Cost / (Saving) £**	**FBC Cost / (Saving) £**
Direct Cost of Re-Provision of Services			
-	Clinical Service Costs	19,631,453	19,576,419
-	Non Clinical Service Costs	10,725,278	10,010,984
Less	Current Clinical Service Costs	(20,220,657)	(20,165,419)
Less	Current Non-Clinical Service Costs	(4,885,363)	(4,872,846)
Less	NPD Funding provided by SGHSCD	(5,327,150)	(4,594,500)
Less	Estate Rationalization Savings	(151,773)	(154,110)
Net Revenue Cost / (Saving)		**(228,171)**	**(199,472)**

10.6.2 The doubling of non-clinical service costs are primarily due to the introduction of a unitary charge of £5.1m, but also depreciation costs more than double from £595,000 to £1.356m for the ‘ on-balance sheet ‘ accounting treatment of the asset. Further detail on the revenue costs are contained in Appendix P.

10.6.3 The associated estate rationalisation measures have increased the overall recurring revenue saving to £0.199m, which has been covered in the medium term Financial Plan (this updates the savings of £0.228m highlighted in the OBC).

10.6.4 The following non-recurring revenue costs have also been provided for in the medium term Financial Plan :-

Excess travel costs (annual costs up to 4 years) £101,863

Residual running costs of vacated property at Ailsa/Crosshouse (property related annual running costs prior to re-use or demolition as appropriate) £622,207

10.7 Impact on Balance Sheet

10.7.1 The Valuers have reviewed the plans and identified that life expectancy for the new build elements will be 50 years with 25 years for refurbished elements.

10.7.2 The Valuers have agreed that the fair valuation for the NPD on-balance sheet valuation of the asset will equate to the overall cost of construction. The non-value adding elements have been assessed at £3.456m (mainly fees from the previous Framework Scotland contract). These non-value adding fee costs are being recognised as a DEL non-cash impairment in 2013/14.

10.7.3 The write-down of buildings zoned for demolition, have already been actioned as AME impairments with SGHSCD following the approval of the Outline Business Case.

10.8 European System of Accounts (ESA 95) Assessment

10.8.1 Revenue Funding

The new development will be procured within the Scottish Government's programme of revenue funded investment through the Non Profit Distributing (NPD) model. The NPD model follows the traditional PPP structure and the HM Treasury UK-wide standard contract known as SOPC4, except that returns to the private sector are capped. The contract structure requires that the private sector design, build, finance and maintain the asset. The private sector receives any returns due on any sub-debt investment they make, however, any profits or surpluses made in the PPP project (at SPV level) over the duration of the concession are returned to the public sector.

10.8.2 Scottish Government Revenue Funding

10.8.2.1 The Scottish Government reports on two bases – departmental resource accounts which treat contracts according to International Financial Reporting Standards (IFRS) and National Accounts which treat contracts according to the European System of Accounts 1995 (ESA95) standards.

10.8.2.2 In most circumstances the treatment of contracts is consistent under the two reporting mechanisms. However, for long term projects which require the provision of public services through the creation of dedicated assets there is a requirement for dual reporting as different accounting treatments apply under the two bases. Under the two bases, it is possible for assets procured under long term contracts to be classified as "on balance sheet" for Departmental Resource Accounts and as "non-government assets" for National Accounts purposes.

10.8.2.3 The allocation of budgets follows the National Accounts classification, thus an asset which is classified as a "government" asset requires to be met from capital budgets and an asset that is classified as "non-government" can be paid for from revenue budgets.

10.8.3 **National Accounts Classification**

10.8.3.1 For an infrastructure asset to be classified as non-government for national purposes it :-

- needs to be classified as within the scope of IFRIC12 which provides guidance on the accounting for Service Concession Arrangements. IFRIC12 was originally designed to provide guidance to PPP partners in the private sector on how to account for assets constructed for the public sector under long term contracts.

10.8.3.2 This has been used as the basis to establish the principles of how public sector procuring authorities should account for assets acquired under NPD or DBFM contracts (i.e. the mirror image of the private sector guidance). For an asset to be within the scope of IFRIC12, the following two conditions must be met :-

I. The Procuring Authority (grantor) controls or regulates what services the operator must provide with the infrastructure, to whom it must provide them and at what cost; and

II. The Procuring Authority (grantor) controls (through beneficial entitlement or otherwise) any significant residual interest in the infrastructure at the term of the arrangement. This second test is considered to have been met if the concession is for the whole of the useful economic life of the assets created.

10.8.3.3 Contracts that do not involve the transfer or creation of an infrastructure asset or do not involve the delivery of services fall out with the scope of IFRIC12.

10.8.3.4 NHS Ayrshire and Arran's development falls within the scope of IFRIC12 as it meets the two conditions above.

10.8.3.5 If the concession is deemed to be within the scope of IFRIC12, then ESA95 requires that an assessment is made to "consider if there is strong evidence that the partner is bearing most of the risks attached to the asset (directly and linked to its use)". It requires that the following three risks are assessed:-

I. Construction risk: covering events like late delivery, respect of specifications and additional costs;

II. Availability risk: covering volume and quality of output (i.e. performance of the partner): and

III. Demand risk: covering variability of demand

10.8.3.6 This assessment is made on the basis of the contract after excluding any separable elements. Separable elements relate to items of the contract which can be separated for example, on the basis of market testing or benchmarking.

10.8.3.7 For assets to be classified as non-government, the private sector partner must bear construction risk and at least one of availability or demand risk. If the sharing of risks is deemed to be borderline then consideration is given to what happens to the asset at the end of the concession. This is known as residual value risk and assesses who bears the risk of fluctuations in the value of the asset at the end of the concession. This is normally a procuring authority risk as under the standard contracts the assets revert to the procurer at nil cost.

Classification

10.8.3.8 NHS Ayrshire and Arran will adopt the NPD Standard Form Project Agreement developed by Scottish Futures Trust with limited derogations for project specific elements. The Project Agreement follows the principles of SOPC4 and transfers construction risk to the private sector partner. Availability risk is also transferred primarily through the operation of the payment mechanism. NHS Ayrshire and Arran have progressed the calibration of the payment mechanism to ensure that sufficient availability risk transfers to the private sector partner. NHS Ayrshire and Arran will retain demand risk.

10.8.3.9 As construction and availability risk have transferred, the assets should be classified as non-government with the annual expenditure being recognised as an expense in the national accounts i.e. being met from revenue budgets rather than requiring to be met from capital budgets.

10.9 Asset Impairment

10.9.1 The investment will require the following capital impairment, agreed with the Valuers, to be funded by SGHSCD as a DEL non-cash impairment in 2013/14:-

- Non-value adding element of capital build £3,456,000

10.10 Conclusion

10.10.1 This programme is a strategically vital investment to the NHS Board which will provide the means to deliver national and local priorities for Mental Health and other patient improvements which demonstrate affordability and value for money within the funding envelope allocated by the Board.

10.10.2 Under the “Hub and Spoke” model in the Estates Development Strategy, the programme will complete the NHS Board’s programme of community hospital investments starting with East Ayrshire Community Hospital opened in 2000 and Girvan Community Hospital opened in 2010.

10.10.3 The proposed programme will act as an enabling investment promoting service improvement, best use of resources as well as providing a “state-of-the-art” environment to better meet needs and aspirations of patients, staff and the local communities.

The Management Case

11.0 The Management Case

11.1 Overview

11.1.1 This section aims to outline the project management arrangements leading up to Financial Close and moving through design and build into the operation of the completed development.

11.2 Programme Framework

11.2.1 The diagram (Figure 23) sets out:

- The overall governance structure;
- How the Programme Board and the Project Teams fit into this structure; and
- The key roles for the redevelopment – the Senior Responsible Owner (SRO) and Programme Director.

Figure 23: Programme Governance

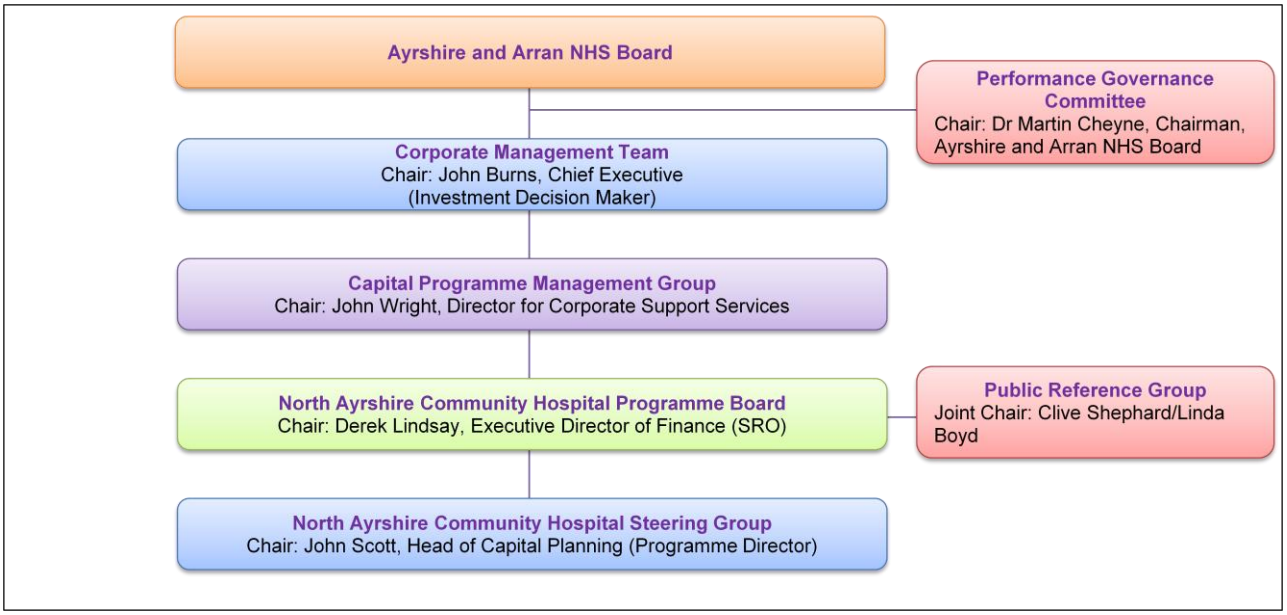


Figure 24: Programme Team structure

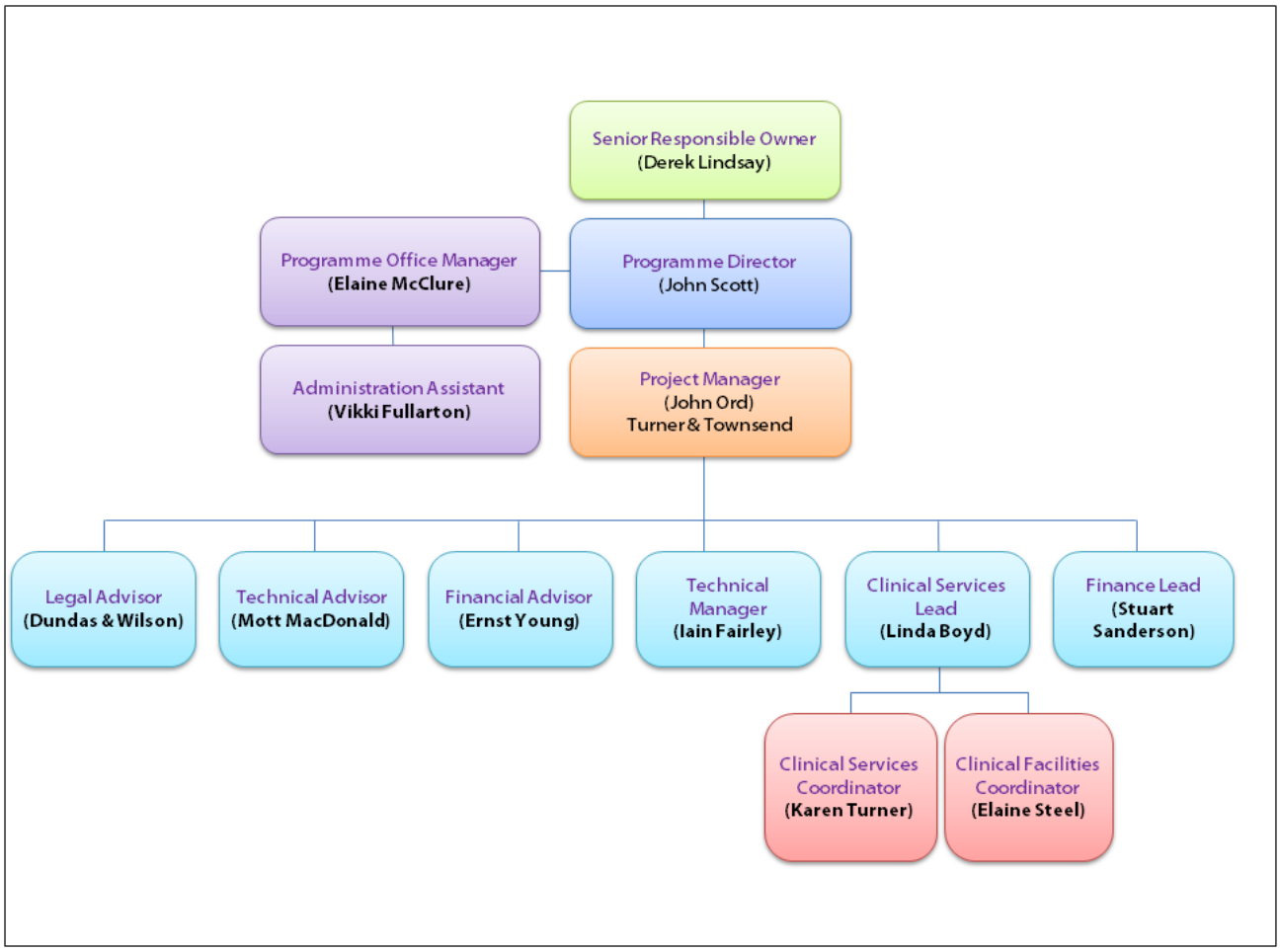
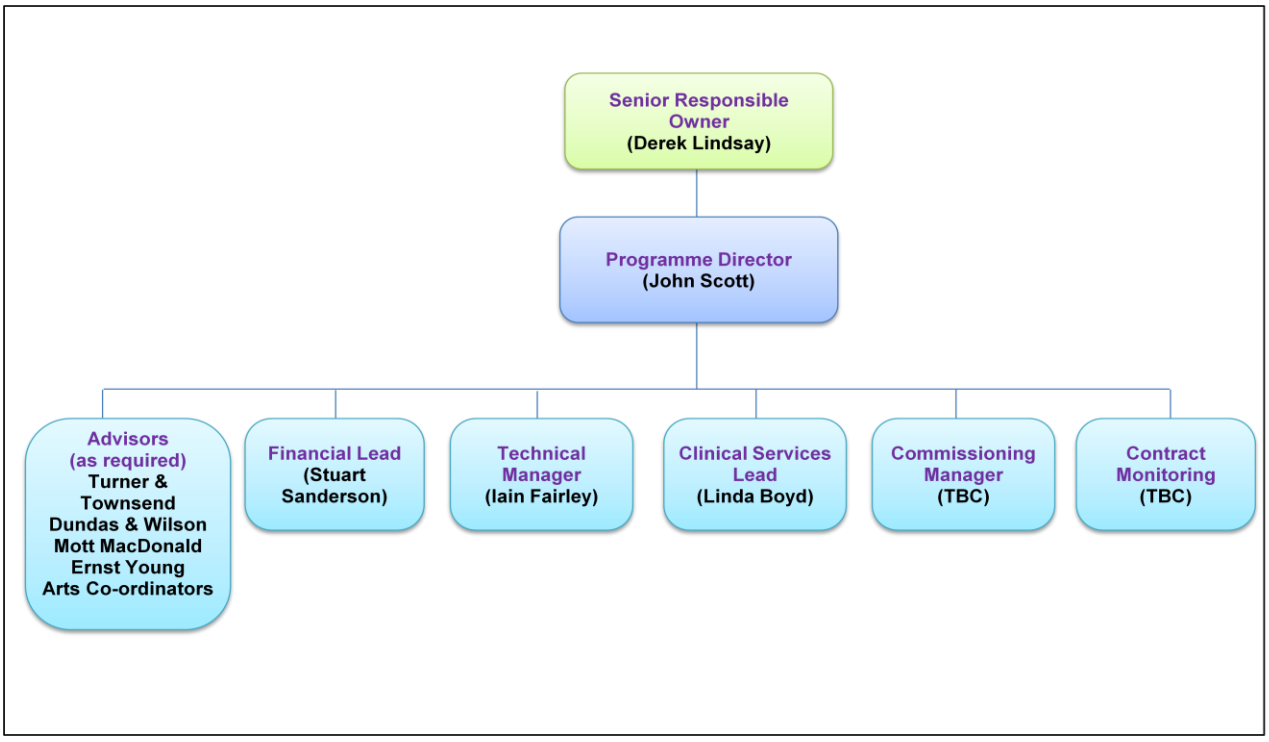


Figure 25: Programme Team Structure (From Financial Close to Operation)



11.2.2 The SRO chairs the Programme Board.

11.2.3 To support the delivery of the programme the following programme team has been established.

11.3 Programme Roles and Responsibilities

11.3.1 The programme governance structure outlined in Figure 23 will remain in place right through to project completion and operation.

11.3.2 The programme team structure outlined in Figure 24 is current up to Financial Close. Beyond Financial Close the structure will evolve to recognise the need for Commissioning, Contract Management and Contract Monitoring, this is illustrated in Figure 25.

11.3.3 The detailed roles and responsibilities of the Boards and Teams within the structure are set out in the Figure 26 and reflects Managing Successful Programmes model.

Figure 26: Roles and responsibilities

Team or Group	Responsibilities
NHS Ayrshire & Arran Board	• Oversee the programme • Review the progress • Approve the business case • Resolve matters outside Board's delegated authority
Corporate Management Team	• Deliver the service modernisation programme • Develop vision of NHS Ayrshire & Arran overall clinical services strategic direction • Agree and prioritise the Capital Plan • Maximise the integration of development opportunities across directorates and with external partners • Authorise mandate for capital planning programme i.e. initial agreements, and submit to CPMG to ensure strategic fit • Endorse bids for capital allocation, ensuring that they are processed in line with Standing Financial Instructions (SFIs) and where appropriate submitted to Finance Committee for approval for those projects in excess of £1.5m • Report to Audit Committee on the process and outcome of KSR reviews • Ensure the Capital Plan is aligned to support service development priorities • Monitor progress of programme against programme objectives • Resolve issues which need the agreement of senior stakeholders to ensure progress of programme • Provide recommendations to the NHS Board on Property Strategy • Provide commitment and endorsement of programme at communication events • Support the SRO • Exercise leadership/ championing the Capital Plan • Confirm sign off at programme closure
Capital Programme Management Group	• Accountable and responsible to Corporate Management Team for delivery of individual projects / programmes within agreed timescales and costs • Monitor and investigate variances • Define acceptable risk profiles and thresholds for the programme • Ensure programme is delivered within agreed parameters (cost, timescale) • Resolve strategic issues between projects which need the agreement of senior stakeholders to ensure progress

Team or Group	Responsibilities
	of programme • Provide assurance of operational stability and effectiveness throughout the programme delivery lifecycle • Overall management of requests for changes to office accommodation
Programme Board	• Establish project organisation • Agree and prioritise the Project Capital Plan • Maximise the integration of development opportunities across directorates and with external partners • Authorise the allocation of programme funds • Monitor project performance against strategic objectives • Resolve strategic issues which need the agreement of senior stakeholders to ensure progress of programme • Maintain commitment to the programme • Promote the programme at communication events • Produce the FBC document • Manage the governance structure • Co-ordinate submission of Papers
Steering Group	• Meet as required to report and review progress. • Agree responsibilities for the production of information and documentation. • Receive and agree actions on reports from the User and Project Groups, Adviser Team and other bodies. • Prepare and develop the Brief • Agree the content of operational policies. • Agree the schedules of accommodation. • Agree the provision of equipment • Agree the risk models including transferred and retained risks. • Make recommendations for approval to the Programme Board.

11.3.4 The key roles are those of the Investment Decision Maker, Senior Responsible Owner, Board Programme Director, Authority Observer, Clinical Services Programme Manager, and Change Managers. These are summarised and named individuals outlined in Figure 27 below.

Figure 27: Key roles

Role	Named individual	Summary of Role
Investment Decision Maker (IDM)	John Burns, Chief Executive	Decides whether to invest financial and human resources in any given project, and correspondingly will have ultimate responsibility for the programme.
Senior Responsible Owner (SRO)	Derek Lindsay, Executive Director of Finance	The SRO has overall responsibility and is accountable directly to the Capital Programme Management Group and provide the strategic direction, leadership and ensure that the business case reflects the views of all stakeholders.
Board Programme Director	John Scott, Head of Capital Planning	The Board Programme Director is the Project Lead from the outset, and provides the strategic direction, leadership and ensures that the business case reflects the views of all stakeholders.
Authority Observer	TBC	Will attend and participate (but not vote) at the Project Company's board meetings.
Clinical Services Programme Manager / Clinical Services Lead	Linda Boyd, Health Care Manager, Mental Health and Offender Services	Working collaboratively with the Board Programme Director and as an integral part of the Project Team in ensuring that the required changes associated with the proposed service models in respective service areas are successfully implemented and that associated benefits realised. Ensure transition and commissioning plans are developed and implemented.
Change Managers	Karen Turner, Clinical Services Co-ordinator Elaine Steel, Clinical Facilities Co-ordinator	Work with preferred bidder to financial close to further develop the design in line with the Authority Construction Requirements etc and within the financial limits Ensure transition and commissioning plans are developed and implemented.

Role	Named individual	Summary of Role
	Audrey Fisher Head of Clinical Support Service (North) Iain McInally Head of Estates And Associated Teams	Ensure Benefits are realised. Lead projects as defined ensuring outcomes are delivered on time and to remit.
Financial Programme Manager	Stuart Sanderson Assistant Director of Finance	The Board Finance Lead has the overall responsibility for all finance aspects relating to Capital Plan / Capital Programme, all aspects of financial input to the Corporate Support Services and lead financial input into the Development.
Service Continuity Programme Manager	Iain Fairley, Senior Project Manager Iain McInally, Head of Estates Audrey Fisher, Head of Clinical Support Services (North)	The Service Continuity Group was originally formed in June 2009 with the sole purpose of decanting and relocating the services within the proposed new build boundary. The services within the boundary have now been relocated and pavilions 4 to 9 have been demolished, clearing the site in preparation for the start of construction. Since then the group has been charged with ensuring that existing clinical and operational services remain fully functional throughout the construction period, by providing a safe and secure environment.
Contract Monitoring Programme Manager	TBC, Contract Monitoring Manager	The role will ensure that NHS Ayrshire & Arran expenditure is effective and efficient and that a productive relationship is established and maintained with Project Co.
Commissioning Programme Manager	TBC, Commissioning Manager	To lead and co-ordinate the transition of services into the Development in conjunction with Project Co.

11.3.5 The Board's Programme Team is supported by a team of external advisors, as set out in Figure 28 below.

Figure 28: Roles and Responsibilities of Advisors

	Role
Project Manager – Turner & Townsend	The main role of the Project manager will be to co-ordinate the inputs of the appointed Advisors and their interface with NHS Ayrshire & Arran and Preferred Bidder. Following Financial Close the main role of the Project Manager will be. • Coordinate due diligence on bidder solutions • Support the Programme Director
Legal Advisors - Dundas & Wilson	Up to Financial Close the primary role of the legal advisor is to give appropriate advice in their areas of expertise. • Developing the contract documentation for the programme using SFT specific standard documentation where appropriate; • Developing the risk process in conjunction with the technical advisors; • Developing other legal aspects of programme bid documents; • Preparing the legal and contractual submission requirements; • Up to Appointment of Preferred Bidder, ensuring all bidders' solutions meet the legal and contractual submission requirements; and • Evaluating and advising on all legal and contractual solutions throughout the procurement.
	Following appointment of Preferred Bidder and up to Financial Close the main role of the Legal Advisor will be:- • Undertaking legal due diligence on Preferred Bidder's solutions; and • Supporting the Programme Director in clarification and fine tuning of legal aspects.
Financial Advisors - Ernst Young	Up to Financial Close the Primary role of the financial advisor will to be to give appropriate advice in their areas of expertise. For the financial advisor this will

	Role
	include: • Supporting the development of the financial aspects of the FBC; • Developing the payment mechanism in conjunction with the technical advisors; • Developing the risk process in conjunction with the technical advisors; • Preparing the financial submission requirements; • Ensuring that all financial aspects of the bidders' solutions meet the financial submission requirements; • Optimising and scrutinising the financial models submitted by bidders'; • Evaluating and advising on all financial proposals throughout the procurement; • Reviewing funding and taxation aspects of the solutions; and • Preparing the accounting opinion for the Director of Finance.
	Following Financial Close the main role of the Financial Advisor will be:- • Assisting the Board on implementation of the contract, for instance in the operation of the payment mechanism and reviewing calculation of the annual service payment.
Technical Advisors - Mott MacDonald	Up to Financial Close the Primary role of the technical advisor will to be to give appropriate advice in their areas of expertise. For the technical advisor this will include: • Supporting the development of the technical aspects of the Full Business Case; • Review of Preferred Bidder's proposals; • Review of Reviewable Design Data; • Review and agree the Payment Mechanism in conjunction with Financial Advisors; • Developing the risk process in conjunction with Financial and Legal Advisors • Review the construction proposals of the Preferred Bidders so that they meet in full, the programme objectives; • Evaluating and advising on all technical solutions throughout the Preferred Bidder period including the bidder's Method Statements; • Scrutinising costs of the bidders' solutions

	Role
	throughout the Preferred Bidder period; • Undertaking technical due diligence on the bidder's solutions' • Review the Preferred Bidder's planning application; • provide support required in relation to the finalisation of the Technical Schedules; and • Supporting the Project Director in clarification and fine –tuning of technical issues.
	Following Financial Close the main role of the Technical Advisor will be:- • Assist with general queries and assist with technical due diligence.
Insurance Advisors - Willis	Up to Financial Close the Primary role of the Insurance advisor will to be to give appropriate advice in their areas of expertise. Post Financial Close dealing with any Insurance queries.
Arts Co-ordinators	Developing and implementing the approved Art Strategy in conjunction with Preferred Bidder until construction.

11.3.6 Additionally NHS Ayrshire & Arran is being supported by SFT who retain responsibility for managing the NPD programme nationally.

11.3.7 The Programme Team shall continue to review the advisory appointments to ensure appropriate and continued advisor support is made available throughout the construction period and into early operation stage as necessary.

11.3.8 SFT will nominate a Public Interest Director for the Project Company to perform the duties in accordance with the Articles if Association for that company.

11.4 Project Plan

11.4.1 The dates detailed in Figure 29 below highlight the key milestones for the project.

Figure 29: FBC Project milestones

Milestone	Date
Endorsement of FBC by Steering Group	20 February 2014
Approval of FBC by Programme Board	26 February 2014
Approval of FBC by Capital Programme Management	3 March 2014

Milestone	Date
Group (CPMG)	
Approval of FBC by Corporate Management Team (CMT)	4 March 2014
Approval of FBC by Performance Governance Committee	10 March 2014
Approval of FBC by NHS Ayrshire & Arran Board	31 March 2014
Submission of FBC to SGHSCD CIG	18 March 2014
Approval of FBC by SGHSCD CIG	22 April 2014
Construction commence (mobilsation)	July 2014
Construction complete	March 2016
Commence Post project/Post occupancy evaluation	March 2017

11.5 Programme Plan

11.5.1 The summary milestones from Preferred Bidder to Financial Close are shown in Figure 30.

Figure 30: Preferred Bidder to Financial Close Project milestones

Milestone	Date
Preferred Bidder Appointment	18 February 2014
Preferred Bidder/Authority Project Initiation Workshop	27 February 2014
Planning Application	10 March 2014
Targeted Planning Committee (date TBC by North Ayrshire Council)	28 May 2014
Financial Close	13 June 2014
Construction commences	July 2014
Construction completion	March 2016
Decant/Occupation Period	March to April 2016
Ailsa Refurbishment	2016-2018

11.6 Communication and Reporting Arrangements

Communication

11.6.1 The project has a consistent and evolving Stakeholder Management Plan a key component of which is ensuring effective communication amongst stakeholders through a communication plan.

11.6.2 The purpose of the communication plan is to:

- Ensure that all stakeholders have the opportunity to feel informed and engaged;
- Keep-up-to-date with the ongoing developments before the planned start of the build in 2014; and
- Encourage involvement of local communities in engagement.

11.6.3 The Stakeholder Management Plan responds to the various stages of the programme and consists of the following, the full plan is in Appendix Q:-

- Stakeholder Map
- Influence/Interest Matrix
- Communications Plan
    - Introduction
    - Overview
    - Key Messages
    - Target Groups and methods
    - Action Plan

The Plan will be updated to support the project plan for Ailsa Refurbishment works nearer 2016.

Reporting Arrangements

11.6.4 All governance functions are supported by a range of reports, these consist of the Progress Update Report, Risk Register Report (Appendix R), Financial Report, Asset Management Report and a range of supplementary reports.

11.6.5 All reports are commissioned on behalf of the Programme Board by the Steering Group and submitted for approval. Progress Reports are submitted to the Capital Programme Management Group and Key Reports are submitted to the Corporate Management Team as part of internal governance requirements, as described in the Capital Governance Arrangements document in Appendix S.

11.7 Key Stage Review

11.7.1 As part of the governance process for NPD projects, there is a requirement to participate in SFT Key Stage Reviews (KSRs) at specific stages up to Financial Close. All KSR reviews are detailed below:

- Pre-issue of OJEU Notice - 21 December 2012;
- A follow up review on the Pre-issue of ITPD - 28 March 2013;
- KSR (Pre-Close of Dialogue) - 20 November 2013; and
- A follow up review on the Pre-preferred bidder appointment - 14 February 2014 and this KSR Report is available in Appendix T.

11.7.2 Following submission of the FBC to the SGSCHD Capital Investment Group (CIG) a final KSR (Pre- Financial Close) will be required in advance of Financial Close.

11.8 Conclusion

11.8.1 This section of the FBC demonstrates that NHS Ayrshire & Arran have developed a robust programme management framework outlining the following:-

- Governance structure;
- Project team structure;
- The roles and responsibilities of key members;
- Project and Programme plan including key milestones;
- Key Stage Review; and
- The communication and reporting arrangement.

12.0 Change Management

12.1 Overview

12.1.1 This section sets out NHS Ayrshire & Arran's approach to change management and how it helps to deliver the preferred option, discussing:

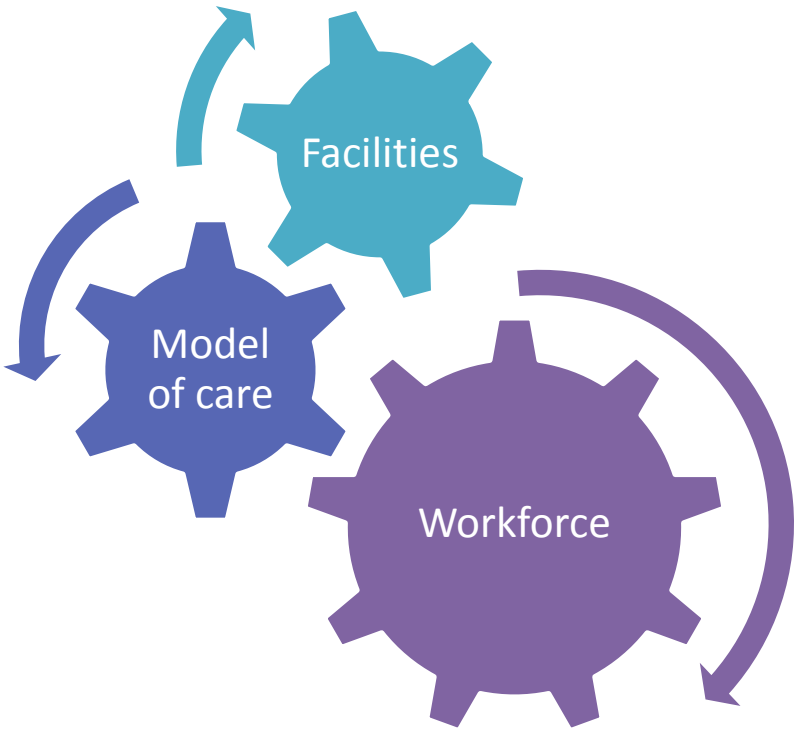
- Change management philosophy;
- NHS Change Management model; and
- Conclusion.

12.2 Change Management Philosophy

12.2.1 The Development represents a significant change point for the NHS Board. The change to the physical infrastructure is simply an enabler to a more fundamental change in the way that healthcare will be delivered for the residents of Ayrshire & Arran.

12.2.2 The simplified diagram below shows the three key elements encompassed in Figure 31.

Figure 31: Scope of change



12.2.3 The impact of the change on these three aspects of the organisation will be fundamental. Figure 32 below summarises some of the main impacts of the changes across four areas as indicated below.

Figure 32: Impact of change

Area	Impact
Culture	The culture of the organisation will change from one where care is provided in a variety of wards to one where the patient is seen as being at the centre of care. The need for improvements in quality placing service users at the heart of our values, provides the foundation of cultural changes. These changes will impact upon culture and therefore staff right across the Board.
Systems	Systems will be more responsive and geared to supporting the new models of care. In particular more emphasis will be placed on good communication and effective handover between inpatient, community and primary care to make the patient experience seamless.
Processes	The improved models of care that will be made possible by this development will provide enhanced and more efficient services within modern facilities that will also deliver enhanced environmental quality, sustainability and more opportunities for teaching and training and many other benefits. The physical environment will also improve the way care is delivered and will mean that some of the approaches adopted in the past because of restrictions in physical configuration will cease.
People	There will be changes to roles and responsibilities, particularly for clinical staff. Some of this will arise from clinical process within the Development.

12.2.4 The Board's change management philosophy is to:

- Recognise the significance of the change;
- Embrace the change, taking the opportunity to improve the quality of healthcare to maximise benefits realisation from the investment; and
- Implement the change in a structured and well managed way to empower staff to succeed.

NHS Change Management Model

12.2.5 The NHS Change Model in Figure 33 has been created to support the NHS to adopt a shared approach to leading change and transformation. It brings together what makes change happen and informs how NHS Ayrshire & Arran make change happen and who needs to be involved and is shown below:

Figure 33: NHS Change Model

12.2.6 NHS Ayrshire & Arran have reviewed the NHS Change Model and used each of the eight components to shape the way in which the process is managed. In particular evaluating the programme against each area:

- **Our shared purpose** - does this improvement meet our shared NHS purpose? The new Acute Mental Health and Community Hospital development supports the NHS Ayrshire & Arran purpose of, "Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran". The proposed investment provides modern, fit for purpose facilities which allow an improved model of care to be fully implemented;
- **Leadership for change** - do all our leaders have the skills to create transformational change? Leadership is at the centre of the programme and the development of the improved model of care. This is provided from the Programme Managers and Change Managers;
- **Engagement to mobilise** - are NHS Ayrshire & Arran engaging and mobilising the right people? The programme has been the subject of wide engagement e.g. the development of the workforce planning group includes representatives from all services affected;
- **System drivers** - are our processes, incentives and systems aligned to enable the change? Supporting workstreams managed through the management structure will deliver the changes in the improved model of care;
- **Transparent measurement** - are NHS Ayrshire & Arran measuring the outcome of the change continuously and transparently; Project leads have identified measures for each of the model of care improvements
- **Rigorous delivery** - do NHS Ayrshire & Arran have an effective approach for the delivery of the change and monitoring of progress towards our planned objectives? Programme office established to use best practice project management techniques to deliver the change;
- **Improvement methodology** - are NHS Ayrshire & Arran using an evidence-based improvement methodology? Adoption of best practice and Kaisen techniques; and
- **Spread of innovation** - are NHS Ayrshire & Arran designing for the active spread of innovation from the start? Wide use of knowledge transfer/peer group review from other areas.

12.2.7 The change management philosophy and change management principles are being communicated to all staff as part of the launch of the change management process.

12.2.8 The Board has designed a change management approach that encompasses the philosophy and principles outlined above and has already made progress in delivering a core change management plan to implement the changes required to make the redevelopments a success.

12.3 Conclusion

The Board has:

- A sound change management philosophy, underpinned by specific change management principles; and
- Developed a clear approach to change management to facilitate effective delivery of the development.

13.0 Benefits Realisation Plan

13.1 Overview

13.1.1 NHS Ayrshire & Arran will undertake a thorough and robust Post-Project Evaluation (PPE) at key stages in the process to ensure that positive lessons can be learnt and will ensure that PPE and wider benefits realisation management are fully embedded within the project management arrangements. The importance of the subject is understood and the methodology used is largely based on the principles and practical steps outlined in the Scottish Capital Investment Manual (SCIM) and associated material provided by Scottish Government.

13.1.2 A Benefits Realisation Plan (BRP) has been developed. This section outlines the process undertaken in order to achieve this and includes the benefits and SMART measures. The Benefits Realisation Plan can be found in Appendix D.

Background to the Benefits Realisation Process

13.1.3 A BRP is the process of organising and managing the identified benefits during project implementation, such that the potential benefits arising from the planned investment are actually realised.

13.1.4 A BRP needs to be explicit, and proactively managed, in order for the organisation to be capable of realising the wide range of potential benefits of the project (as well as avoiding possible negative impacts).

13.1.5 The BRP is used to identify what benefits will result from the Project and how these will be measured. This provides evidence that the investment has been worthwhile to the local health economy post project implementation.

13.1.6 Additionally, all benefits identified should be defensible against third party scrutiny.

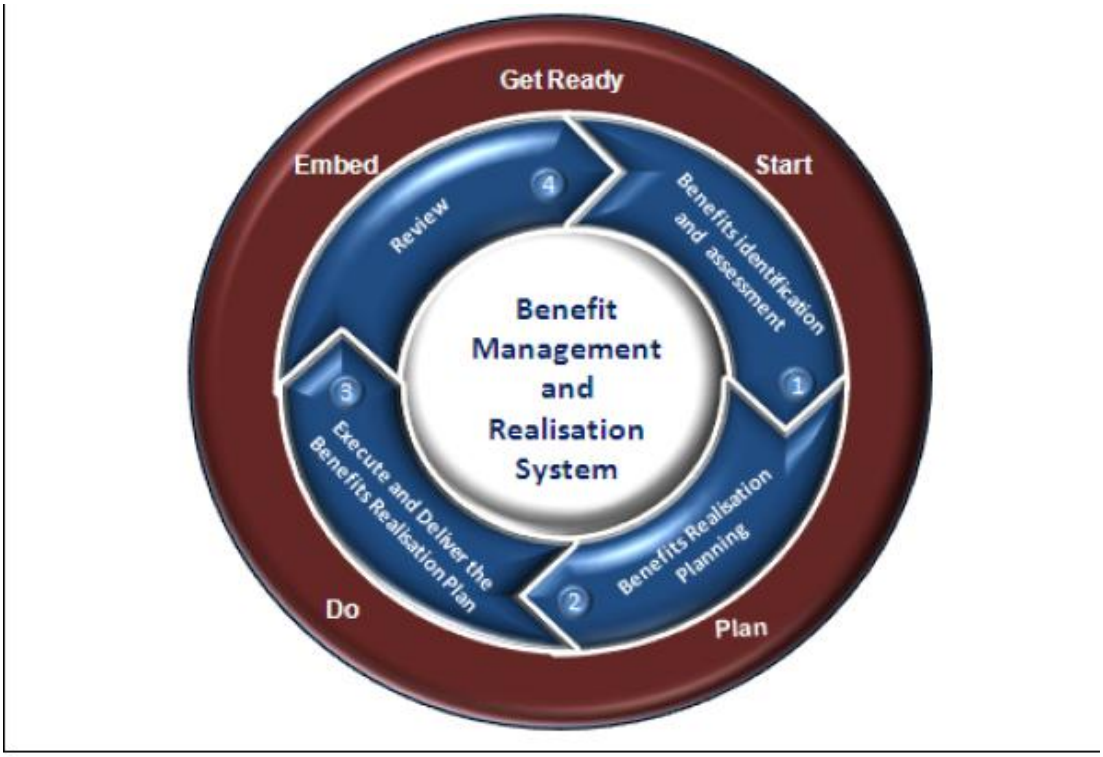
13.1.7 This section of the report outlines the benefits realisation process, describes its key elements and sets it in the wider context of benefits management.

Benefits Management

13.1.8 Benefits management is the overarching process of continuous review which incorporates the BRP as part of a process of continuous improvement. It takes due account of changes in the programme during the delivery phase which impact on, or alter the anticipated benefits.

13.1.9 The benefits management approach is a cycle of selection, planning, execution and review as illustrated below in Figure 34.

Figure 34: Benefits management approach



13.1.10 Further details of each stage is provided below.

- Stage 1 - Benefits Identification and Assessment: Selection of appropriate and significant benefits that makes the best use of scarce resources;
- Stage 2 - Benefits Realisation Planning: Rational decisions about how, when, and by whom benefits will be delivered, with clear ownership, accountability and timetable;
- Stage 3 - Execute and Deliver the Benefits Realisation Plan: Successful delivery of the Benefits Realisation Plan; and
- Stage 4 - Review: Input to a culture of continuous improvement either through incremental change to the existing system or by triggering the inception of new programmes / projects.

13.2 Conclusion

13.2.1 A review of best practice methodologies has been undertaken and the principles contained with guidance have been adopted.

13.2.2 The Board now has a robust benefits management approach in place that will secure the improvements required and ultimately optimise achievement of the overall objectives of the planned investment.

14.0 Risk Management Plan

14.1 Overview

14.1.1 This section sets out NHS Ayrshire & Arran's approach to risk management, discussing:

- Risk management philosophy;
- Categories of risk;
- Responsibility for managing the Risk Register;
- The current Risk Register; and
- Conclusion.

14.2 Risk Management Philosophy

14.2.1 The Board's philosophy for managing risks is a holistic approach, seeing effective risk management as a positive way of achieving the project's wider aims, rather than simply a mechanistic 'tick box' exercise, to comply with guidance. The organisation regards risk as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the programme. A Risk Management Strategy was developed for the programme and can be found in Appendix U.

14.2.2 The Board recognises the value for putting in place an effective risk management framework to systematically identify, actively manage and minimise the impact of risk. This is done by:

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

14.2.3 The response for each risk will be one or more of the following types of action:

- Prevention, where countermeasures are put in place that either stop the threat or problem from occurring, or prevent it from having an impact on the business or the development;
- Reduction, where the actions either reduce the likelihood of the risk developing or limit the impact on the business or development to acceptable levels;
- Transfer, the impact of the risk is transferred to the organisation best able to manage the risk, typically a third party (e.g. via a penalty clause or insurance policy);
- Contingency, where actions are planned and organised to come into force as and when the risk occurs; and
- Acceptance, where the Programme Board decides to go ahead and accept the possibility that the risk might occur, believing that either the risk will not occur or the potential countermeasures are too expensive. A risk may also be accepted on the basis that the risk and any impacts are acceptable.

14.3 Categories of Risk

14.3.1 In developing the FBC, the Board examined four categories of risks. These are set out in Figure 35.

Figure 35: Risk Categories

Risk Categories – definitions			
Business	**Staff**	**Clinical**	**Reputational**
Risks which impact on financial and operational performance e.g. IT, external/ political risk, business continuity, business processes	**Risks which impact on the implementation of staff governance** e.g. implementation of staff governance action plan and staff survey: ensuring staff are well informed, appropriately trained and consistent treated have a safe working environment	**Risks which impact on the quality of services to patients and the public** e.g. impact on the services, patients, general public and donors	**Risks which have an impact on the reputation of the organisation** e.g. when an event causes adverse publicity, negative impact on reputation with stakeholders (NHS Boards, The Scottish Government (SG), the public)

14.4 Conclusion

14.4.1 The Board has:

- A sound risk management philosophy that is based on effective risk management;
- A clear risk management framework, whose structure will facilitate effective risk management; and
- Already made considerable progress in identifying, evaluating and addressing the risks for the preferred solution.

15.0 Contract Management Arrangements and Plan

15.1 Overview

15.1.1 This section sets out NHS Ayrshire & Arran's

- Contract Management Philosophy;
- Roles & responsibilities; and
- Conclusion.

15.2 Contract Management Philosophy

15.2.1 The primary aim of contract management is to ensure that the needs of the project are satisfied and that the NHS Ayrshire and Arran Board receives the service it is paying for, within the boundaries of the Contract whilst achieving value for money. This means optimising efficiency, effectiveness and economy of the service or relationship described in the contract, balancing costs against risks and actively managing the client - contractor relationship.

15.2.2 The contract management for this project is based on collaborative working and joint decision making. Whilst the NHS Ayrshire and Arran Board is the Client and as such responsible for setting and agreeing the scheme objectives, the partnership approach enjoys the benefit of the Client and Project Co working together to resolve problems and objectively develop the best Value For Money (VFM) solutions.

15.2.3 Contract Management also involves recognising the balance of the roles and responsibilities as defined within the contract and aiming for continuous improvement over the life of the Project.

15.2.4 The Board's contract management will:

- Maximise the chances of contractual performance in accordance with the contract requirements by providing continuous and robust contract management which supports both parties;
- Optimise the performance of the project;
- Support continuous development, quality improvement and innovation throughout the Project;
- Ensure delivery of best Value for Money;
- Provide effective management of commercial risk;
- Provide an approach that is open to scrutiny and audit;
- Support the development of effective working relationships between both parties;
- Allow flexibility to respond to changing requirements;

- Demonstrate clear roles, responsibilities and lines of accountability; and
- Ensure that all works and services are in compliance with the Authority's Requirements, current legislation, relevant changes in Law and Health & Safety requirements, and NHS Scotland policies and procedures.

15.3 Roles and responsibilities

15.3.1 The governance structure outlined within section 1.5 (Figure 1) has been utilised for all stages of this contract and will continue into Construction and Handover, providing a clear and concise process for the flow of information and identifiable organisational governance arrangements within NHS Ayrshire and Arran.

15.3.2 The Board Programme Director is accountable for the delivery of the Programme to meet the strategic and business needs of the NHS Ayrshire and Arran Board. The Board Programme Director reports to the Programme Board and leads the Steering Group. Membership of the Programme Board is outlined in Appendix C.

Programme Board

15.3.3 The Programme Board will approve the Full Business Case document.

15.3.4 The North Ayrshire Community Hospital Programme Board have set up the governance structure, established the user groups, provided supporting information for the business case, and coordinated submission of papers to the relevant governance committees of NHS Ayrshire and Arran.

15.3.5 The membership the North Ayrshire Community Hospital Programme Board is outlined in Appendix C.

15.3.6 The North Ayrshire Community Hospital Programme Board meetings are held regularly and dates are presented in the latest meeting schedule, located in Appendix V.

15.4 Conclusion

15.4.1 The section has outlined the contract management plan.

15.4.2 This section of the FBC shows that NHS Ayrshire & Arran have developed a robust contract management approach with clear governance.

16.0 Arrangements for Post Project Evaluation

16.1 Overview

16.1.1 This section sets out the plans which the Board has put in place to undertake a thorough and robust post-project evaluation (PPE). The areas covered are:

- The requirement for Post-Project Evaluation;
- Framework for Post-Project Evaluation;
- The expected timing of the evaluation stages; and
- Conclusion.

16.2 The requirement for Post-Project Evaluation

16.2.1 Sponsors of capital projects in NHS Scotland are required by the Scottish Government to evaluate and learn from their projects. This is mandatory for projects with a cost in excess of £1.5million and should be applied as best practice for all projects.

16.2.2 The requirements are set out in detail within the SCIM Post-Project Evaluation.

16.2.3 The aim of this post project evaluation is to assess the impact of the programme within a year of it becoming operational.

16.2.4 It involves consideration of the economy, efficiency and effectiveness of the development to determine whether the original objectives, as identified in the business case, have been achieved. The PPE identifies the lessons learnt in order to inform future decision making.

16.2.5 Business cases for capital projects will not be approved unless post-project evaluation has been properly planned in advance and suitably incorporated into the FBC.

16.2.6 Therefore NHS Ayrshire & Arran have an evaluation framework in place as follows:

- A post project evaluation will be carried out 12 months after occupation;
- The benefit realisation register detailed in the FBC will be used to assess project achievement; and
- Clinical benefits through patient and carer surveys will be carried out and reviewed against baseline surveys.

16.3 Framework for Post-Project Evaluation

16.3.1 The Board is committed to ensuring that a thorough and robust post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the programme.

16.3.2 To ensure maximum pay-off from evaluation, the following criteria are deemed as important:

- The evaluation is viewed as an integral part of the programme and is planned for at the outset;
- The evaluation will be funded and resourced as part of the programme;
- There is commitment from senior managers within the organisation;
- All key stakeholders are involved in its planning and execution;
- Relevant criteria and indicators will be developed to assess programme outcomes from the outset of the programme;
- Mechanisms will be put in place to enable monitoring and measurement of progress; and
- Feedback will be given to Scottish Government monitoring groups.

16.4 Key Stages

16.4.1 Although evaluation will be carried out continuously throughout the life of a project to identify opportunities for continuous improvement, evaluation activities will be undertaken at four main stages shown below in Figure 36.

Figure 36: The four stages of PPE

Stage	Evaluation undertaken	When undertaken
1	Plan and cost the scope of the PPE work at the project appraisal stage. This should be summarised in an Evaluation Plan.	Plan at OBC, fully costed at FBC stage
2	Monitor progress and evaluate the project outputs	On completion of the development
3	Initial post-project evaluation of the service outcomes	12 months after the development has been commissioned
4	Follow-up post-project evaluation/post occupancy evaluation to assess longer-term service outcomes two years after the development has been commissioned. Beyond this period, outcomes should continue to be monitored. It may be appropriate to draw on this monitoring information to undertake further evaluation after each market testing or benchmarking exercise	2 years

16.4.2 At each of these stages, evaluation will focus on different issues. In the early stages, emphasis will be on formative issues. In later stages, the main focus will be on summative or outcome issues.

- **Formative Evaluation** - As the name implies, is evaluation that is carried out during the early stages of the project before implementation has been completed. It focuses on 'process' issues such as decision-making surrounding the planning of the project, the development of the business case, the management of the procurement process, how the project was implemented, and progress towards achieving the project objectives; and

- **Summative Evaluation** - The main focus of this type of evaluation is on outcome issues. It is carried out during the operational phase of the project. Summative evaluation builds on the work done at the formative stage. It addresses issues such as the extent to which the project has achieved its objectives; how out-turn costs, benefits, and risks compare against the estimates in the original business case; the impact of the project on patients and other intended beneficiaries; and lessons learned from developing and implementing the project.

16.5 Stage 1 - Evaluation Plan

16.5.1 Figure 37 below sets out what will be included in the Evaluation Plan:

Figure 37: Evaluation Plan

What	How
A clear view of the objectives and purpose of the evaluation	• Who is the audience for the evaluation? • What are their information needs? • What decisions will the evaluation inform?
Consideration of the structural context	• What is the baseline situation (status quo)? • What are the internal and external constraints? • What are the desired outcomes?
Inclusion of a comparative element	• Are there plans to conduct a 'before and after' assessment? • Is it clear what would have happened in the absence of the project?
Coverage of all relevant project impacts (outcomes and	• Is there a plan to assess immediate, intermediate and ultimate outcomes?

What	How
processes)	• Does the plan take into account the processes by which the outcomes are generated? • Does the plan consider the impact of the project on patients, staff and other stakeholders?
An emphasis on learning	• What are the lessons? • Is there a plan to disseminate the lessons learnt? • Is there an action plan to ensure the lessons are used to inform the project or future projects?
Recognition of need for robustness and objectivity	• Is the evaluation team equipped with the skills and resources to undertake the evaluation? • Should the evaluation be conducted by external contractors? What should be the role of in-house staff? • Are there suitable arrangements to quality-assure the findings?
Sound methodology	• What methods of data collection will be used to undertake the study? • Are the proposed methods appropriate to meet the objectives of the evaluation?

16.6 Conducting the evaluation

16.6.1 There are a number of factors to consider in judging the importance of evaluation including:

- Likely benefits – Is there scope to feedback any lessons from evaluation into the improvement of the project? Does the project have the potential to provide useful lessons to the wider NHS?
- Interest – Is the project of major interest to senior managers, policy-makers, ministers, and the public? Is it likely to attract much media coverage? Are there signs or risks of something going wrong?
- Ignorance and novelty – do we have comprehensive and reliable information about the performance and results of the project?
- Corporate significance – how important is the project to stakeholders? Is it likely to have a major impact on how services are delivered?

16.6.2 Government recommendation is that the Logical Framework should continue to be used for evaluation of NHS capital schemes. This is a matrix listing project objectives against indicators and measures for assessing outcomes. The underlying assumptions and risks are also considered.

16.6.3 The technical issues arising from application of the Logical Framework include:

- the merits and demerits of different data collection methods;
- the role of different participants in the data collection process;
- sampling methods;
- sample size;
- questionnaire design (types of questions, etc) ;
- piloting;
- how to achieve a satisfactory response rate;
- security and confidentiality of data; and
- data analysis and report writing.

16.6.4 The potential value of an evaluation will only be realised when action is taken on the findings and recommendations emanating from it. We will require the adoption of processes to ensure that this happens.

16.6.5 To promote consistency, the content of the evaluation report should, as far as possible, address the following issues:

- Were the objectives achieved?
- Was the project completed on time, within budget, and according to specification?
- Are users, patients and other stakeholders satisfied with the project results?
- Were the business case forecasts (success criteria) achieved?
- Overall success of the project – taking into account all the success criteria and performance indicators, was the project a success?
- Organisation and implementation of programme – did we adopt the right processes? In retrospect, could we have organised and implemented the project better?
- What lessons were learned about the way the programme was developed and implemented?
- What went well? What did not proceed according to plan?
- Project team recommendations – record lessons and insights for posterity. These may include, for example, changes in procurement practice, delivery, or the continuation, modification or replacement of the project.

16.6.6 Evaluation results will then be signed off by senior management or at Board level.

16.6.7 The results from the evaluation should generally lead to recommendations for the benefit of the organisation and wider NHS.

16.6.8 These may include, for example, changes in procurement practice; delivery; or the continuation, modification, or replacement of the project, programme or policy. The results should be widely disseminated to staff concerned with future project design, planning, development, implementation and management.

16.7 Expected Timings

16.7.1 The timings of the different stages of the PPE process are set out in Figure 38 below.

Figure 38: Timing of key stages of the PPE process

Stage	Requirement	Timing
1	Produce a costed Evaluation Plan. This includes: • Confirming objectives, benefits and risks of the project; • Considering whether the evaluation will be carried out in house or by an external party; • Agreeing participants in the Evaluation Steering Group and Evaluation Team, including patient and public representatives; and • Costing the process, including requirements to backfill staff time.	Completed
2	Monitor progress and evaluate the programme outputs. This includes: • Monthly monitoring of construction and other elements of project delivery; • Formal reporting at key milestones of the project plan; and • Production of completion report once construction work has been completed.	Within six to eight weeks of the completion of the development
3 (PPE)	Initial post-project evaluation of the service outcomes. This includes: • Review of the Project Objectives and BRP to measure the extent to which they have been achieved; • Evaluation of the project management and control processes to assess whether they have worked satisfactorily; and • Submission of the PPE to the SGHSCD.	12 months after the new development has been operative

Stage	Requirement	Timing
4 (POE)	Follow-up post-project /post occupancy evaluation to assess longer-term service outcomes. This will include: • Clinical evaluation – whether the model of care has been successfully implemented and maintained; • Quality evaluation – whether the anticipated patient outcomes and benefits have been realised; • Overall benefits assessment – whether the full range of projected benefits in the benefits realisation plan have been realised; and • Financial evaluation – whether the overall costs of the scheme have remained within the expected cost envelope.	Two years after the development has been operative.

16.8 Conclusion

16.8.1 The Board has identified a robust plan for undertaking PPE in line with current SCIM guidance, which is fully embedded in the project management arrangements of the project.

17.0 Conclusion

This FBC sets out a robust case for transforming the existing Ayrshire Central Hospital site into a health hub for the 21st century by providing a new acute mental health inpatient facility for the population of Ayrshire and Arran and a new community hospital for people living in North Ayrshire.

The capital investment reflects NHS Ayrshire & Arran's Local Plan in responding to national strategies. It will transform the way in which health care will be delivered and address major deficiencies in the current estate. The development will provide enhanced services and quality for patients and enable staff to work more efficiently and effectively, in modern, safe and sustainable facilities located in the heart of the community.

The FBC describes the management planning and the governance structure established by the Board to take the programme forward on an affordable basis, monitored at every stage. In submitting the FBC, approval and support is sought to move to the next stage of the Development.

NHS Ayrshire & Arran would like to acknowledge the effort, energy and enthusiasm of everyone who has been involved in the development of this FBC.

18.0 Support from NHS Ayrshire & Arran Board

18.1 The Acute Mental Health and North Ayrshire Community Hospital FBC is signed off by the NHS Ayrshire & Arran Chairman and Chief Executive on behalf of the NHS Ayrshire & Arran Board, for submission to the Scottish Government for FBC approval and permission to proceed to Financial Close.

Dr Martin Cheyne
Chairman
NHS Ayrshire & Arran Board

Mr John Burns
Chief Executive
NHS Ayrshire & Arran

Appendices

Executive Summary

A	Acute Mental Health and North Ayrshire Community Hospital Outline Business Case Approval Letter

Introduction

B	Planning Permission in Principal Approval Letter
C	Membership of the Programme Board and Steering Group

Economic Case

D	Benefits Realisation Plan
E	Value for Money Assessment
F	Final Schedule of Accommodation
G	Drawings, 1:200 layouts, 1:500 site drawings
H	Equality and Diversity Impact Assessment

Negotiated Deal and Contractual Arrangements

I	Project Plan from Official Journal of the European Journal to Construction Completion
J	Evaluation report on Short-Listing of Bidding Consortia
K	Financial Evaluation of Final Tenders and selection of Preferred Bidder
L	Key elements of Preferred Bidder Funding Structure
M	Preferred Bidder Letter
N	Letter of Opinion from Ernst Young as Financial Advisers to NHS Board

The Financial Case

O	NHS Ayrshire & Arran Capital Investment Plan
P	Financial Schedules

The Management Case

Q	Stakeholder Management Plan
R	Risk Register
S	Capital Arrangements Governance Structure
T	Pre-Preferred Bidder Key Stage Review Report
U	Risk Management Strategy
V	Programme Board Meeting Schedule 2014

Glossary of Abbreviations

ACH	Ayrshire Central Hospital
AHP	Allied Health Professional
AME	Annually Managed Expenditure
BREEAM	Building Research Establishment Environmental Assessment Method
BRP	Benefits Realisation Plan
CAMHS	Child & Adolescent Mental Health Services
CDU	Central Decontamination Unit
CEL	Chief Executives Letter
CIG	Capital Investment Group
CIP	Capital Investment Plan
CPMG	Capital Planning Management Group
CMHT	Community Mental Health Team
CMT	Corporate Management Team
DBFM	Design, Build, Finance Maintain
EAC	Equivalent Annual Cost
ECT	Electro-Convulsive Therapy
FBC	Full Business Base
FM	Facilities Management
HAI	Healthcare Acquired Infection
IDM	Investment Decision Maker
IFRS	International Financial Reporting Standards
IPCU	Intensive Psychiatric Care Unit
ISFT	Invitation to Submit Final Tender
ITPD	Invitation to Participate in Dialogue
KSR	Key Stage Review
MHS	Mental Health Services
MOI	Memorandum of Information
NHS	National Health Service
NPD	Non Profit Distributing
NPC	Net Present Cost
OBC	Outline Business Case
OJEU	Official Journal of the European Union
PAV	Pavilion
PFI	Private Finance Initiative
POE	Post Occupancy Evaluation
PPE	Post-Project Evaluation
PPP	Public Private Partnership
PQQ	Pre-Qualification Questionnaire
SCIM	Scottish Capital Investment Manual
SFI	Standing Financial Instructions

SFT	Scottish Futures Trust
SGHSCD	Scottish Government Health Social Care Directorate
SMART	Specific, Measurable, Achievable, Relevant, and Timely
SPSP	Scottish Patient Safety Programme
SPV	Special Purpose Vehicle
SRO	Senior Responsible Owner
TBC	To be confirmed
TMFAA	Towards a Mentally Flourishing Ayrshire & Arran
TUPE	Transfer of Undertakings (Protection of Employment)
VAT	Value Added Tax
VFM	Value For Money