Barra Health and Social Care Hub
Outline Business Case

17 August 2017

Contents:

EXECUTIVE SUMMARY

Introduction

This Outline Business Case (OBC) has been developed in partnership between NHS Western Isles (NHS WI) (Western Isles Health Board) and Comhairle nan Eilean Siar (CnES) (Western Isles Council). It sets out the case for investment in health and social care services for the resident and visiting populations of Barra and Vatersay.

The scope of the project was originally developed within an Initial Agreement (IA) which outlined a new model of care that includes the formation of a Health and Social Care Hub bringing together the existing St Brendan's hospital and care home on the island of Barra. The IA was approved by the Scottish Government Health Directorates (SGHSCD) Capital Investment Group (CIG) on 24 September 2013.

A draft OBC was presented to Scottish Government Health Directorates (SGHSCD) Capital Investment Group (CIG) on 2 July 2014. Since then further work has been undertaken to further develop the model of care and test the value for money of potential options to deliver the proposed solution. The results of this are outlined in this document including the key findings described below.

Key findings

- Existing arrangements are not sustainable given the compliance risks associated with the condition of current facilities and the need to adopt new ways of working in order to continue to meet demand and deliver high quality, safe, person-centred services within ongoing financial constraints.
- The Project Board has undertaken a robust options appraisal. This has identified that developing a purpose built integrated health and social hub which will enable the delivery of a fully integrated model of care offers the best value for money.
- A range of alternative options has been explored by the Project Board, all of which require significant levels of capital investment in order to address compliance risks, but will deliver only limited benefits and will not support the delivery of strategic priorities including health and social care integration.
- It is estimated that delivery of the preferred option will require capital investment of £18.122m including quantified risk and optimism bias.
- It is anticipated that £2.9m of this will funded by CnES and so NHS WI seek a capital funding allocation from SGHSCD CIG of £15.222m.
- In addition to addressing compliance risks and the delivery of a range of qualitative benefits, the preferred option is expected to deliver cash releasing benefits of c.£150k p.a. and non-cash releasing benefits of £31k p.a. This will partly mitigate the ongoing cost pressure resulting from growing demand for service.

A short summary of each of the five cases explored in this business case is included below.

The Strategic Case

Strategic Context

The proposals remain relevant and strongly aligned to NHSScotland's strategic priorities, specifically the National Clinical Strategy and the Health and Social Care Delivery Plan as well as the policies and strategies identified in the Initial Agreement. In addition, it is central to delivering the strategic priorities outlined in the Western Isles Health and Social Care Partnership Strategy 2016-19 for the Barra and Vatersay locality.

Case for change

The case for change is based on the need to develop a fully integrated model that delivers safe, effective and person-centred care by consolidating health and social care and ambulance services within suitable facilities in order to:

- Respond to the changing needs of an ageing population located on a remote island;
- Provide a sustainable service by driving out inefficiencies and optimising integrated working and minimising the £248k p.a. cost pressures expected to arise by 2030/31 in relation to growing demand for services;
- Deliver a wider range of services closer to home;
- Deliver a person-centred flexible and responsive care;
- Provide appropriate facilities for the resuscitation and retrieval of patients;
- Ensure compliance with regulatory standards, particularly in relation to reducing fire safety and health acquired infection risks;
- Provide appropriate mortuary facilities as there are none currently; and
- Provide modern fit-for-purpose facilities that enable safe ways of working, and improve health and social care user experience.
- Optimise the use of e-health technologies to support local care and reduce unnecessary patient /client travel.

This project offers a particularly unique opportunity to design and implement an integrated care system that could be replicated in other areas of Western Isles and nationally to support the national clinical strategy to move towards a successfully integrated system of adult health and social care for Scotland.

Impact of continuing with existing arrangements

It is clear that continuing with existing arrangements is not a feasible option if NHSWI is to continue to deliver high quality and safe services to the population of Barra and Vatersay.

The age and condition of the existing facilities, which have and will continue to deteroriate over time, present significant challenges in complying with current and future regulatory standards, particularly in relation to increased fire safety and health acquired infection risks. A feasibility study, undertaken in 2012, recommended that addressing this through a refurbishment programme is not possible, due to the lack of alternative capacity available on the island to absorb the displaced demand that would arise during the required 12-month decant of patients and residents.

Divesting in the existing facilities that are housed within St Brendan's Hospital would result in the Island of Barra and Vatersay becoming the largest island population in Scotland with no access to Accident and Emergency services, short term medical beds, and outpatient services. This would create a significant clinical risk as it is essential, particularly given the geographic challenges of the island, that the population has access to emergency facilities to allow the resuscitation and retrieval of patients, as well as appropriate mortuary facilities when required.

Similarly, CnES continue to have a need to provide safe and compliant residential accommodation on the island. In the absence of an integrated solution, the council will need to identify an alternative site for a standalone development, which is likely to prove challenging given constraints around timescales and capital funding availability.

While investing in appropriate health facilities and residential housing is essential, this project is more than a building solution. Creating an integrated facility that brings togetherhospital, primary care, social care, ambulance services and provides housing with extra care is fundamental to maximising the benefits of this project for patients and service users, as well

as delivering the local integration strategy that is integral to both NHSWI and CnES medium term strategies and the success of Western Isles Health and Social Care Partnership.

In addition, there are wider socio-economic factors to consider since any divestment in services would result in reduced employment and reduced access to safe and effective care. This would significantly impact on the sustainability of the Barra population.

Investment objectives

Stakeholders agreed the following investment objectives to address the need for change.

Investment objectives

- We will have the infrastructure to deliver a wider range of fully integrated services closer to home
- We will have the facilities and pathways to support more people to live independently at home, or in a homely setting in the community, for as long as possible
- We will have fit for purpose, modern facilities that comply with fire, health and safety, and infection control regulations to improve physical access to services and enable the delivery of safe, effective care with dignity
- We will have a flexible care hub for the Barra locality that will enable improved response times and provide safe spaces suitable for the resuscitation and retrieval of patients and the delivery of urgent and intermediate care
- We will have a health and social care locality hub that will enable co-located multi-disciplinary teams to deliver well co-ordinated care that reduces duplication and minimises gaps in service provision
- We will have a model of care that makes the best use of resources and reduces inefficiencies

The Economic Case

Critical Success Factors

Critical success factors were identified that describe the main attributes essential for the successful delivery of the project and provide a basis for assessing the long list of options.

Critical success factors

- Strategic fit
- Value for money
- Potential achievability
- Supply side capacity and capability
- Potential affordability

Developing the long list of options

Stakeholders used the options framework, as outlined in the HM Treasury Green Book guidance, to identify and filter a broad range of options within the following five dimensions:

Options framework

- **Scope:** What is included in the potential coverage of the project
- **Solution:** How the preferred scope will be delivered
- **Service delivery:** Who will deliver the preferred scope and solution
- **Implementation:** Timescales for delivering the project
- **Funding:** Funding arrangements for the project

A range of potential options was identified within each of these dimensions. Each option was evaluated to assess how well it meets the investment objectives and critical success factors, as well as reviewing advantages and disadvantages. This development and assessment of the long list was undertaken during a series of stakeholder workshops.

A summary of the final long list and the results of the evaluation are shown below.

Longlist assessment

Scope					
Minimum	Intermediate				Maximum
1.1 Continue with existing arrangements	1.2 Deliver some existing health and social care services off island	1.3 Deliver existing services plus housing with extra care (tenanted units only)	1.4 Deliver existing services plus housing with extra care (tenanted and flexible units)	1.5 Deliver services in 1.4 plus increase range services available on island	1.6 Deliver all health and social care services locally
Carry forward as baseline	Discount	Possible	Preferred way forward	Discount	Discount
Does not support integration strategy	Clinical risk too great	Does not provide flexibility of step up / step down care	Optimum solution	Clinical risk too great and limited workforce capacity	Not achievable or affordable

Service solution					
Minimum	Intermediate				Maximum
2.1 Refurb existing facilities	2.2 Provide health facilities and housing with extra care (8 tenanted units) on two separate sites		2.3 Incorporate all health and social care services in one purpose built facility (including 8 tenanted + 2 flexible housing with extra care units)		2.4 Incorporate space for other public services
	Version A: Re-provide health facilities with greatest compliance risk (e.g. hospital and dental only)	Version B: Re-provide all health facilities (e.g. hospital, dental, primary care, ambulance, shared office facilities, shared storage)			
Carry forward as baseline	Possible	Possible	Preferred way forward		Discount
Not possible to make current hospital compliant	Significantly limits integration opportunities	Limits integration opportunities	Fully integrated solution		Not necessary - no significant requirement identified

Service delivery				
Minimum	Intermediate			Maximum
3.1 Separate dedicated health and social care teams with joint leadership in form of IJB	3.2 Co-located teams, joint leadership, some MDTs	3.3 Integrated MDT, some flexibility between hub and community		3.4 Fully integrated health and social care teams
Possible	Discount	Discount		Preferred way forward
Already in place and would support Options 2.1 and 2.2	Partial solution no longer considered appropriate given the introduction of single locality managers under the IJB	Partial solution no longer considered appropriate given the introduction of single locality managers under the IJB		Considered to be the most feasible solution given the current strategic direction of IJBs

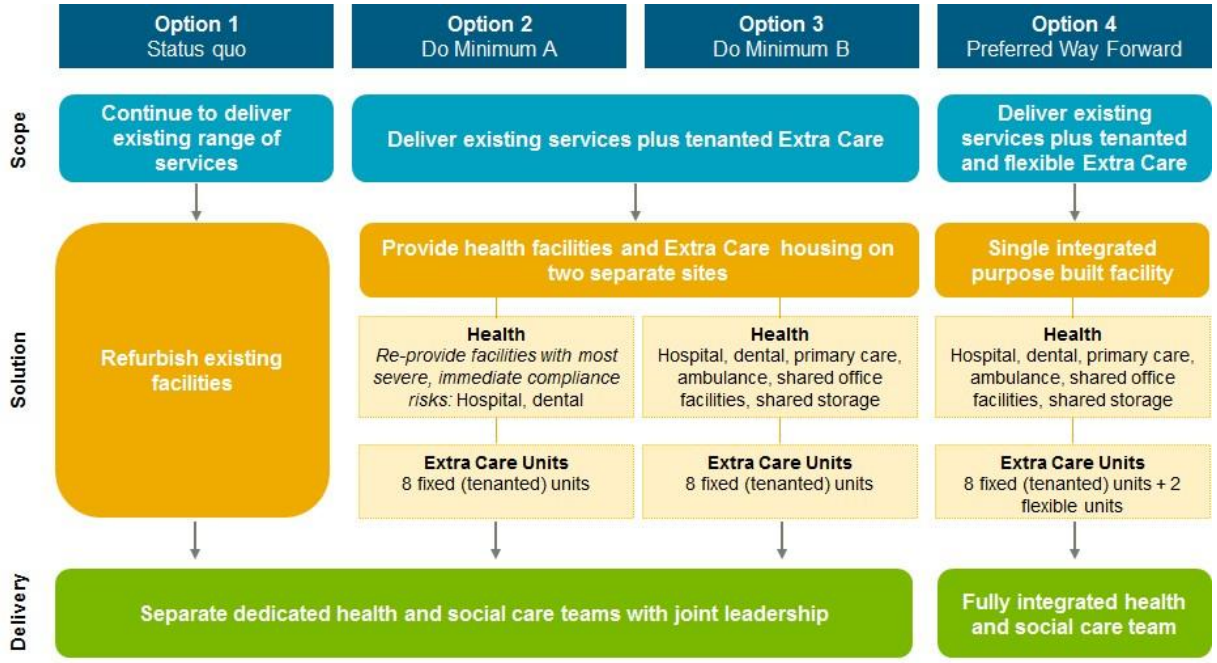
Implementation			
Minimum	Intermediate		Maximum
4.1 Phased backlog maintenance	4.2 Single phased move to new build		4.3 Phased move to new build
Carry forward as baseline	Preferred way forward		Discount
Required to support the baseline status quo option	Required to support the preferred way forward		Not feasible

Funding				
Minimum	Intermediate			Maximum
5.1 Traditional capital	5.2 Separate capital funding arrangements for NHSWI and CnES	5.3 Capital contributions from both NHSWI and CnES		5.4 Funded through alternative financing (e.g. prudential borrowing)
Carry forward as baseline	Possible	Preferred way forward		Possible
For the purposes of the Economic Appraisal, all options are considered to be financed through capital funding. The specific options are considered in detail in the Finance Case.				

Developing the short list of options

Based on the results of the longlist assessment, the options that it was determined should be carried forward from the Scope, Solution, and Service Delivery dimensions were aggregated to develop a shortlist of options, as illustrated in the diagram below.

Developing the shortlist



This generated an overall shortlist of four options, to which the appropriate options from the Implementation and Funding dimensions were added. The final shortlist is shown below.

Shortlist of options

Dimension	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Scope	Deliver current services from existing facilities	Deliver services from existing facilities where possible; for areas with greatest compliance risk from new purpose built health facilities; provide housing with extra care on a separate site	Deliver services from new purpose built health facilities and provide housing with extra care on a separate site	Deliver integrated services from a single co-located purpose-built facility
Estate solutions	Refurbish existing hospital and care home	**Standalone re-provision of health facilities** • 3 x 72-hour beds • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental **Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Standalone re-provision of health facilities** • 3 x 72-hour beds • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage **Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Re-provision of health facilities** • 3 x 72-hour beds • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage **Co-located provision of housing with extra care** • 8 x fixed (tenanted) units • 2 x flexible units
Service delivery	Separate dedicated health and social care teams with joint leadership in form of IJB	Separate dedicated health and social care teams with joint leadership in form of IJB	Separate dedicated health and social care teams with joint leadership in form of IJB	Fully integrated health and social care team
Implementation	Phased refurbishment programme	Single phased separate programmes for health and housing with extra care	Single phased separate programmes for health and housing with extra care	Single phase programme
Funding	Traditional capital – existing capital programme	Health facilities - NHS WI traditional capital Extra Care Housing – CnES traditional capital	Health facilities - NHS WI traditional capital Extra Care Housing – CnES traditional capital	Capital contributions from NHS Western Isles & CnES

In summary, the four shortlisted options are:

Shortlisted options

- **Option 1 - Status Quo:** Deliver current services from existing facilities
- **Option 2 - Do Minimum A:** Re-provide health facilities with greatest compliance risk; develop housing with extra care on a separate site
- **Option 3 - Do Minimum B:** Re-provide all health facilities; develop housing with extra care on a separate site
- **Option 4 - Preferred Way Forward:** Integrated health and social care hub

Non-financial benefits appraisal

Stakeholders identified the main benefit criteria against which to evaluate the four shortlisted options. These were ranked and weighted according to their relative importance to the project.

Benefit criteria

Criterion	Rank	Weighting
Sustainability and safety of services	1	22%
Quality of patient care and clinical effectiveness	2	20%
Integration of service	3	18%
Quality of physical environment	4	15%
Appropriate number of adequately trained staff	5	14%
Enhanced care in homely settings	6	11%

Each of the shortlisted options was evaluated against these criteria and scored by stakeholders. The scores were used to calculate an overall weighted benefits score for each option, the results of which are shown below. The maximum score for an option is 1,000.

Non-financial weighted benefits score

Criterion	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Weighted benefits score	215	532	628	795
Rank	4	3	2	1

This demonstrates that the Preferred Way Forward provides the greatest level of non-financial benefits and that there are very limited benefits associated with the Status Quo option.

Risk assessment

Stakeholders identified a range of risks and categorised as:

- Quantifiable capital risks
- Quantifiable revenue risks
- Qualitative risks

The quantifiable capital risks were assessed by stakeholders early in the OBC development process and used to calculate the optimism bias factor. The resulting optimism bias

assumption of 9.2% for the Status Quo option and 8.0% for all other options has been retained and used to calculate the capital costs for the revised shortlist of options.

Quantifiable revenue risks were assessed to assess the mean risk value (i.e. the likelihood of the risk occurring multiplied by the average of the minimum, most likely and maximum impact should it occur). The resulting expected values have been expressed in cash values to calculate the discounted Net Present Cost over the 30 year appraisal period. This is shown in the table below.

Expected revenue risk value over 30 year appraisal period

Criterion	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Risk value (NPC)	£877k	£854k	£858k	£796k
Rank	4	2	3	1

Risks that could not be quantified were assessed to determine the impact of the risk overall and the likelihood of it occurring for each of the shortlisted options. A score was allocated on a scale from low to high and this was used to calculate the overall qualitative score for each option shown in the table below.

Qualitative risk score

Criterion	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Risk score	328	283	224	149
Rank	4	3	2	1

This assessment demonstrates that the Preferred Way Forward represents the lowest risk option overall while the Status Quo option represents the highest level of risk due to compliance issues and lack of opportunity to provide integrated services to patients. The Do Minimum options represent a relatively high level of risk despite investment in new facilities as it provides limited opportunities to deliver integrated services.

Outcome of economic appraisal

Following the identification and measurement of the costs and benefits for each option an economic appraisal was undertaken.

A discounted cash flow was prepared to calculate the Net Present Cost of each option. The key assumptions are in line with relevant HM Treasury and Scottish Capita Investment Manual guidance.

Key assumptions

- Costs are calculated for a 30 year appraisal period including initial capital costs, ongoing lifecycle capital costs, transition costs and recurring revenue costs.
- Recurring revenue costs include the cost of increasing demand for services based on population forecasts up to 2031/32 and any financial benefits.
- Costs are all rebased to 2016/17 prices.
- Costs exclude VAT, general inflation, depreciation and capital charges.
- A discount rate of 3.5% is applied to the economic appraisal.

The outcome of the economic appraisal is summarised below. The Status Quo option is provided as a baseline against which the other options are assessed.

Outcome of economic appraisal (30 year appraisal at 2016/17 prices)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Initial capital costs	326	11,787	14,157	15,390
Total lifecycle costs	3,139	779	1,019	1,089
Total capital costs	**3,465**	**12,566**	**15,176**	**16,479**
Transitional costs	0	214	268	268
Total one-off revenue costs	**0**	**214**	**268**	**268**
Current baseline costs	43,552	43,552	43,552	43,552
Impact of growing demand	6,050	6,050	6,050	6,050
Revised baseline costs	**49,602**	**49,602**	**49,602**	**49,602**
Productivity savings from integrated workforce	0	0	0	(3,980)
Direct cash releasing benefits	**0**	**0**	**0**	**(3,980)**
Impact on off-island inpatient bed days of continuing with existing arrangements	1,499	0	0	0
Indirect additional costs	**1,499**	**0**	**0**	**0**
Reduction in NHS costs for Extra Care residents	0	(241)	(241)	(241)
Reduction in social care costs for Extra Care residents	0	(264)	(264)	(264)
Impact on off-island inpatient bed days of flexible units	0	0	0	(358)
Indirect non cash releasing benefits	**0**	**(505)**	**(505)**	**(863)**
Total recurring revenue costs including direct and indirect costs and benefits	**51,101**	**49,097**	**49,097**	**44,760**
Undiscounted Net Present Cost	**54,566**	**61,878**	**64,541**	**61,507**
Rank	**1**	**3**	**4**	**2**
Discounted Net Present Cost (NPC)	**33,653**	**41,725**	**44,063**	**42,754**
Risk adjustment	877	854	858	796
NPC risk adjusted	**34,530**	**42,579**	**44,921**	**43,551**
Rank	**1**	**2**	**4**	**3**

This demonstrates that the Do Minimum and Preferred Way Forward options all result in a higher Net Present Cost over the 30- year period, due to the level of investment required to deliver facilities that are compliant with current legislation. However, it is clear that Option 4 offers the greatest level of potential financial benefits.

The additional analysis below is required to compare the level of non-financial benefits in relation to costs to fully assess the value for money that each of these options offer.

Value for money appraisal

	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Net Present Cost (£'000)	34,530	42,579	44,921	43,551
Benefits points (weighted benefits score)	215	532	628	795
Net Present Cost ratio to benefits score (£'000)	**161**	**80**	**72**	**55**
Rank	**4**	**3**	**2**	**1**

It is clear from this that Option 4 offers the best value for money having the lowest ratio of Net Present Costs to benefits points.

Identifying the preferred option

The overall option appraisal below summarises the results of the economic appraisal, benefits appraisal and risk assessment.

Summary of overall option appraisal

Option Appraisal Measure	Option 1: Status Quo	Option 2: Do Minimum A	Option 3: Do Minimum B	Option 4: Preferred Way Forward
Initial capital cost including optimism bias and VAT (£000)	373	13,997	16,919	18,122
Annual recurring revenue costs by 2030/31 (£000)	1,715	1,635	1,635	1,471
Net Present Cost (£000)	**34,530**	**42,579**	**44,921**	**43,551**
Non-financial benefit points	215	532	628	795
Net Present Cost per benefit point (£000)	**161**	**80**	**72**	**55**
Qualitative risk assessment score	**328**	**283**	**224**	**149**

The conclusion from the options appraisal are:

Option 1 – Status Quo

The Status Quo option, which involves addressing the backlog maintenance of the existing facilities, offers the lowest Net Present Cost when discounted over a 30 year appraisal period due to the low level of upfront investment required. However, it does not generate any financial benefits and it has the highest ratio of costs to benefits, indicating it does not represent value for money. Overall, it does not represent a feasible option due to the high level of non-compliance risk, particularly related to hospital, care home, and dental facilities.

Option 2 – Do Minimum A

Option 2, which involves providing new health facilities for those areas with the most severe compliance risks (hospital and dental) and developing housing with extra care on a separate site, offers the next lowest New Present Cost when discounted over a 30 year appraisal period. This is because the level of investment required is slightly lower than the alternative options. However, it generates limited financial benefits, meaning recurring revenue costs remain at a similar level to the Status Quo option, and has a relatively high ratio of costs to non-financial benefits. Furthermore, the level of risk associated with this option remains high because of the limited opportunities for integrated working. Given the scale of investment remains relatively high at £14m but the solution generates only minimal financial and non-financial benefits and does not adequately mitigate risks, this option does not offer value for money.

Option 3 – Do Minimum B

Option 3, which involves providing new facilities for all areas but developing health facilities and housing with extra care on separate standalone sites, offers the highest Net Present Cost, since the level of investment required is relatively similar to Option 4 at £17m and results in fewer benefits and a higher level of risk due to limited opportunities for integrated working. This option does not offer value for money.

Option 4 – Preferred Way Forward

Option 4, which involves new co-located facilities with a fully integrated workforce, offers the best value for money despite requiring the highest level of upfront investment of £18m. This is because it provides fit for purpose facilities which support integrated working and the delivery of safe, high quality, patient-centred care. This minimises risk and results in the highest level of non-financial benefits. In addition, to this it offers the most efficient solution with recurring revenue costs estimated to be 11% lower than the Status Quo option. This option is therefore considered to offer the best value for money.

The Preferred Option

It is recommended that Option 4, the Preferred Way Forward, is taken forward as the preferred option, since it is considered to offer optimal value for money. An overview of the key features of the option is provided below.

New purpose built co-located facilities on identified site that include

- Re-provide St Brendan's hospital (including 3 x 72-hour NHS beds, 2 x resuscitation and retrieval bays and multi-purpose consulting rooms), dental facilities, primary care facilities, and create an ambulance station;
- 8 x tenanted housing with extra care units and 2 x flexible units
- Fully integrated health and social care team

Main advantages

- Purpose built, fit for purpose compliant health facilities – reducing current risks to patients, staff, and service sustainability
- Co-location of all services promotes integration of teams, enabling the delivery of more co-ordinated care and improving patient / service user experience
- Creation of an ambulance station improving response times and providing storage
- Providing housing with extra care will support residents to live independently
- Flexible units provide opportunities to improve choice for services such as respite and palliative care
- Reduced risk when unable to evacuate patients from the island due to weather and transport failures (e.g. facilities will provide suitable place of safety for mental health patients)

The Commercial Case

The SCIM guidance proposes that the default position for delivering the preferred option, having an equivalent capital value in excess of £750,000 should be via the Scottish Futures Trust hub initiative.

Hub North Scotland, which incorporates the Western Isles area, is now operational and Alba Community Partnerships, comprising Miller Corporate Holding Limited ("Miller") and Sweett Investment Services Ltd has been selected to help the public sector Participants to deliver real benefits in community and social care services to the people within the hub North Territory. Both NHS Western Isles and CnES are shareholders in hub North Scotland and signatories to the Territory Partnering Agreement.

The potential advantages to the public sector partners in using hub as an alternative to more traditional forms of procurement include faster and more efficient procurement timescales as well as cost savings through standardised processes and documentation.

It has been elected to proceed with this project as a Design and Build (D&B) project. One advantage in proceeding with the hub initiative as a procurement model is to significantly reduce the procurement timescales, and to ensure that the project is delivered as soon as practical, dispensing with the additional time and expense of a standard procurement exercise.

The Design and Build Development Agreement forms the basis of the contract between hub North Scotland and NHS Western Isles & CnES for the development of this project. This is a standard, pre-prepared contract by SFT for the commercial arrangements of D&B projects delivered through the hub initiative.

The Financial Case

The financial implications of implementing the preferred option are summarised below.

Financial implications

- Capital investment requirement of £18.122m, which is expected to be funded by:
    - £2.9m from CnES capital plan;
    - NHS WI seeking approval from Scottish Government for central capital funding of £15.222m;
- £150k p.a. of cash releasing benefits that are expected to be realised by 2030/31, which will partly offset the cost pressure caused by the forecast growing demand for services;

- £32k p.a. of non-cash releasing savings which are expected to benefit the wider system; and
- Increased capital charges of £324k p.a.

The Management Case

Management arrangements

The project plan is based on the following timescales and key milestones.

Management timescales

Action		Responsibility	Duration	Target Completion
1	Completion of OBC	Project Board	-	August 2017
2	Approval of OBC by Project Board and internal approvals as required	Project Board	Action 1 + 0 month	August 2017
3	Approval from Capital investment Group Scottish Government	Project Board	Action 1 + 3 month	November 2017
4	Preparation & approval of New Project Request	Project Board	Action 3 + 2 months	January 2018
5	hub North Scotland Stage 1	hub North Scotland	Action 4 + 5 months	June 2018
6	hub North Scotland Stage 2	hub North Scotland	Action 5 + 6 months	December 2018
7	FBC development	Project Team	Action 4 + 12 months	December 2018
8	FBC Submission to Scottish Government	Project Board	Action 8	December 2018
9	Conclude commercials	Project Board/ hub North Scotland	Action 8 + 3 months	March 2019
10	Enabling works	hub North Scotland	Action 10 + 1 month	April 2019
11	Construction commence	hub North Scotland	Action 10 + 1 month	May 2019
12	Construction complete	hub North Scotland	Action 11 + 12 months	May 2020
13	Commissioning of new buildings	Project Board	Action 12 + 1 month	June 2020
14	Demolition of existing buildings	hub North Scotland	Action 13 + 3 months	September 2020

Recommendation

The Project Board seeks approval from Scottish Government Health Directorates (SGHSCD) Capital Investment Group (CIG) for this Outline Business Case to proceed to Full Business Case stage.

17 August 2017

1 INTRODUCTION

1.1 Purpose

1.1.1 This Outline Business Case (OBC) has been developed in partnership predominantly between NHS Western Isles (Western Isles Health Board) and Comhairle nan Eilean Siar (CnES) (Western Isles Council). Scottish Ambulance Service and the Third Sector have also been involved as key stakeholders and the OBC sets out the case for investment in health and social care services for the resident and visiting populations of Barra and Vatersay.

1.1.2 The scope of the project was originally developed within an Initial Agreement (IA) which outlined a new model of care that includes the formation of a Health and Social Care Hub bringing together the existing St Brendan's hospital and care home on the island of Barra. The IA was approved by the Scottish Government Health Directorates (SGHSCD) Capital Investment Group (CIG) on 24 September 2013.

1.1.3 A draft OBC was presented to Scottish Government Health Directorates (SGHSCD) Capital Investment Group (CIG) on 2 July 2014. Since then further work has been undertaken to further develop the model of care and test the value for money of potential options to deliver the proposed solution.

1.1.4 This section of the OBC provides an overview of:

- The context of the proposed investment;
- Relevant NHS Scotland Capital Investment Guidance;
- The project's structure; and
- The structure and content of the OBC.

1.2 Context for the proposed investment

1.2.1 The Barra Health and Social Care Hub aims to fully integrate services in an innovative way that will lead to tangible benefits for patients and users, more efficient use of resources and improved team working and learning for other health and social care providers.

1.2.2 The Initial Agreement explored the Health and Social Care Hub concept and demonstrated the case for change from current arrangements. It identified a preferred way forward which was supported by a short list of options. The purpose of this OBC is to develop and test the value for money of the shortlisted options.

1.2.3 The concept of the Health and Social Care Hub is to allow services to be delivered in a fully integrated and effective way across the care home, GP practice, hospital and at home. The hub will provide safe and modern facilities that allow the co-location of health social care, inpatient and community based teams. This will enable a seamless service for patients and users, and make flexible and efficient use of people, skills and monetary resources. The focus will be on developing pathways, skills and expertise to support keeping people well and at home for as long as possible, then providing appropriate inpatient and residential care when required.

1.2.4 The Health and Social Care Hub model will also take on an important role in the coordination of care provided to its residents by other providers, particularly off-island healthcare and ensure it is received as part of an end-end pathway.

1.2.5 The model recognises the health and social care requirements to the population of Barra and Vatersay.

1.2.6 These proposals look to challenge current deficits in the accommodation and environment at St Brendan's hospital. These deficits have between recognised for

some time and currently present risks to safety and the quality of care. Realising these improvements is the

priority for NHS Western Isles and any new development will need to respond to all these concerns in an efficient and effective manner. .

1.2.7 While the existing care home currently meets required standards, it has significant environmental weaknesses and limited personalised and flexible living space. There are issues of privacy and dignity with no en-suite facilities and difficulties manoeuvring users with mobility issues.

1.2.8 Any solution will need to support efficient processes and support closer working between health and social care teams.

1.2.9 This OBC takes forward the case for change developed within the IA into a formal option appraisal to identify a preferred option. Subsequently working with Hub North Scotland it assesses alternative procurement routes available to deliver the preferred option including determining the overall capital and revenue affordability. Finally the project management arrangements to deliver the final solution are set out.

1.3 Compliance with National Capital Investment Guidance

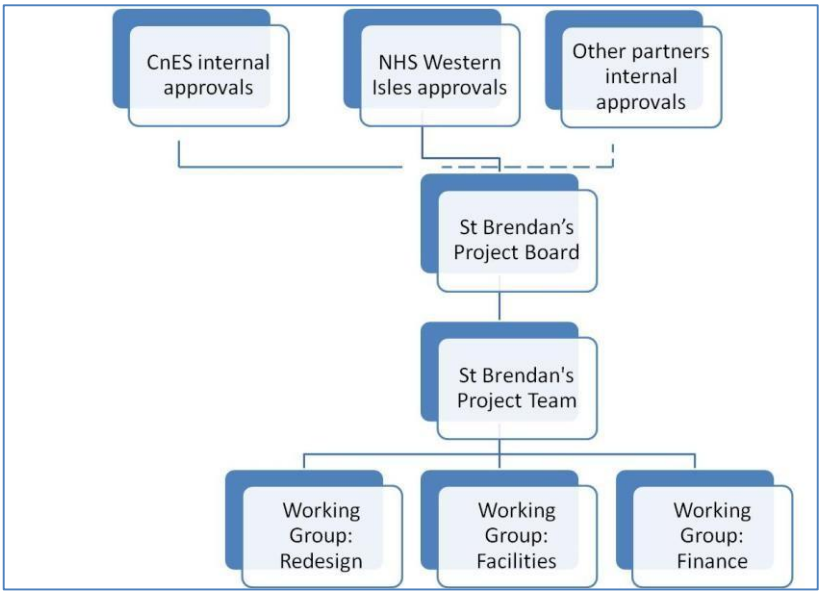
1.3.1 The proposals are presented in the form of an Outline Business Case (OBC) consistent with the requirements of the Scottish Government Health Directorates Capital Investment Manual issued via CEL 19 (2009) and the current supplementary guidance.

1.3.2 The OBC framework allows the investment benefits, costs, and risks to be identified and evaluated in a systematic way. It ensures that NHS Western Isles and CnES can demonstrate convincingly that the investment is economically sound, financially viable, clinically efficient and deliverable.

1.4 Project Structure

1.4.1 A comprehensive project governance structure has been established. A summary of the project structure is provided in the diagram below.

Figure 1-1 Governance structure



1.4.2 The Project Board is chaired by the Project Sponsor who is in turn supported by a Project Director. There is also a Project Team which includes representation from each of the services and relevant clinical and non-clinical support functions.

1.5 Structure of the Outline Business Case

1.5.1 The structure and content of the OBC is outlined below. This structure reflects the Five Case approach reflected in current Scottish Government Health Directorates guidance and accepted best practice in Business Case development and presentation.

Figure 1-2 Structure of the outline business case

The Strategic Case	**Section 2 – Strategic Context:** sets out the strategic context within which the changes proposed in this OBC will take place, the national context for healthcare developments in Scotland, and the local context for developing services in Barra.
	Section 3 – Current arrangements: provides details of 'where are we now?' which forms the basis of the 'Do Nothing' option while demonstrating the basis for particular services continuing to be provided.
	Section 4 – Case for change: builds on the analysis of the current arrangements provided in the previous section and outlines the case for change for investing in a Health and Social Care Hub based on the island of Barra by exploring the need for change, setting out investment objectives and setting out the design objectives
	Section 5 – Future Model of Care and Service Specification: sets out the fully integrated model of care developed for the proposed investment in health and social care services to form a Health and Social Care Hub based on the island of Barra.
	Section 6 – Benefits, Risks, Constraints and Dependencies: sets out the key benefits, risks, and project constraints and also considers the key project dependencies.
The Economic Case	**Section 7 – Option Identification:** summarises the longlist of options, the criteria used by stakeholders to evaluate these and the resulting option shortlist to be incorporated into the option appraisal.
	Section 8 – Non-Financial Benefits Appraisal: identifies the anticipated non-financial benefits of each of the shortlisted options, measured against weighted criteria.
	Section 9 – Risk Assessment and Identification: assesses and quantifies the capital and revenue risks associated with each option incorporating an assessment of optimism bias.
	Section 10 – Economic Appraisal: explains the value for money assessment, and presents the risk adjusted Net Present Cost (NPC) and Equivalent Annual Cost (EAC) analysis for each option.
	Section 11 – Preferred Option: sets out the rationale for the selection of the preferred option as well as a detailed analysis of its key features and anticipated benefits.

The Commercial Case	**Section 12 - Procurement Route Assessment:** outlines the proposed deal in respect of the preferred option outlined in the Economic Case and presents the value for money assessment of the potential procurement routes.
	Section 13 – Proposed Contractual Arrangements: sets out the proposed deal in respect of the preferred way forward.
The Financial Case	**Section 14 – Financial Appraisal of Preferred Option:** presents a profile of the capital and revenue costs of the preferred option and the associated projected impact on the income and expenditure of each organisation.
The Management Case	**Section 15 – Project Management & Project Implementation Timetable:** describes how the Project Board intends to manage the various phases of the project and sets out the proposed timetable and key milestones.
	Section 16 – Change Management: sets out the change management strategy framework and outline plans for the successful delivery of the preferred option.
	Section 17 - Benefits Realisation Plan: sets out the key benefits that will be delivered by the preferred option identifying the actions necessary to realise the benefits and explains how the benefits will be monitored and measured.
	Section 18 – Risk Management Plan: sets out the outline risk management plan for the preferred option going forward.
	Section 19 – Arrangements for Post Project Evaluation: sets out the proposed approach to PPE and its key phases.

1.5.2 Appendices to the OBC are contained within a separate volume.

1.6 Further Information

1.6.1 For further information about this outline business case please contact:

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STRATEGIC CASE

2 STRATEGIC CONTEXT

2.1 Introduction

2.1.1 This section of the OBC outlines the strategic background to the proposed investment in health and social care services to form a Health and Social Care Hub based on the island of Barra that enables an integrated approach to service delivery, combining primary, community, and hospital healthcare with social care.

2.1.2 It considers the following:

- Who is affected with a stakeholder analysis;
- Links to NHSScotland's strategic priorities;
- Links to other policies and strategies; and
- Influence of external factors.

2.2 Stakeholder overview

2.2.1 The proposal has been instigated by a partnership between NHS Western Isles and Comhairle nan Eilean Siar (CnES). The resulting changes will impact on a wide range of stakeholders. As part of the development of the project an extensive engagement programme has been undertaken.

2.2.2 The table below lists the organisations that have led the development of the proposed changes and how the project is incorporated within their strategic plans.

Figure 2-1 Lead organisations

Stakeholder group	Engagement that has taken place
NHS Western Isles	• Lead role in developing the project • Representatives have attended all workshops and public meetings • The project is incorporated into key strategies including the Local Delivery Plan
Comhairle nan Eilean Siar (CnES) Board	• Lead role in developing the project • Representatives have attended all workshops and public meetings • The project is incorporated into key strategies
Western Isles Integration Joint Board (IJB)	• Lead role in developing the project • Representatives have attended all workshops and public meetings • The project is incorporated into the Strategic Plan 2016-19

2.2.3 The table below lists the other key stakeholder groups who are central to the development of the project and provides details of what engagement has taken place and the level of support for the proposal.

Figure 2-2 Key stakeholder groups

Stakeholder group	Engagement that has taken place
St Brendan's Hospital	• Nominated leads have been involved in design and attended workshops

Stakeholder group	Engagement that has taken place
St Brendan's Care Home	• Nominated leads have been involved in design and attended workshops
GP practice	• Nominated leads have been involved in design and attended workshops
Scottish Ambulance service	• Nominated leads have been involved in design and attended workshops
Dental practice	• Nominated leads have been involved in design and attended workshops
Community team	• Nominated leads have been involved in design and attended workshops
Staff	• Staff have been involved from the groups above
Patients / service users	• Community groups have been involved in discussions around developing the model of care
General public	• Changes to services in a small and remote island community have a significant impact on the general public therefore a range of public consultation events have taken place

2.3 Links to NHSScotland strategic priorities

2.3.1 The proposal to develop the Barra Health and Social Care Hub aligns with the Strategic Investment Priorities outlined in A National Clinical Strategy for Scotland, the Health and Social Care Delivery Plan and NHS Scotland's Quality Strategy and the 2020 Vision for Health and Social Care.
. The table provided below outlines how the proposal responds to each of the priorities.

Figure 2-3 NHSScotland Strategic Investment Priorities

NHSScotland Strategic Investment Priority	General definition	How the proposal responds to this priority
Person centred	To provide care that is person centred, based on a long term relationship with patients, supporting and promoting personal responsibility, independence and self-management for individuals.	Changes to the model of care to enable integrated working and Extra Care Housing will: • Better support people to live independently • Enable more people able to be cared for at home or closer to home Investment in ageing facilities will: • Improve the physical condition of estate • Reduce the age of the estate • Improve care home environment All the proposed changes • Improves health and social care users experience

NHSScotland Strategic Investment Priority	General definition	How the proposal responds to this priority
Safe	Improves quality and safety in the healthcare environment - building on the Scottish Patient Safety Programme in Acute Care, Primary Care, Maternity Services, Paediatrics and Mental	Investment in facilities will: • Reduce backlog maintenance • Improve statutory compliance • Reduce the risk of adverse harmful events • Reduce the risk of Healthcare Associated Infection
Effective quality of care	Improves the effective Quality of Care particularly focused on evidence where available, increasing the role of primary care, integrating health and social care, improving the delivery of unscheduled and emergency care, and improving the current approach to supporting and treating people who have multiple and chronic illnesses	Changes to the model of care to enable integrated working and Extra Care Housing is anticipated to: • Support reduction in avoidable emergency admissions, readmissions, and timely discharge Providing multi-purpose rooms enabled with new technology will allow off-island clinicians to: • Improve access to more services closer to home Flexible Extra Care Housing Units will provide opportunities: • Improve end of life care to be as comfortable as possible in a homely environment Provision of an ambulance base: • Will improve emergency response time
Health of population	Improves health of the population particularly focused on the importance of Early Years, reducing Health Inequalities, and preventative measures on alcohol, tobacco, dental health, physical activity and early detection of cancer	Providing multi-purpose rooms enabled with new technology will allow off-island clinicians to: • Improve access to more services closer to home

NHSScotland Strategic Investment Priority	General definition	How the proposal responds to this priority
Value and sustainability	Supports implementation of the 2020 Workforce Vision through modernisation, leadership and management. Fully multi-disciplinary teams with maximum integration and co-location. Introduces investment in new innovations to increase quality of care and reduce costs. Increases efficiency and productivity through unified approaches, local solutions and decision making.	Changes to the model of care to enable integrated working and Extra Care Housing is anticipated to: • Optimise flexible and responsive resource usage.

2.4 Links to national strategic priorities

2.4.1 The proposal to develop the Barra Health and Social Care Hub is consistent with key government priorities including delivering high quality care, integrating health and social care, and serving rural populations.

2.4.2 The Initial Agreement identified a number of national strategies and policies, all of which remain key strategic drivers. These include:

- A National Clinical Strategy for Scotland
- Health and Social Care Delivery Plan
- Realistic Medicine
- 2020 Vision;
- Healthcare Quality Strategy;
- Re-shaping Care for Older People: A Programme for Change;
- Self Directed Support Act;
- Regulation of Care (Scotland) Act; and
- Registration of the Social Care Workforce and Public Services – Reform Act.

2.4.3 In addition a number of further national policies that have a key influence in driving and supporting the development of Barra Health and Social Care Hub have been identified. These are summarised in the table provided below.

Figure 2-4 National drivers

Policy / driver	How the proposal responds to this priority	Links
The Public Bodies (Joint Working) (Scotland) Bill , May 2013	The development of the hub that is underpinned by a model of care delivered by an integrated workforce supports plans for moving towards a successfully integrated system of adult health and social care for Scotland.	Public Bodies Joint Working Scotland Bill

Policy / driver	How the proposal responds to this priority	Links
Independent Review of NHS Continuing Healthcare, May 2014	One of the key recommendations included within this report is that the primary eligibility question for Hospital Based Complex Clinical Care (HBCCC) should be "Can this individual's care needs be properly met in any other setting than a hospital?"	http://www.gov.scot/Resource/0044/00444552.pdf
Shifting the Balance of Care, 2009	The aim of this initiative is to provide more continuous care which is supported closer to home, through a partnership approach between NHS, Local Authorities and the third sector advocated here. The Health and Social Care Hub will enable the delivery of a future model of care which is more community based, replacing some services previously provided in hospital, including end of life care in the setting that the patient wishes.	http://www.shiftingthebalance.scot.nhs.uk/
Delivering for Remote and Rural Healthcare, 2007	The development of the Health and Social Care Hub on the Island of Barra addresses the main aim of this report which is to ensure that accessible healthcare is available in remote and rural Scotland through integration between different aspects of the 'continuum of care'.	http://www.gov.scot/Resource/Doc/222087/0059735.pdf
Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021, December 2011	The introduction of Extra Care housing within the Health and Social Care Hub is aligned with the commitment that is outlined within the strategy to develop new models of housing with care and support in all tenures.	http://www.gov.scot/Publications/2011/12/16091323/0
Housing with Care for older people, Joint Improvement Team & Chartered Institute of Housing (CHI) Scotland	The report showcases a range of housing with models and outlines a number of common themes that make them successful. The design of the Health and Social Care Hub takes this into account.	http://www.cih.org/resources/PDF/Scotland%20general/REPORT%20FOR%20WEB.pdf

Full report on The Future of Residential Care for Older People in Scotland, February 2014	The report sets out a vision "to support older people in Scotland" to "live in homes where they feel safe and respected as members of their communities" and suggests that future residential care provision is more likely to take the form of housing with care which has a greater level of personalisation. The Extra Care housing solution proposed within the Health and Social Care Hub.	http://www.gov.scot/Publications/2014/02/6217

2.5 Links to local strategic priorities

2.5.1 The proposal to develop the Barra Health and Social Care Hub is consistent with key national, organisational, and local service strategies, as well as meeting NHS Western Isles' and CnES overarching commitment to deliver high quality care to the population of Barra and Vatersay that represents value for money and meets unique local needs.

2.5.2 The Initial Agreement identified a number of these that remain key strategic drivers. These include:

- Clinical Strategy for NHS Western Isles;
- NHS Western Isles Property and Asset Management Strategy (PAMS);
- NHS Western Isles' Health Improvement and Inequalities Strategy;
- Extended Community Care Teams; and
- Community resource hubs.

2.5.3 In addition, a number of further local policies that have a key influence in driving and supporting the development of Barra Health and Social Care Hub have been identified. These are summarised in the table provided in Figure 6 below.

Figure 2-5 Local drivers

Policy / driver	How the proposal responds to this priority
Western Isles Health and Social Care Partnership Strategy 2016-19	Plans to redevelop St Brendan's into a health and social care hub with extra care housing that will provide older people with individual tenancies, while retaining the high-level care input of traditional residential care. The proposal will support the Partnership's strategic priorities for the delivery of its vision of high quality, sustainable and integrated care within the three broad themes: 1. Quality of care 2. Health of the population 3. Value and financial sustainability
NHS Western Isles Local Delivery Plan 2016/17	The creation of clinical hubs, one being on Barra was outlined in the comprehensive Clinical Strategy which was extensively consulted on around 2008/9. Barra is the last hub to deliver.
NHS Western Isles Property and Asset Management Strategy (PAMS) 2017	A replacement for St Brendan's care home and hospital on Barra is highlighted as a key priority with this strategy, since some of the hospital accommodation is assessed and functionally 'not satisfactory' and is required to support the integration of health and social care services.
CnES strategy corporate plan	The creation of housing with extra care for residents to Barra is a key strategy for CnES.
Western Isles, Joint Commissioning Strategy 2013-23	One of the key aims of the strategy is to improve the pathways for older people, through improved integrated working and efficient use of resources across the Western Isles.

2.6 Conclusion

2.6.1 The proposal to develop the Barra Health and Social Care Hub is integral to delivering national and local strategic priorities, as well as addressing external factors that impact on the population of Barra and Vatersay.

2.6.2 With the establishment of the Western Isles Integrated Joint Board, CnES and NHS Western Isles are well placed to deliver this agenda. Their history of working in partnership across Western Isles and specifically on the island of Barra, including the joint development of this proposal, demonstrates their commitment to the collaborative working that will be critical for the successful delivery of the project.

2.6.3 As part of the partnership approach to deliver a more user-centred and flexible health and social care service, the three organisations are pro-actively engaging with broader stakeholders, to design the facilities and develop the future model of care. This will ensure that fully integrated practices and new ways of working can be successfully embedded to meet future demand within the appropriate resource envelope.

3 CURRENT ARRANGEMENTS

3.1 Introduction

3.1.1 The remainder of the Strategic Case describes why the proposed investment in health and social care services to form a Health and Social Care Hub based on the island of Barra remains a 'good thing to do'.

3.1.2 This section provides details of 'where are we now?' which forms the basis of the 'Do Nothing' option while demonstrating the basis for particular services continuing to be provided, looking specifically at:

- Overview of existing services;
- Demand and capacity analysis;
- Service providers and workforce arrangements;
- Existing assets; and
- Public and service user feedback.

3.2 Overview of existing services

3.2.1 Currently, services are delivered from two main locations. The hospital and care home are located in two buildings located on the existing St Brendan's site, while GP services are delivered from a medical practice approximately a ten minute walk away. Community Teams are currently based across these two locations and other CnES owned properties. Scottish Ambulance Service staff are home based.

3.2.2 The table below summarises the existing arrangements of the services that will be affected by this proposal.

Figure 3-1 Services affected by this proposal

Service	Existing location	Existing arrangements
General Medical Services	GP Practice	• Stand-alone practice • 2 General Practitioners 2 x GP consulting rooms are available) • Same-day patient access as standard • Practice nurse • Health visitors • Visiting services (including Podiatry, C.A.M.H.S, Retinopathy, Psychiatry)

Service	Existing location	Existing arrangements
A&E (Designated major accident / incident receiving area)	St Brendan's Hospital	• 24 hour service provided and staffed at St Brendan's as part of hospital services • Non-bypass A&E so all emergencies triaged and assessed (Minor & major injuries, paediatric) • Separate entrances for walk-in and blue-light patients • One small assessment room • Over-spill managed in IP or clinic rooms • Limited space for relatives • Telephone GP if required (usually meets ambulance) • Access to point of care diagnostics (including, Doppler, ECG, cardiac monitoring, INR) • All imaging requires transfer off-island for reporting. • Access to helicopter-pad – hold patients for transfer to mainland / other Western Isles hospital
Health Inpatient services	St Brendan's Hospital	• 5 inpatient hospital beds based on 3 single rooms and one double room • Management of acute episodes, respite care, and palliative care needs • Some patients historically had been in inpatient beds for prolonged periods of time (>6months) • Emergency admissions have to pass inpatient rooms for assessment • Shared sluice with A&E • Joint catering facilities management and some shared storage with care home
Ambulatory health services	St Brendan's Hospital	• Dental services from one clinic room with limited supporting office and storage space • One further clinic room suitable for outpatients or therapy • Range of visiting services using one clinic / therapy room (including podiatry, Ophthalmology, Dietetics, Occupational therapy, Physiotherapy, Screening services, Drugs and alcohol)
Residential care	St Brendan's Care Home	• 10 care home beds (including respite beds and off-island placements) • Communal lounge and dining room area • Registered for 2 adult day care placements • Joint catering and laundry and some shared storage with hospital.

Service	Existing location	Existing arrangements
Community services	Mixed accommodation between St Brendan's, GP and other CnES offices	• Community nursing team located in St Brendan's, putting pressure on space. (Includes palliative care, public health, family health, specialist nursing). • Visiting services • Health visitor at GP • Social care community support based at CnES offices
Scottish Ambulance Service	No dedicated ambulance base in Barra	• Staff have no facilities and are based at their own home. • There are no dedicated facilities for the actual vehicle with it kept overnight at the staff addresses • No satisfactory arrangements for equipment storage/decontamination.

3.3 Demand and capacity analysis

3.3.1 Health care services are provided both on and off the island of Barra. Current activity levels (based on 2014/15 is outlined below.

Figure 3-2 Current activity levels for health care services (2014/15)

Service	Inpatient	Outpatient	Community
On island activity			
Inpatient bed days	825 bed days (1825 staffed bed days)	-	-
A&E attendances	-	460	-
General Medical	-	27	-
Audiology	-	6	-
Physio	2	132	2
Podiatry	4	14	330
Occupational Therapy	21	1	389
Speech and Language	1	1	347
Off island activity			
Inpatient bed days	1239	-	-

3.3.2 All social care services are currently delivered on the island of Barra. An analysis of activity levels in recent years is provided in the table below.

Figure 3-3 Current activity levels for social care services

Service	2013/14	2014/15	2015/16
Residential care	13 residents	11 residents	11 residents
Respite care	346 nights (24 people)	270 nights (17 people)	255 nights (19 people)
Home care	149 hours per week (20 clients)	146 hours per week (24 clients)	157 hours per week (24 clients)

3.3.3 Forecast future demand is likely to be impacted by forecast population changes outlined in Figure 3-4. These include the following:

- Current overall population is 1,195 (2015 figures) and is predicted to increase 2.2% by 2030 to 1,221 people.
- 40.1% of the population is currently over 65 equating to 426 people.
- The over 65 population is anticipated to increase by 34.6% by 2030 to 46% of the population, equating to 572 people.
- Almost half of the growth of the over 65 population is expected to relate to over 75s.

Figure 3-4 Population forecast

Age	2015	2020	2025	2030	Movement 2015 - 2030
Under 65s	770	729	689	649	-15.7%
65-75	287	316	353	362	+26.1%
75+	139	173	198	210	+51.1%
Over 65s	425	489	541	572	+34.6%
Total population	**1,195**	**1,219**	**1,230**	**1,221**	**+2.2%**

3.3.4 It is likely that such a significant increase in the number of older people will mean an increased prevalence in Long Term Conditions (particularly dementia) which is forecast to increase by 73% across the Western Isles) resulting in growing demand for services.

3.3.5 At the same time, the anticipated decline in the overall population combined with a smaller proportion of under 65s will reduce the pool for potential workforce and unpaid carers.

3.3.6 Similarly, recent shifts to delivering care, where appropriate, closer to home, rather than within the acute hospital environment means greater demand for care within the community in future.

3.4 Current cost of delivering services

3.4.1 It currently costs £1,451k p.a. to deliver health and social care services to the residents of Barra and Vatersay. An analysis of this is provided in the table below.

Figure 3-5 Baseline recurring revenue costs 2016/17 (£'000)

	NHS WI £'000	CnES £'000	Total £'000
Pay costs	781	475	1,256
Non pay costs	146	70	216
Income	0	(67)	(67)
Depreciation	32	14	46
Baseline recurring revenue costs	**959**	**492**	**1,451**

3.4.2 It is assumed that demand for services in likely to increase in line with the forecast growth in over 65s population on the island. Based on the analysis in the preceding section, demand is anticipated to increase by 23.21% between 2016/17 and 2030/31, creating additional cost pressures for NHS WI and CnES.

3.4.3 The table below shows the estimated annual recurring revenue costs that will be required in order to meet this growing demand under the current model of care.

Figure 3-6 Annual recurring revenue costs adjusted for demand (£'000)

Year	NHS WI £'000	CnES £'000	Total £'000	Increase since 16/17 £'000
2016/17	959	492	1,451	0
2017/18	972	499	1,470	19
2018/19	998	514	1,512	61
2019/20	1,007	519	1,526	75
2020/21	1,011	521	1,532	81
2021/22	1,027	530	1,557	106
2022/23	1,036	535	1,571	120
2023/24	1,038	536	1,575	124
2024/25	1,054	545	1,600	148
2025/26	1,074	556	1,631	179
2026/27	1,085	563	1,648	197
2027/28	1,103	572	1,675	224
2028/29	1,106	574	1,681	229
2029/30	1,128	587	1,715	264
2030/31	1,118	581	1,700	248

3.4.4 This represents an overall increase in revenue funding of £248k, before inflation, by 2030/31 if we are to continue to meet demand and deliver high quality and safe services to the population of Barra and Vatersay.

3.5 Workforce arrangements and plans for locality management structure

3.5.1 Health and social care services are currently delivered by a workforce of 38.21 WTE. While budgets have been consolidated as part of the development of the Integrated Joint Board in 2016/17, staff remain employed specifically by health or social care, with separate teams of nursing staff deliver hospital and community care. An analysis of roles within each of the teams is provided in Figure 3-2 below.

Figure 3-7 Existing workforce

Role	WTE
Band 7 Nurse	1.00
Band 5 Nurse	5.49
Band 3 Nurse	5.73
Hospital nursing	**12.22**
Band 6 Nurse	2.00
Band 5 Nurse	1.60
Band 3 Nurse	1.19
Community nursing	**4.79**
Grade C	4.62
Grade E	5.08
Grade H	1.00
Grade G	2.00
Social care	**12.70**
Laundry	1.51
Kitchen	2.41
Domestic	2.05
Estates	2.00
Admin	0.53
Non clinical staff	**8.50**
TOTAL IJB STAFFING	**38.21**

3.5.2 The current reporting arrangements for nursing services both within the Hospital and the Community are managed via a Senior Charge Nurse (SCN), directly to the Lead Nurse (Community). For clinical governance and safety reasons, there remains a line of responsibility for the management of the Hospital facility that operates under the accountability of the Western Isles, Hospital Manager. The post of SCN Hospital and Community is Barra based, with the Lead Nurse (Community) and the Western Isles, Hospital Manager holding centrally based posts in Stornoway.

3.5.3 The locality management proposal for Barra and Vatersay is an opportunity to realise the aspiration, building on the premise of maximising the potential of the hub formation of services and employees.

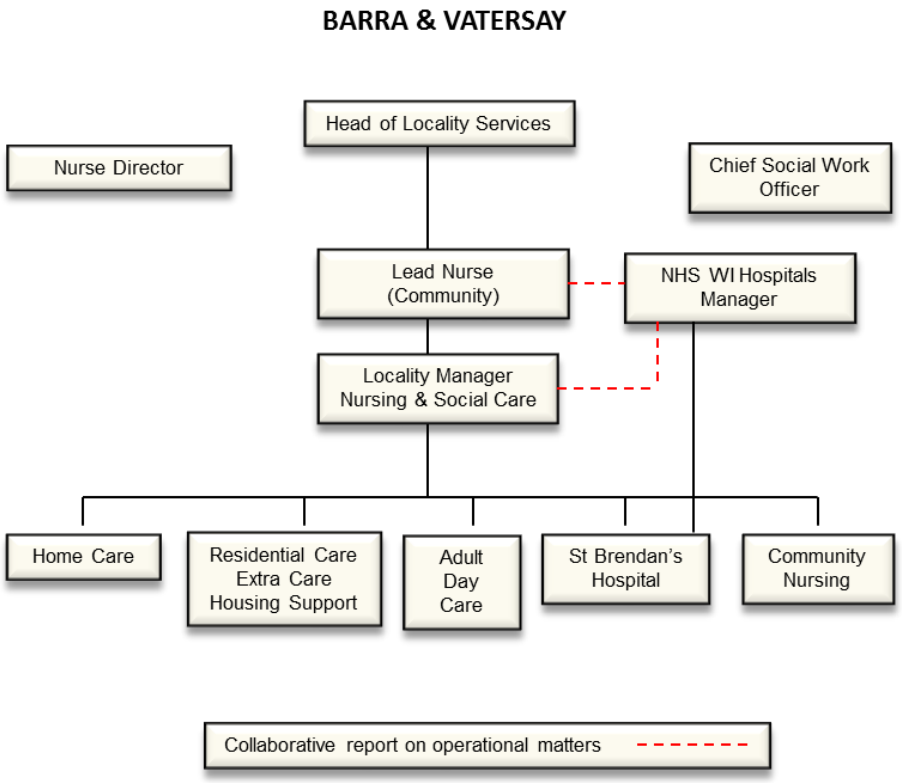
3.5.4 The current reporting arrangements for social care vary. There are currently locally based Registered Managers in residential and day care (temporary) with the line management reporting for home care services, temporarily supported by the Uists Registered Management structure. There is no local or central structure of senior management coverage of social care supporting the services on Barra. The senior management structure was disestablished to create the capacity for integrated arrangements to form. There has been a senior operational arrangement in place for Adult Services and Home Care for specific areas, but no overarching structure.

3.5.5 The services operating on Barra that are line managed by the Locality Services structure are:

- Residential Care (locally managed)
- St Brendan's Hospital (Nursing Services) (locally managed)
- Community Nursing (locally managed)
- Home Care (currently line managed from Uists)
- Adult Day Care (temporarily locally managed)
- Housing Support (temporarily locally managed)

3.5.6 The structural diagram below at indicates an operational and professional opportunity for reporting lines to form that have been consulted upon, in respect of the over-arching structure. It is considered at this stage that a Senior Charge Nurse role would continue to function which would retain the current level of clinical resource operating in the Hospital and Community based health services, whilst the Locality Manager role would undertake the Registered Management function of social care services as part of their broader remit.

Figure 3-8 Proposed locality management structure



3.5.7 In order to localise a sustainable and resilient model that joins up safe and effective care for patients and service users on Barra and Vatersay the establishment of a Locality Manager post with responsibility for the operational delivery for all locality based services would not only act as a conduit to bringing the local agendas together but would lead on the implementation of the Locality Plan, whilst being fully engaged in the strategic priorities of NHSWI, CnES and the IJB in a wider context.

3.5.8 Consideration of the inclusion of hospital based services and the continued direct reporting line to the Lead Nurse (Community) and an established role relationship with the Western Isles, Hospital Manager coupled with the retention of a Senior Charge Nurse, at this stage indicates that locality management and leadership on Barra and Vatersay would not require to be person specific in respect of the professional background required. At this stage of consultation it is considered that a person with a knowledge, skill set and qualification that has been obtained in a Health and Social Care discipline could competently lead the local service arrangements.

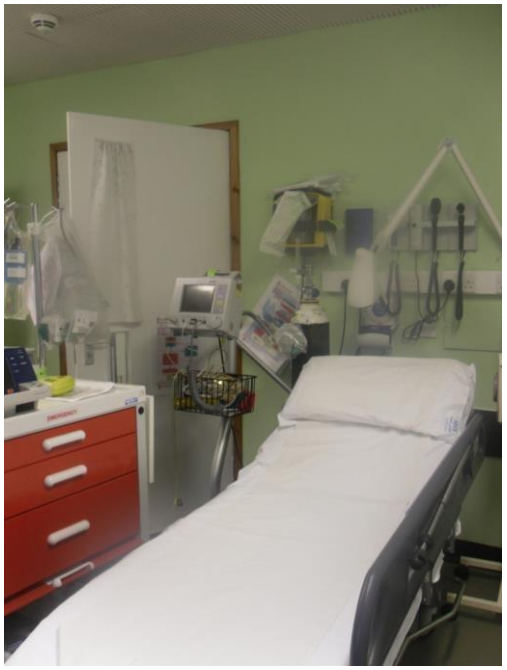
3.6 Existing assets

3.6.1 The St Brendan's building was erected circa 1980 and has received significant investment in maintenance since 2005. The construction of the building envelope

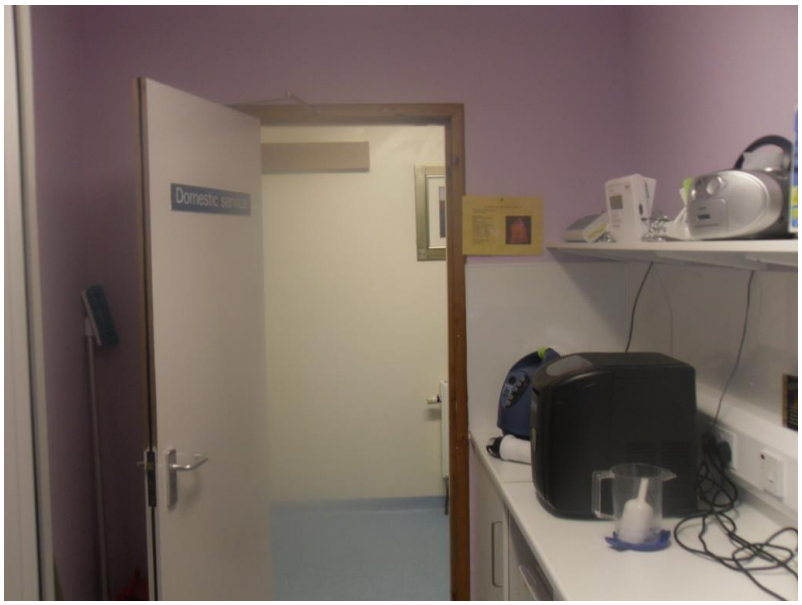
does not meet current energy standards and would require significant upgrading to achieve a satisfactory level of insulation and performance.

3.6.2 The hospital building falls significantly short of the standards recommended by NHS Design Guidance and the National Care Standards. In particular, there is a lack of functional space required to effectively support the required operational and clinical processes in an environment that is conducive to effective patient recovery and social care client residence. A summary of the main issues for the existing estate is provided below along with some supporting images to evidence the main factors highlighted.

- Separation of ambulant and emergency flows
- Insufficient waiting space adjacent to the main entrance area
- Insufficient and inadequate A&E space for resuscitation and assessment



- A lack of clinical rooms to effectively support ambulatory activities e.g. near point of testing lab located in sluice room



- A lack of clinical support rooms, with some existing rooms being inappropriately utilised for multiple functions
- No appropriate area for childbirth
- Inpatient accommodation does not provide adequate space for manoeuvring patients with ease and creates an enhanced risk in terms of the control and prevention of infection

- A severe shortage of storage space

- Storage and staff support accommodation is inconveniently located

- Facilities management support space is insufficient

3.6.3 The Care home estate is also regularly inspected by the Care Inspectorate against environment and compliance with statutory requirements. Whilst it meets the minimum standards there are however operational limitations to the current accommodation which include:

- Some bedrooms are too small for the required functionality
- There are no en-suite facilities
- A lack of / poor location of support rooms and storage space
- Challenges in meeting individuals' assessed needs
- Limitations in moving users with mobility issues

3.6.4 The Care Home meets regulatory compliance, however is outdated and requires to be replaced.

3.6.5 The service is fit for today but not for the near future. Financial investment is inevitable in order to comply with current standards.

3.6.6 The layout and design of the facility does not allow for personalised care, nor does it provide for recent improvements in technology to reduce the impact of invasive intimate care practices and manual handling.

3.6.7 The GP practice is also fit for today but not for the near future. Potential issues include:

- Ambulance / stretcher access to the practice is difficult
- The Community Psychiatric Nurse is in the basement of the building and seeing patients there can present a risk to staff
- Access to the building for community teams out of hours is limited
- There is no space to accommodate an increase in clinics / visiting services

3.6.8 There is no dedicated ambulance base for staff and vehicles with staff based from their own homes which can impact on response times.

3.6.9 At Workshop 1, stakeholders confirmed problems with the existing arrangements in relation to the main service areas.

Figure 3-9 Problems with existing arrangements

Existing Service	Problems
Hospital	• Treatment room inadequate in relation to infection control and fire, health and safety standards • Multiple use of rooms • No provision for telemedicine • No place of safety for individuals with mental health crisis • No interim mortuary • No general storage space • No office space • Resuscitation and retrieval team significant space constraints • No facility for rehabilitation
Care Home	• Not fit for purpose (fire, health and safety regulations) • Inefficiency of staff deployment (different registrations) • Inability to meet priorities in community as staff in building-based model • Building does not support multi-disciplinary working – encourages silo working • Not capable of being dementia friendly • Lack of supported housing impacting ability to support independence
GP Surgery	• Currently based in a converted house • Too few consulting rooms available when operating at full capacity and a reliance on shared spaces (estimated to be 1 room short) • Ability to meet future infection control standards • Limited facilities for CPN, health visitor, midwife • Difficulties related to physical access • Risks related to DDA compliance
Dental Services	• Ability to meet future clinical standards • Reliance on supply chain to meet standards (e.g. decontamination services) • Increasing physical access difficulties for certain patient groups (e.g. Obesity) • Facilities restricting practice (e.g. orthodontics) • Inappropriate facilities for cash handling systems • Barriers to integrating electronic systems
Ambulance Services	• No base • No ability to connect to technology through N3 connection • Slower response time due to time taken to meet up with partner • No space for cleaning equipment supplies storage and
General	• IT – barriers to storing information • No End of Life or hospice facility • Multi-skilled workforce already in place but environment creates barriers to working in the right place, at the right time, in the right way • Impact of home care provision delaying discharges

4 CASE FOR CHANGE

4.1 Introduction

4.1.1 This section builds on the analysis of the current arrangements provided in the previous section and outlines the case for change for investing in a Health and Social Care Hub based on the island of Barra by:

- Exploring the need for change; and
- Setting out the investment objectives.

4.2 Need for change

4.2.1 The proposed investment is driven by a need for change that has been identified through the need to overcome problems with existing arrangements, respond to drivers for change, and opportunities to improve outcomes.

4.2.2 The main reasons causing the need for change are listed in the table in Figure 4-2 which also describes the likely impact of the status quo continuing as well as highlighting why action is required now through this proposal.

Figure 4-1 Main issues causing the need for change

Causes of the need for change	Effect of the cause	Why action now
Future service demand	An ageing population is likely to result in an unprecedented increase in demand for services, creating a cost pressure of £248k p.a. by 2030/31. In addition to this there is an increasing need to deliver services closer to home	To ensure that the growing demand for different types of services can be met to ensure patients receive the right care at the right time in the right place and minimise the associated cost pressures.
Dispersed service locations	Services are currently delivered from different locations creating challenges in implementing integrated working. Lack of technology-enabled areas mean services rely on visiting consultants or patients accessing services off-island, resulting in inequalities and increased travel costs.	Service access is currently inequitable for this locality when compared with other catchment areas
Ineffective service arrangements	Potentially inefficient service performance with workforce dedicated to specific areas and potentially underutilised	Continuation of the existing service performance is unsustainable
Service arrangements not person centred	Service is not meeting current or future user requirements	A service that isn't meeting user requirements is unsustainable, even in the short term

Causes of the need for change	Effect of the cause	Why action now
Accommodation with high levels of backlog maintenance and poor functionality	Increased safety risk from outstanding maintenance and inefficient service performance	Building condition, performance and associated risks will continue to deteriorate if action isn't taken now
Introduction of locality management structure	The introduction of a locality management structure drives the need for an integrated workforce	Current arrangements create a barrier to integrated working and threaten the success of the planned implementation of the locality management structure

4.3 Impact assessment

4.3.1 Further work has been undertaken to assess the impact of continuing with existing arrangements.

4.3.2 The 2012 feasibility study made clear that the refurbishment of the existing buildings was not recommended, since it would involve a 12-month decant of patients and residents. No alternative capacity on the island could absorb the displaced demand.

4.3.3 Were the OBC not to be supported by the Scottish Government, the Comhairle would still want to look at the option of a new residential or extra care housing facility elsewhere on the island, were a suitable site to be identified. However, timescales and constraints on capital funding would impact on the feasibility of this exercise.

4.3.4 Were NHS Western Isles to divest itself of a cottage hospital on the Isle of Barra, it would become the largest island in Scotland not to have access to an A&E, short-term medical beds, and outpatient services. This would have a major impact on the delivery of healthcare, as well as wider socio-economic factors. It would have a significant overall impact on the sustainability of the Barra population, result in job losses and nursing and medical care required to keep people on the island to the safest extent that can be provided.

4.3.5 There is also a case for containing a mortuary within a new hospital as there is no existing facility on Barra for this. Recently due to poor weather and relatives travelling a distance for a funeral, the remains had to be held in a refrigerated lorry until the funeral could take place. This falls short of the standard we would like and since then NHS Western Isles have invested in a single-bed cooling unit that can be used in the existing hospital. This still falls short of the kind of service we should provide for the community as it still requires that the remains are held within the hospital until such time that other arrangements can be made.

4.4 Investment objectives

4.4.1 The investment objectives outline 'what we are seeking to achieve' with this proposal. Stakeholders have further developed the objectives originally identified as part of the Initial Agreement and have agreed a list of six SMART investment objectives that respond to business needs.

4.4.2 The refined investment objectives are outlined in the table in Figure 4-3 below. They are shown in relation to what is required to overcome the 'effects of the causes of the need for change' that were identified in the previous section.

Figure 4-2 Investment objectives

Business needs (Effect of the cause of the need for change)	Investment objectives (What needs to be achieved to overcome this need)
Improve access to services	We will have the infrastructure to deliver a wider range of fully integrated services closer to home
Support independent living	We will have the facilities and pathways to support more people to live independently at home, or in a homely setting in the community, for as long as possible
Compliance with fire, health, and safety regulations	We will have fit for purpose, modern facilities that comply with fire, health and safety, and infection control regulations to improve physical access to services and enable the delivery of safe, effective care with dignity
Deliver safer services	We will have a flexible care hub for the Barra locality that will enable improved response times and provide safe spaces suitable for the resuscitation and retrieval of patients and the delivery of urgent and intermediate care when required
Enable effective integrated care	We will have a health and social care locality hub that will enable co-located multi-disciplinary teams to deliver well co-ordinated care that reduces duplication and minimises gaps in service provision
Contribute to sustainable services	We will have a model of care that makes the best use of resources and reduces inefficiencies

4.5 Design statement

4.5.1 An overview of the work undertaken to date to develop the design statement is provided in Appendix B3. Further work is required to complete it and this will be commenced following approval of the OBC.

4.6 Conclusion

4.6.1 The case for change demonstrates that the proposed investment in health and social care services to form a Health and Social Care Hub based on the island of Barra remains a 'good thing to do'.

4.6.2 The investment objectives are a direct response to problems with existing arrangements ad clearly outline what the proposal seeks to achieve.

4.6.3 These inform the potential scope of the project that is explored in the first part of the Economic Case and the future model of care that is explored within section 5.

4.6.4 Benefits and risks are explored in detail within the Management Case.

5 FUTURE MODEL OF CARE AND SERVICE SPECIFICATION

5.1 Overview

5.1.1 The replacement of St. Brendan's Hospital and Care Home, offer a unique opportunity to modernise health and social care services and optimise the opportunities to future proof our services for the population of Barra and Vatersay.

The development of the model of care has been taken forward in partnership between NHS Western Isles, Comhairle nan Eilan Siar and Western Isles Integrated Joint Board. All of the key stakeholder groups who have an interest in what their services will look like, both to work in and to use have been central in the development process. An all-inclusive Stakeholder Group was established in March 2013. The membership includes staff from St Brendan's Hospital, St Brendan's Care Home, the local GP and Dental Practices, Scottish Ambulance Service and the Community Team. Pivotal to the development and agreement of the model has been the involvement and input from patients and carers, the third sector and other community groups. While it has taken us some time to develop our model we believe that the time taken has been beneficial in that we now have a model which is robust, innovative and which reflects the Scottish Government vision that people will be living healthier, longer lives at home, or in a homely setting and only admitted to hospital when clinically necessary.

The Model

Our model is predicated on an Integrated Health and Social Care Hub, bringing together Emergency Medicine, General Practice, Dentistry, Social Work, Social Care, Mental Health, Community Nursing, Homecare and Scottish Ambulance Service (SAS) within a single campus. It will be a leading example of how an integrated health and social care system should operate. The redeveloped St Brendan's Hospital/Care Home site will become the Hub for this full range of integrated services and will provide a support base for our wider community services.

Care will be delivered to the highest standards of quality and safety, with the person who uses our services at the centre of all decisions. planned around services not buildings.

The redeveloped St Brendan's hospital will comprise 3 short term beds, 2 resuscitation and retrieval bays, 3 primary care consulting rooms, 2 multi-purpose clinical rooms, 2 Dentistry rooms, 1 SAS room (workspace, storage for kit and drugs and cleaning/decontamination ability). Whilst it is not envisaged that hospital patients will require day care, it is likely that tenants within the housing and extra care will have a need for day care. Tenants will have the choice of commissioning day care under their own self-directed care or attending one of the third sector day care providers on Barra**.**

The model includes the replacement of the current 10 bedded residential care home facility with Extra Care Housing comprising 8 permanent residencies and 2 flexible spaces .We are also planning on extending support beyond the extra care housing to individuals in the wider community.

The integration of the existing Care Home staff with Health Service staff has already began with cross-working between the current facilities. Staff response is positive and there is enthusiasm to develop this further as plans progress for the new facilities.

The fully integrated resources available across the St Brendan's Hub will embed the provision of person centred care on a continuum from routine housing support and care at home, expanding and extending through to the most complex hospital care, through to end of life care, responding to individuals' circumstances and needs. The flexible environment of both permanent and short term tenancy of the housing facility, allows for a stepping up, or stepping down of care to meet the person's needs responsively and as an alternative to their current or former home, either temporarily or permanently.

Patients/clients within the physical environments on the hub site, will wherever possible and appropriate, receive care within their current setting, without the need to move from housing to hospital. A fully integrated single staffing resource will allow for maximum flexibility in the way staff deliver care.

The co-location of the Primary Care services as part of the Hub will enhance the ability to provide efficient and effective anticipatory care planning and provision for vulnerable individuals.

The hub development will see the full integration of hub based health and social care staff and those in the wider community setting. Streamlined, integrated management will allow the assessment and delivery of a flexible, responsive service working horizontally in response to patient/client need as opposed to the current vertical arrangements which are less efficient and/or effective.

The improvement to the current out-moded single chair dental facility to accommodate 2 chairs will provide the community of Barra and Vatersay with modern dental services comparable to those provided elsewhere in the Western Isles and Scotland.

The Scottish Ambulance Service (SAS) does not currently have a designated base and the ambulance is currently home based. Co-location with the Hub will result in better planning for

unscheduled care, increased input to the hospital by the Paramedic and improved communications between the whole clinical team.

We are currently developing interesting remote diagnostic capacity and we will take the opportunity to look at how this can be applied in the new model**.** Comprehensive IT cover will be provided in the Hub including VC facilities in emergency, ambulatory, GP, dental, consulting and treatment areas including tele-health care carts as required. Emergency area will also have remote analysers for blood/gases etc. Access to desktop IT as appropriate for staff and access to telephones throughout public access to wifi will also be considered.

A wider consideration is the consultation currently underway for legislating safe and effective staffing levels in health and social care, it is anticipated that this Integrated Workforce Planning approach to the Model of Care will support the delivery of the duties of both the Health Board and the Comhairle. This legislation seeks to introduce a requirement for the provision of appropriate numbers of suitably qualified staff, similar and learning from the current requirements for Care Service Providers, set out in the 2011 regulations.

5.2 Potential Scope

5.2.1

5.2.2 Coverage and services are considered on the following continuum of need:

- **Core:** Essential changes without which the project will not be judged a success
- **Desirable:** Additional changes which the project can potentially justify on a cost/benefit and thus value for money basis
- **Optional:** Possible changes which the project can potentially justify on a marginal low cost and affordability basis

5.2.3 The potential scope of services and the way in which they will be delivered within each of these categories is outlined in the table below.

Figure 5-1 Potential scope of services

Area	Core	Desirable	Optional
Healthcare Services: On Island			
Inpatients and A&E: • Emergency and urgent care • Intermediate care • GP assessment • Retrieval	Re-provide in purpose built health care Hub	Co-locate with social care in single Hub	

Outpatients: • General Medical • Audiology • Physiotherapy • Podiatry	Re-provide in purpose built health care Hub	Co-locate with social care in single Hub	
Community • Podiatry • OT • Speech and Language	Provide office and meeting space within health care Hub	Co-locate with social care in single Hub	
Primary Care GP services	Re-provide in purpose built health care Hub	Co-locate with social care in single Hub	
Dental Services	Re-provide in purpose built health care Hub	Co-locate with social care in single Hub	
Ambulance Service	Provide ambulance base within purpose built healthcare Hub allowing enhanced integrated working	Co-locate with social care in single Hub	
Healthcare Services: Off Island			
Inpatients and A&E: • General / Medical acute/surgery/ diagnostics	Continue with existing arrangements		

Area	Core	Desirable	Optional
• Obstetrics • Psychiatry			
Social care services			
Residential Care	Re-provide with fixed tenanted Extra Care Units	Add flexible units for step up / step down	
Respite Care	As above	As above	
Day Care	TBC		
Home Care	Provide office and meeting space within health care facilities	Co-locate with health care in single hub	
Other public services			Co-locate with health and social care hub

5.3 Key service requirements

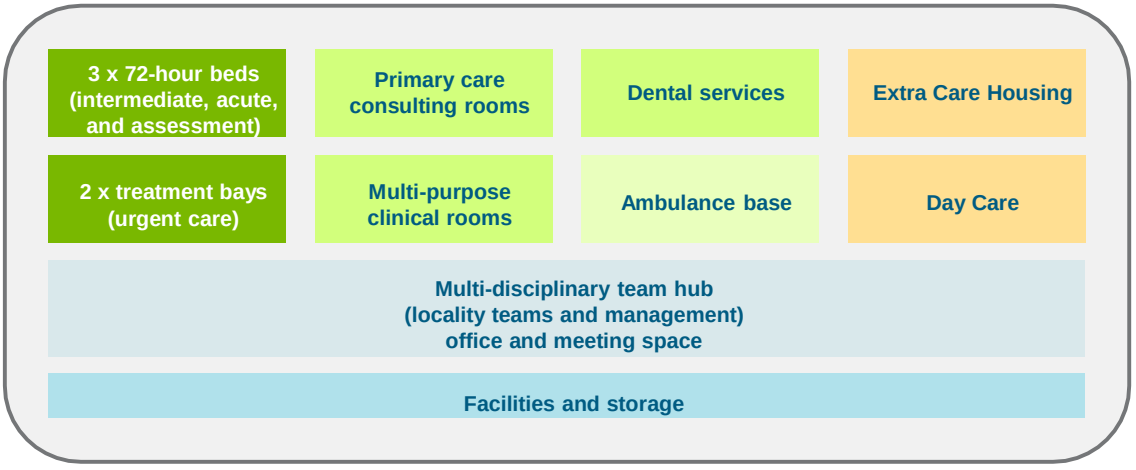
5.3.1 At a series of workshops, stakeholders identified a number of key service requirements that need to be incorporated within the future model of care. These are outlined in Figure 5-2 below.

Figure 5-2 Key service requirements

Service area	Requirements
General	• Co-located services • Fit for purpose facilities • Improved physical access to facilities
Health facilities	• Multi-functional rooms providing the flexibility to accommodate emergency maternity situations, palliative care, etc • New consulting rooms with telehealth facilities • Safe and appropriate resuscitation facilities
	• Ambulance base co-located with hub
Care facilities	• Extra Care housing plus extra
Ways of working	• Staff integrated in a multi-disciplinary team, working in an integrated way to provide a seamless service for patients and service users • Locality based single management structure • Improved access to services (earlier interventions – right care at the right time delivered in the right way)

5.3.2 The proposed health and social care hub enables the delivery of the future model of care by co-locating services and enabling staff to work in an integrated way. The key areas to be included in the hub are illustrated in Figure 5-3 below.

Figure 5-3 Overview of health and social care hub



5.4 Estates specification

5.4.1 As part of this work, stakeholders revisited the requirements for the estates solution. The requirements below are believed to best meet business needs, deliver the future model of service and be flexible to meet future demand.

Figure 5-4 Key service requirements: estates

Area	Core	Desirable	Optional
Beds	3 x 72 hour beds		
resuscitation and retrieval bays	2 x resuscitation and retrieval bays		

Primary care consulting rooms	1 x GP 1 x Nurse Practitioner 1 x GP Registrar / Medical Student / Rural		
Multi-purpose clinical rooms	1 x Physio / Multi-purpose room 3 x Multi-purpose rooms		
Dental services	2 x rooms Reception area		
Ambulance service	1 x room (workspace, storage for kit and drugs)		
Extra Care housing	8 x permanent residencies funded through rental income	2 x flexible spaces	
Day Care	TBC		
Multi-disciplinary team hub: office and meeting spaces	Working space for integrated team and 1 flexible meeting room		
Facilities and storage	Kitchen, pantry, laundry store, equipment stores, mortuary		
Other public services			Housing office

5.5 Service Specification – Workforce implications

5.5.1 The future model of care will require new ways of working. The potential scope of this is outlined in the table below.

Area	Core	Desirable	Optional
Single leadership	IJB leadership and shared budget in line with existing arrangements		
Communication	Health and social care staff located in separate facilities	Staff co-located in single hub	
Staff dedicated to hub or community	Staff based within the hub or as part of the community team	Staff able to work flexibly between the hub and community	
Staff dedicated to health or social care	Staff deliver either health or social care services		Staff able to flex between delivery of health and social care services

6 BENEFITS, RISKS, CONSTRAINTS AND DEPENDENCIES

6.1 Overview

6.1.1 This section of the OBC:

- Sets out the main outcomes and anticipated benefits of the project
- Highlights the main risks of the project as well as the key project constraints and dependencies

6.2 Main Outcomes and Benefits

6.2.1 In developing the key outcomes and benefits NHS Western Isles and CnES have reviewed the Investment Objectives and benefits developed as part of the IA and sought to consider how these translate into more measurable outcomes and benefits arising from the proposed development.

6.2.2 These benefits and outcomes have been used to develop more detailed criteria to assess the extent to which each of the shortlisted options are capable of meeting the overall requirements of the project.

6.2.3 The key outcomes and benefits arising from the proposed investment in services are set out in the table below.

Figure 6-1: Main outcomes and benefits

Benefit	Mapped to benefits identified in IA	Outcome and benefit	Benefit Criteria
Improves service effectiveness	• Improves timely access to services and decision-making • Appropriate utilisation of services • Enable closer and integrated working across all teams involved in provision of care • Joined-up patient and user experience • Department flow reflects patient / user capacity and needs • Reduced cost of service delivery Current and future demand met through new ways of working • Focal point for coordinating health and social care needs for the population • Focus for managing care both in hospital / care home and at home • Joint working and care planning • Flexible use of resources	Provides clinically effective and integrated health and social care services, enabling the full implementation of new models of care.	Clinical effectiveness, integration of service

Benefit	Mapped to benefits identified in IA	Outcome and benefit	Benefit Criteria
Responds to changes in demand	• Service capacity aligned to demand • Service profile reflective of need • Capacity and profile of services reflects anticipated changes to demand • Safe processes for transfers between providers • Costs of increased demand avoided by new ways of working • Cost avoidance of need for expensive adaptations • Sustainability/ longevity of facility	Ensures that services are flexible enough to respond to the changing nature of demand for health and social car services by incorporating anticipated changes in demographics and morbidity into the service	Sustainability & Safety of Services
Improving service quality	• Pride and confidence in local services • Increased patient and user satisfaction • Strong reputation of services • High standards of care • Confidence in quality of care • Reduced unnecessary travel	Supports improved quality of patient care by delivering services closer to home and reflecting latest models of health and social care	Quality of Patient Care
Staffing	• Increased staff satisfaction / morale • Improved staff recruitment and retention • Increased utilisation of staff skills	Will help facilitate NHS Western Isles & CnES in providing the right number of staff with the right skills in the right place at the right time	Appropriate numbers of adequately trained staff

Benefit	Mapped to benefits identified in IA	Outcome and benefit	Benefit Criteria
Enhanced physical environment	• Confidence in long-term suitability of facility • Compliance with statutory requirements • Patients and users are assessed and cared for with dignity in appropriate accommodation • Environment meets health and social care building guidance • Inpatients are not exposed to A&E activity • Maximisation of natural and local resources • Use of green and sustainable energy alternatives • Increased building efficiency • Single-point of access	Provides an enhanced physical environment through improving the range and standard of accommodation required to meet clinical and functional requirements of patients, staff, visitors and other users of the facilities.	Quality of physical environment

6.3 Main Risks

6.3.1 A project risk register has been developed and this is shown below. The risks have been grouped into the follow key areas:

- Capacity & Demand
- Staffing
- Operational
- Reputational & policy
- Timing & Disruption
- Funding
- Technology
- Commercial

6.4 Key Project Constraints

6.4.1 This section considers the parameters that the project is working within and the constraints that are imposed on the project.

6.4.2 **Service Delivery Constraints -** Health and social care services are required to meet statutory and legal requirements and proposed changes will need to retain or improve compliance with a range of standards and indicators. In addition the proposed model of care and identified benefits are unlikely to be realised within existing accommodation and therefore successful service delivery is reliant upon the availability of capital funding to invest in new facilities.

6.4.3 **Capital Funding Constraints -** Due to the current funding constraints faced by public sector organisations, capital funding for this scheme is not necessarily available. Alternative sources of funding are being explored and considered, such as revenue

funding and sale proceeds from existing assets and private investment due to the pioneering aspects of the project in terms of integration and sustainable energy. Funding commitment to this source has not yet been granted and, therefore, remains a constraint on the affordability of the scheme.

6.4.4 **Revenue Funding Constraints –** Initial revenue analysis has been undertaken taking into account energy efficiencies, increased level of maintenance support; opportunities to realise efficiencies through integration and new ways of working.

6.4.5 **Site Availability Constraints -** The current assumption is that land adjacent to the existing site will be jointly acquired and will be used to build the new facilities allowing the existing site to meet parking and other planning requirements. The existing buildings will be demolished on completion and transfer of existing facilities. Whilst other options have been considered there are limited sites available due to cost, flood-risk, and accessibility of location. The option of rebuilding the existing facility was also considered but without any decant options this is not viable.

6.5 Project Dependencies

6.5.1 The proposal for investment in health and social care recognises the complexity of delivering these services in the unique location of Barra. Whilst the CnES and NHS Western Isles are committed to collaboration and the success of the project, both partners recognise that other organisations, decisions and factors are also integral.

6.5.2 The key dependencies are summarised below:

- The development of a fully integrated (physical or operational) model is dependent upon the continued collaboration between CnES and NHS Western Isles. Both organisations have competing pressures and priorities which may inhibit their ability to sustain the required level of time or investment anticipated.
- The GP practice on Barra is pivotal to the design and delivery of any healthcare model and must continue to be closely involved with this project. Any change in personnel in this post could have significant implications for the project.
- Other partners have been identified as being important to the design and delivery of the proposals and these include, Scottish Ambulance Service, other NHS providers, Air ambulance / coast-guard services, local community groups, residents and carers, Highlands and Islands Enterprise (HIE) and IT providers. There are likely to be further partners identified throughout the duration of the project.
- Changes to model of care may lead to the involvement of Trade Unions.
- The Area Partnership Forum has been engaged and regularly updated throughout.
- There may be difficulty in the retention of staff if significantly different ways of working are deployed, as many of the staff have worked within existing systems for long periods of time. Equally recruitment of staff into any new or replacement roles may be difficult due to the remote location.

6.6 Conclusion

6.6.1 The expected outcomes and benefits as well as the main risks, key project constraints and project dependencies from this development have been identified, developed and agreed by NHS Western Isles and CnES during the development of this OBC.

6.6.2 These together with the key investment objectives were used to formulate a shortlist of options and to assess the non-financial benefits of the shortlisted options. This option development process is covered in the first section of the Economic Case.

ECONOMIC CASE

7 OPTION IDENTIFICATION

7.1 Introduction

7.1.1 The purpose of the economic case is to identify and appraise the options for the delivery of the programme and to recommend the option that is most likely to offer best value for money.

7.1.2 The first stage of the economic case explores the preferred way forward by undertaking the following actions:

- Agree critical success factors (CSFs);
- Develop and evaluate the long list of options; and
- Recommend a preferred way forward in the form of a shortlist of options.

7.2 Critical success factors

7.2.1 Critical success factors (CSFs) are the attributes essential for successful delivery of the project. The CSFs are used alongside the project spending objectives to evaluate possible options for the delivery of the project.

7.2.2 The CSFs were outlined at Initial Agreement stage and validated as part of the development of the OBC. The final CSFs are provided in the table below.

Figure 7-1 Critical Success Factors

CSF	Description
Strategic Fit	Meets agreed spending objectives, related business needs and service requirements.
Value for Money	Optimises public value in terms of the potential costs, benefits and risks.
Potential Achievability	Will be delivered within the specified timeframe. Matches the available skills required for successful delivery.
Supply side capacity and capability	Matches the ability of supplier(s) to provide required services within the required timescales. Is likely to be attractive to the supply side.
Potential Affordability	Available capital and revenue resources are sufficient to support the successful delivery of the proposed facility and services.

7.3 The options framework

7.3.1 The options framework, as outlined in HM Treasury's Green Book guidance, provides a systematic approach to identifying and filtering a broad range of options for operational scope, service solutions, service delivery vehicles, implementation timeframes and the funding mechanism for the project.

7.3.2 An overview of these key dimensions is provided below.

Figure 7-2 Options framework

Dimension	Description
Scope	What is the potential coverage of the project
Service solution	How the preferred scope of the project can be delivered
Service delivery	Who can deliver the preferred scope and service solution for the project
Implementation	When the preferred scope, service solution and delivery arrangements for the project can be delivered
Funding	Potential funding requirements for delivering the preferred scope, solution, service delivery and implementation arrangements for the project

7.4 Developing the options long list

7.4.1 The range of possible options within each of the options framework dimensions were initially identified as part of the Initial Agreement. This was further developed as part of the Outline Business Case that was submitted in July 2014.

7.4.2 The long list was revisited and refined based on the outputs of the stakeholder workshops and meetings held on 16 December 2015, 24 February 2016, and 4 July 2016.

7.4.3 As part of this, each of the long listed options was evaluated, focusing on how well each option meets the project's critical success factors and spending objectives, as well as exploring advantages and disadvantages.

7.4.4 Based on this evaluation, an assessment was made about whether it is feasible to carry the option forward in terms of:

- **Preferred way forward:** The option that is most likely to optimise public value for money since it best meets critical success factors and spending objectives, while advantages far outweigh disadvantages.
- **Possible:** Options to carry forward for further evaluation on the basis that they adequately meet a range of critical success factors and spending objectives, while advantages outweigh disadvantages.
- **Discount:** Unrealistic options that do not adequately meet the programme's critical success factors and spending objectives, while disadvantages outweigh advantages.

7.4.5 A detailed analysis of this evaluation is available in Appendix D1.

7.4.6 This evaluation was assessed at the workshop held on 6 March 2017 and updated according to the latest information available. A summary of the final evaluation is provided in Figure 7-3 below.

Figure 7-3 Outputs of long list assessment

Scope					
Minimum	Intermediate				Maximum
1.1 Continue with existing arrangements	1.2 Deliver some existing health and social care services off island	1.3 Deliver existing services plus housing with extra care (tenanted units only)	1.4 Deliver existing services plus housing with extra care (tenanted and flexible units)	1.5 Deliver services in 1.4 plus increase range services available on island	1.6 Deliver all health and social care services locally
Carry forward as baseline	Discount	Possible	Preferred way forward	Discount	Discount
Does not support integration strategy	Clinical risk too great	Does not provide flexibility of step up / step down care	Optimum solution	Clinical risk too great and limited workforce capacity	Not achievable or affordable

Service solution					
Minimum	Intermediate				Maximum
2.1 Refurb existing facilities	2.2 Provide health facilities and housing with extra care (8 tenanted units) on two separate sites		2.3 Incorporate all health and social care services in one purpose built facility (including 8 tenanted + 2 flexible housing with extra care units)		2.4 Incorporate space for other public services
	Version A: Re-provide health facilities with greatest compliance risks (e.g. hospital and dental only)	Version B: Re-provide all health facilities (e.g. hospital, dental, primary care, ambulance, shared office facilities, shared storage)			
Carry forward as baseline	Possible	Possible	Preferred way forward		Discount
Not possible to make current hospital compliant	Significantly limits integration opportunities	Limits integration opportunities	Fully integrated solution		Not necessary - no significant requirement identified

Service delivery				
Minimum	Intermediate			Maximum
3.1 Separate dedicated health and social care teams with joint leadership in form of IJB	3.2 Co-located teams, joint leadership, some MDTs	3.3 Integrated MDT, some flexibility between hub and community		3.4 Fully integrated health and social care teams
Possible	Discount	Discount		Preferred way forward
Already in place and would support Options 2.1 and 2.2	Partial solution no longer considered appropriate given the introduction of single locality managers under the IJB	Partial solution no longer considered appropriate given the introduction of single locality managers under the IJB		Considered to be the most feasible solution given the current strategic direction of IJBs

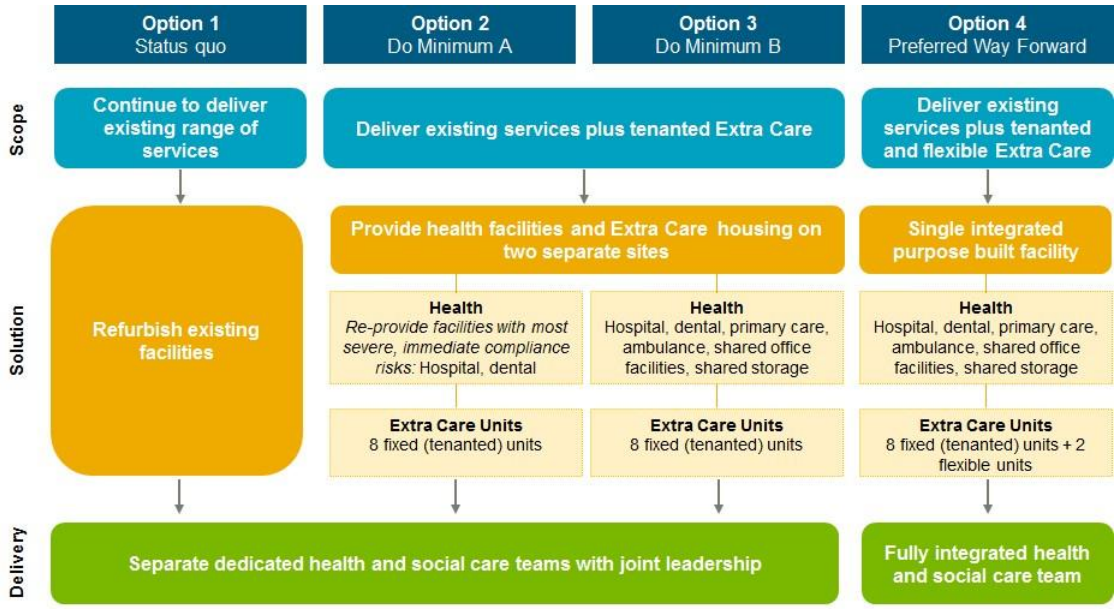
Implementation			
Minimum	Intermediate		Maximum
4.1 Phased backlog maintenance	4.2 Single phased move to new build		4.3 Phased move to new build
Carry forward as baseline	Preferred way forward		Discount
Required to support the baseline status quo option	Required to support the preferred way forward		Not feasible

Funding				
Minimum	Intermediate			Maximum
5.1 Traditional capital	5.2 Separate capital funding arrangements for NHSWI and CnES	5.3 Capital contributions from both NHSWI and CnES		5.4 Funded through alternative financing (e.g. prudential borrowing)
Carry forward as baseline	Possible	Preferred way forward		Possible
For the purposes of the Economic Appraisal, all options are considered to be financed through capital funding. The specific options are considered in detail in the Finance Case.				

7.5 The short list of options

7.5.1 Based on this assessment, the options that it was determined should be carried forward from the Scope, Solution, and Service Delivery dimensions were aggregated to develop a shortlist of options, as illustrated in the diagram below.

Figure 7-4 Development of the shortlist



7.5.2 A detailed overview of these four options using the options framework is shown in Figure 7-5 below.

Figure 7-5 Shortlist of options

Dimension	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Scope	Deliver current services from existing facilities	Deliver services from existing facilities where possible and for areas with greatest compliance risk from new purpose built health facilities; provide housing with extra care on a separate site	Deliver services from new purpose built health facilities and provide housing with extra care on a separate site	Deliver integrated services from a single co-located purpose-built facility
Estate solutions	Refurbish existing hospital and care home	**Standalone re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental **Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Standalone re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage **Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage **Co-located provision of housing with extra care** • 8 x fixed (tenanted) units • 2 x flexible units
Service delivery	Separate dedicated health and social care teams with joint leadership in form of IJB	Separate dedicated health and social care teams with joint leadership in form of IJB	Separate dedicated health and social care teams with joint leadership in form of IJB	Fully integrated health and social care team
Implementation	Phased refurbishment programme	Single phased separate programmes for health and housing with extra care	Single phased separate programmes for health and housing with extra care	Single phase programme
Funding	Traditional capital – existing capital programme	Health facilities - NHS WI traditional capital Extra Care Housing – CnES traditional capital	Health facilities - NHS WI traditional capital Extra Care Housing – CnES traditional capital	Capital contributions from NHS Western Isles & CnES

7.6 Conclusion

7.6.1 The final shortlist includes four options: Status Quo, Do Minimum A, Do Minimum B, and Preferred way forward. A summary of these is provided below.

Figure 7-6 Overview of the final shortlist of options

1. **Status Quo (Deliver current services from existing facilities):** While this is not a feasible option, it is carried forward to provide a benchmark for assessing the value for money of all feasible options. It involves minimal investment in existing facilities to address backlog maintenance and involves continuing with existing arrangements for the delivery of services.
2. **Do Minimum A (Re-provide health facilities with greatest compliance risk; develop housing with extra care on a separate site):** This option offers the least ambitious solution in comparison to the preferred way forward. It involves the re-provision of health facilities for areas that present the most severe and immediate risk (e.g. hospital and dental facilities) and the development of 8 tenanted Extra Care Units on a separate site. Ways of working do not change significantly from existing arrangements.
3. **Do Minimum B (Re-provide all health facilities; develop housing with extra care on a separate site):** This option offers a less ambitious solution in comparison to the preferred way forward. It involves the re-provision of health and social care facilities as standalone units including 8 tenanted Extra Care Units. Ways of working do not change significantly from existing arrangements.
4. **Preferred Way Forward (Integrated health and social Care hub):** This option involves fully integrated health and social care teams delivering services from a single co-located purpose built facility which includes 8 tenanted Extra Care Units and 2 flexible units that can be used to meet a range of health and social care needs.

8 NON-FINANCIAL BENEFITS APPRAISAL

8.1 Overview

8.1.1 A key component of any formal appraisal process is the assessment of the non-financial or qualitative benefits that are likely to accrue from the options under consideration.

8.1.2 Where possible costs and benefits should be valued in monetary or quantitative terms, however, this is not always cost effective or practical. Very often qualitative factors are crucial in informing the decision making process. It is therefore important that the option appraisal process captures these non-financial costs and benefits and presents them alongside the quantitative measures.

8.1.3 Whilst there are a range of techniques available to assess the non-monetary factors, in light of the scale of this project, and in line with the requirements of the Green Book, the stakeholders adopted the weighted scoring method to assign non-financial benefits to the range of shortlisted options.

8.1.4 Although the relative non-financial benefits of the options presented allows for comparisons to be made in this area, the outcome is critical in assessing the overall value for money presented by each of the options.

8.1.5 As part of this process the stakeholders have sought to clearly set out how the options compare in regard to non-monetary factors through a range of measures, namely:

- Developing a range of attributes, or benefit criteria, which relate closely to the project objectives and constraints as set out in Section 5 of this business case;
- Clearly presenting the information relating to each option which allows a comparison to be made with regard to the benefit criteria; and
- Explaining clearly the reasoning behind the weights and scores assigned to the options as part of the non-financial benefits assessment.

8.1.6 The benefits appraisal was carried out in an open and transparent environment, with a range of stakeholders invited to participate in the process.

8.1.7 The weighted scoring method adopted to assess the comparative level of non-financial benefits has four main stages:

- Identification and assessment of the long list of options to arrive at a shortlist;
- Identification of the benefits criteria;
- Weighting of the benefits criteria; and
- Scoring of the short-listed options against the benefits criteria.

8.1.8 The following sections provide a detailed description of the process used to assess the potential benefits of the short-listed options, along with the outcomes of the exercise.

8.2 The Workshop format and participants

8.2.1 A benefits appraisal to assess the relative level of benefits delivered by the shortlisted options was undertaken at the stakeholder workshop held on 6 March 2017.

8.2.2 The objectives of the workshop were to:

- Establish a common understanding and agreed approach to the benefits appraisal process;
- Review and describe the list of options to be evaluated;
- Develop the list of criteria against which each of the options would be evaluated;
- Weight the criteria using established mechanisms; and
- Score the options against the agreed criteria using the assigned weightings.

8.2.3 The role of the stakeholder group was as follows:

- Oversee the benefits appraisal process;
- Ensure the benefits appraisal was conducted rigorously and fairly;
- Review the short list of options developed at the previous workshop and agree a shortlist; and
- Allocate weighting to the criteria.

8.3 The benefit criteria

8.3.1 The role of the benefit criteria in the non-financial appraisal is to provide a basis against which each of the options can be evaluated in terms of their potential for meeting the objectives of the proposed capital investment.

8.3.2 The criteria have been specifically developed in a manner which minimises the extent to which there may be double counting arising from overlap in the attributes or features. In addition due care has been taken of the need to ensure that the full range of attributes are covered even if they are likely to be common to all of the shortlisted options.

8.3.3 Individual criteria will, generally speaking, have differing degrees of importance in determining the preferred solution to emerge from the benefits appraisal. As a result it is necessary to allocate a weight to the criteria in order to reflect their relative importance to each other. This should reflect the degree to which each criterion will affect the outcome of the options scoring exercise.

8.3.4 The investment objectives and related benefits criteria developed at earlier workshops were revisited and validated by stakeholders. These were then ranked and weighted according to order of importance and the resulting list is provided in the table below.

Figure 8-1 Agreed benefit criteria

Criterion	Rank	Weighting
Sustainability and safety of services	1	22%
Quality of patient care and clinical effectiveness	2	20%
Integration of service	3	18%
Quality of physical environment	4	15%
Appropriate number of adequately trained staff	5	14%
Enhanced care in homely settings	6	11%

8.4 Initial assessment of the features of the shortlisted options

8.4.1 Before the scoring process, the key features of each of the shortlisted options were reviewed, to ensure clarity and understanding. This assessment is set out in the following sections.

Option 1 – Status Quo

Deliver current services from existing facilities

8.4.2 The key features, advantages, disadvantages for option 1 the Status Quo option, are set out below.

Figure 8-2 Key features Option 1

Key features:
• Retain separate care home and hospital – refurbish existing facilities • Service continue to be delivered under current operating model (integrated management overseeing separate health and social care teams) • Provides baseline against which to compare the alternative options
Advantages:
• None identified
Disadvantages:
• Health facilities will remain non-compliant in a number of areas (infection control, storage facilities, fire disability access, manual handling risk associated with limited space) – resulting in increased risk to patients, staff and service sustainability • Care home facilities will be compliant with regulatory requirements but will not meet best practice • Retaining care home facilities will mean unable to deliver benefits of housing extra care (supporting independent living) • Does not reduce risks that arise when unable to evacuate patients from island due to weather and transport failures (e.g. facilities will not provide suitable place of safety for mental health patients) • Does not enable the workforce to maximise opportunities for integrated working • Does not enable delivery of the best possible service to patients/service users • Facilities and operating model will not meet wider stakeholders' expectations

Option 2 – Do Minimum A

Re-provide health facilities with greatest compliance risk; develop housing with extra care on separate site

8.4.3 The key features, advantages, disadvantages for option 2 Do Minimum A, are set out below.

Figure 8-3: Key features Option 2

Key features:
• Re-provide St Brendan's hospital and dental practice in new purpose built facilities on identified site • Develop 8 x housing with extra care units on a separate site • Services continue to be delivered under current operating model (integrated management overseeing separate health and social care teams)
Advantages:
• Purpose built, fit for purpose compliant health facilities – reducing current risks to patients, staff and service sustainability • Proving housing with extra care will support residents to live independently • Reduce risk when unable to evacuate patients form the island due to weather and transport failures (e.g. provide suitable place of safety for mental health patients)
Disadvantages:
• No ambulance station • Primary care services continue to be delivered in ageing facilities from other health services • Nursing staff not located with extra care units resulting in fragmented care • No flexible units available to provide opportunities for respite, improved palliative care • Does not enable the workforce to maximise opportunities for integrated working • Does not enable delivery of the best possible service to patients/service users • Operating model will not meet wider stakeholders' expectations • Increased timescales to find and evaluate an alternative site

Option 3 – Do Minimum B

Re-provide all health facilities; develop housing with extra care on separate site

8.4.4 The key features, advantages, disadvantages for option 2 Do Minimum B, are set out below.

Figure 8-4: Key features Option 3

Key features:
• Re-provide St Brendan's hospital, dental practice, GP practice, and create an ambulance station, in new purpose built co-located facilities on identified site • Develop 8 x housing with extra care units on a separate site • Services continue to be delivered under current operating model (integrated management overseeing separate health and social care teams)
Advantages:
• Purpose built, fit for purpose compliant health facilities – reducing current risks to patients, staff, and service sustainability • Co-location of health services promote flexible working between health teams and improve patient experience • Creation of an ambulance station improving response times and providing storage • Providing housing with extra care will support residents to live independently • Reduced risk when unable to evacuate patients from the island due to weather and transport failures (e.g. provides suitable place of safety for mental health patients)
Disadvantages:
• No flexible units available to provide opportunities for respite, improved palliative care • Nursing staff not located with extra care units resulting in fragmented care • Does not enable the workforce to maximise opportunities for integrated working • Does not enable delivery of the best possible service to patients/service users • Operating model will not meet wider stakeholders' expectations • Increased timescales to find and evaluate an alternative site

Option 4 – Preferred Way Forward

Integrated health and social care hub

8.4.5 The key features, advantages, and disadvantages for option 4 The Preferred Way Forward, are set out below.

Figure 8-5: Detailed features of option 4

Key features:
• New purpose built co-located facilities on identified site that include: 1. Re-provide St Brendan's hospital, dental practice, GP practice, and create an ambulance station, in new purpose built co-located facilities 2. 8 x housing with extra care units and 2 x flexible units 3. Fully integrated health and social care team

Advantages:
• Purpose built, fit for purpose compliant health facilities – reducing current risks to patients, staff, and service sustainability • Co-location of all services promotes integration of teams, enabling the delivery of more co-ordinated care and improving patient / service user experience • Creation of an ambulance station improving response times and providing storage • Providing housing with extra care will support residents to live independently • Flexible units provide opportunities to improve choice for services such as respite and palliative care • Reduced risk when unable to evacuate patients from the island due to weather and transport failures (e.g. facilities will provide suitable place of safety for mental health patients)
Disadvantages:
• Cultural change required to implement new ways of working

8.5 Scoring the options

8.5.1 Participants undertook a scoring exercise to assess the relative benefits of each of the four shortlisted options. This was undertaken as a single group exercise.

8.5.2 Workshop attendees scored each of the shortlisted options in relation to how well it is deemed to meet the benefits criteria on a scale of 0-10 (with 0 representing the lowest and 10 the highest). The results are shown below.

Figure 8-6 Benefit criteria scores

Benefit Criteria	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward	Comments
Sustainability and safety of services	0	5	7	9	• Hospital remains non-compliant in Option 1 meaning services cannot be sustained in the long term • Options 2, 3, and 4 all improve safety but sustainability increases in relation to greater degrees of integration
Quality of patient care and clinical effectiveness	4	6	7	9	• Currently deliver high quality of care but existing facilities create challenges to delivering most effective care • Quality and effectiveness increases in relation to greater degrees of integration with better co-ordination of care and improved patient experience
Integration of service	4	5	6	8	• The current facilities do not promote integrated working • Options 2 and 3 bring some services together but not all • Option 4 offers the best opportunity for integrated working but is an enabler rather than a complete solution
Quality of physical environment	0	6	7	8	• Quality of environment will be relatively high for Options 2,3, and 4
Appropriate numbers of adequately trained staff	2	5	5	5	• Operating from non-compliant facilities likely to act as a deterrent to recruitment in the future • Options 2,3,4 will address this equally but challenges of small rural population will remain
Enhanced care in homely settings	3	5	6	8	• Options 2,3,4 offer increased opportunities to deliver more care in the community

8.5.3 To calculate the weighted benefit score (WBS) for each option, the raw scores for each of the six criteria were multiplied by the relevant criterion weight. These values were then aggregated to calculate the total score for each option.

Figure 8-7 Weighted benefit criteria scores

Criteria/ Options	WEIGHT	Option 1 - Status Quo		Option 2 - Do Minimum A		Option 3 - Do Minimum B		Option 4 - Preferred Way Forward	
		Score	W x S	Score	W x S	Score	W xS	Score	W xS
Sustainability & Safety of Services	22.0%	0.0	0.0	5.0	110.0	7.0	154.0	9.0	198.0
Quality of Patient Care and clinical effectiveness	18.0%	4.0	72.0	6.0	108.0	7.0	126.0	9.0	162.0
Integration of service	20.0%	4.0	80.0	5.0	100.0	6.0	120.0	8.0	160.0
Quality of physical environment	14.0%	0.0	0.0	6.0	84.0	7.0	98.0	8.0	112.0
Appropriate numbers of adequately trained staff	15.0%	2.0	30.0	5.0	75.0	5.0	75.0	5.0	75.0
Enhanced care in homely settings - more community-facing settings	11.0%	3.0	33.0	5.0	55.0	5.0	55.0	8.0	88.0
TOTAL	100%		215.0		532.0		628.0		795.0
RANK			4		3		2		1

8.5.4 This shows that Option 4 the Preferred Way Forward offers the highest level of non-financial benefits. The potential benefits reduce in relation to degree of ambition. Unsurprisingly, Option 1 the Status Quo option offers the lowest level of non-financial benefits.

8.5.5 Sensitivity testing was undertaken to assess the degree of certainty around the ranking of the options. The table below shows the original weighted scores alongside the scores if all criteria were to be equally weighted (total available score is 1000 points). This demonstrates that the ranking remains unchanged in each scenario.

Figure 8-8: Results of sensitivity testing

Option	Weighted Benefit Score	Ranking (weighted)	Non-weighted Benefit Score	Ranking (equal weighting)
Option 1 – Status Quo	215	4	217	4
Option 2 – Do Minimum A	532	3	533	3
Option 3 – Do Minimum B	628	2	617	2
Option 4 – Preferred Way Forward	795	1	784	1

8.6 Conclusion

8.6.1 In assessing the non-financial benefits of the shortlisted options NHS Western Isles and CnES have adopted an open and transparent assessment process involving staff from both clinical and non-clinical areas as well as patient representatives.

8.6.2 In assigning weights and scores to the shortlisted options, NHS Western Isles and CnES have worked hard to clearly outline the supporting rationale and justification.

8.6.3 In overall terms the results of the benefits scoring exercise were conclusive. Based on the composite scores:

- Option 4 delivers the highest level of non-monetary benefits when measured against the criteria; and

- The Status Quo option (option 1) results in the lowest level of overall benefits.

8.6.4 The weighted scores will subsequently be contrasted with the analysis of the monetary costs and benefits as expressed through the Net Present Costs (NPC's) of the options to help assess the relationship between monetary and non-monetary factors.

9 RISK ASSESSMENT AND IDENTIFICATION

9.1 Overview

9.1.1 This chapter provides an assessment of both the qualitative and quantifiable risks associated with each of the short-listed options. This is so that the economic appraisal can properly reflect the risk differentials between the different options. The net present costs of quantified risk calculated in this chapter will be applied within the Economic Appraisal so that the discounted cash flow analysis incorporates the full expected value of the options.

9.1.2 The section outlines the methodology used to derive the risks, along with the net present cost of these risks. Careful attention has been paid to ensure that no double counting between risk and optimism bias has occurred.

9.2 Capital Risks

9.2.1 The capital risks were jointly assessed by project team members, Hub North Scotland and hub North Scotland's cost consultants. These are expressed in terms of a capital cost contingency and the value is included within the capital costs outlined in the next section.

9.3 Optimism Bias (OB)

9.3.1 In line with HM Treasury guidance and the Scottish Capital Investment Manual (SCIM) NHS Western Isles and CnES have assessed the level of optimism bias associated with each of the shortlisted options.

9.3.2 In assessing optimism bias, NHS Western Isles and CnES have sought to base their assessment on evidence from other NHS and local authority schemes. It has therefore adopted the optimism bias tool that has been tailored by the Department of Health in England, and consistent with the requirements of the Scottish Capital Investment Manual (SCIM), to reflect the key contributions to optimism bias in health build projects. The spreadsheets used to identify the upper bound and the level of mitigation is included in **Appendix E1.**

9.4 Upper Bound Assessment

9.4.1 The following factors were consistent in the upper bound assessments of the short-listed options:

- **Number of Phases** (0.5%): All options are expected to have no more than 2 phases and a value of 0.5%.
- **Facilities Management** (0%) - the procurement of the scheme will not involve FM services. FM services will continue to be provided by NHS Western Isles & CnES and therefore are excluded from the procurement.
- **Information Technology** (1.5%) - the options only cover IT infrastructure. This reduces the optimism bias upper bound
- **External Stakeholders** (1%) – There are a number of stakeholders in this project – NHS Western Isles, CnES, Scottish Ambulance Service and GP practice. However they are already working together and health and social care are currently co-located therefore the lower level selected.
- **Service Changes** (5%) - No known service changes are expected during the procurement and construction phase.

9.4.2 The following contributors to the upper bound varied across the options:

- **Length of build** – it is expected that option 2 would be less than two years (value 0.5%) and the do minimum and multi-phased option between 2-4 years with a value 2%.
- **Number of Sites involved** – under the do minimum there is 1 site with a value of 2% as services remain on existing site. Under option 2 & 3 GP and SAS move into the same site as the existing hospital and social care provision with value 2% also.
- **Location** - options 2 & 3 are a new build on a green field site with a value of 3%. The Do Minimum 15% - 50% refurbishment with a value of 10%.
- **Equipment**: All options except the Do Minimum include all equipment with an adjustment of 5%; the Do Minimum including Group 1 & 2 equipment only with an adjustment of 0.5%.
- **Gateway Score**: All options except the Do Minimum are assessed to be high risk score of 5%; the Do Minimum is assessed at low risk score 0%.

9.5 Mitigation of Optimism Bias

9.5.1 NHS Western Isles and CnES have assessed the mitigation of optimism bias that can be applied at this stage in the design development process. As the project progresses through the procurement stage, the level of optimism bias will diminish, as key features of the project become more defined and agreed. The level of optimism bias mitigation will be assessed regularly as the project progresses through the procurement process.

9.5.2 The level of mitigation for the shortlisted options is shown in the table below. This reflects the anticipated level of residual optimism bias remaining after the mitigation factors have been applied.

Figure 9-1: Mitigation of optimism bias

Area	Contribution to OB	Option 1 Status Quo	Option 2 Do Min A	Option 3 Do Min B	Option 4 PWF
Robustness of Output Specification	25	10	7	7	7
Stable policy environment	20	15	5	5	5
Client capability and capacity	6	2	2	2	2
Involvement of Stakeholders	5	2	1	1	1
Agreement to output specification	5	1	2	2	2
Progress with Planning Approval	4	0	4	4	4
Other Regulatory	4	2	2	2	2
Detail of design	4	2	2	2	2
Design complexity	4	0	1	1	1
Other factors	23	7	8	8	8
Total	**100**	**41**	**34**	**34**	**34**

9.5.3 Further details of the rationale behind these levels of mitigation are included within **Appendix E2**. The key areas are outlined below.

- Development of schedule of accommodation and clinical brief with clarity in some areas and further work in others
- Limited experience of client team

9.5.4 The table below shows the resultant level of optimism bias.

Figure 9-2: Optimism bias of short-listed options

Option	Upper bound assessment	Percentage remaining after mitigation	Residual Optimism Bias
Option 1: Status Quo	29.5%	41%	9.2%
Option 2: Do Minimum A	30.5%	34%	8.0%
Option 3: Do Minimum B	30.5%	34%	8.0%
Option 4: Preferred Way Forward	30.5%	34%	8.0%

9.6 Relationship between Optimism Bias and Risk

9.6.1 NHS Western Isles and CnES have sought to eliminate the risk of double counting between optimism bias and risk. In particular, when developing the risk quantification, it has sought to achieve the following:

- Where a risk clearly duplicates an area covered by the optimism bias, this risk has not been quantified. Examples of risks that were not quantified are risks relating to NHS legislative or regulatory change.
- Where there is an overlap between areas covered by factors contributing to optimism bias and risk, NHS Western Isles and CnES have valued the risk, but sought to tightly constrain the scope of the risk that is valued. An example of this is the risk associated with the planning application. The cost impact of any delay in gaining planning approval has been assessed as part of the capital risk contingency. However the risk that planners require changes to the scope of the scheme has been captured via optimism bias.

9.7 Revenue Risks

9.7.1 The revenue risks were identified via a workshop attended by members of the Project Board, Design Team facilitated by Capita. The workshop was also used to identify and assess qualitative risks for the original shortlist of options and was updated by a working group in July 2017 after the shortlist had been updated.

9.7.2 The first stage of the workshop involved agreeing the risk register. This was developed by reviewing the main project risk register and updating where necessary.

9.7.3 The next stage involved determining if the risk could be quantifiable or not. The table below outlines the risk register and the nature of the risks to be assessed.

Figure 9-3: Risk register

Ref	Risk Description	Quantifiable
1	***Capacity & Demand Risks***	
1.1	Facilities not flexible enough to respond to changes in service and demand	No
1.2	Changes to population demographic impact on service requirements	No
1.3	Insufficient facilities on Barra resulting in more transfers off island	No
1.4	Incorrect demand and capacity planning assumptions	Yes
2	***Staffing Risks***	
2.1	Staff are not able to develop and retain skills required for new ways of working	No
2.2	Staff are not adequately supported through changes in procedures	No
2.3	Loss of key personal or staffing resources or specialist knowledge base that could impact upon the project work load; key events or milestones.	No
2.4	Availability of carers to support the social care model	No
3	***Operational Risks***	
3.1	Failure to deliver required levels of quality	No
3.2	Inadequate patient environment	No
3.3	Facility does not meet stakeholder expectations	No
3.4	Disruption to on-going delivery of clinical and non-clinical services.	No
3.5	Partners are unable to agree and implement model of service	No
3.6	Recurring revenue costs underestimated	Yes
4	***Reputational & Policy Risks***	
4.1	Lack of clear links between the project and the organisations' key strategic priorities, including agreed measures of success	No
4.2	Lack of clear senior management ownership and leadership	No
4.3	Lack of ministerial ownership and leadership	No
4.4	Communication and Stakeholder involvement inadequate	No

Ref	Risk Description	Quantifiable
4.5	Adverse publicity resulting from failure to justify levels of investment	No
4.6	Lack of clear delivery strategy	No
5	***Timing & Disruption Risks***	
5.1	Accidental loss of engineering services to existing facilities	No
5.2	Incorrect planning assumptions resulting in delays in commissioning of facilities	Yes
6	***Funding Risks***	
6.1	Capital envelope available does not support	No
7	***Technology Risks***	
7.1	Unable to integrate health & social care (and other partners) information systems	No
8	***Commercial Risks***	
8.1	Limited market interest causes delay in procurement process	No

9.8 Revenue Risk Quantification

9.8.1 For the non-quantifiable risks a qualitative assessment was undertaken and is described within the next section. The quantifiable risks have been assessed in four stages, namely:

- **Stage 1** assesses the likely chance of the risk occurring
- **Stage 2** identifies the years in which the risk will occur
- **Stage 3** assesses the minimum, most likely and maximum impacts of the risk with the chance of each scenario happening.
- **Stage 4** assesses the expected differences between the expected risks of the options

9.8.2 The risk modelling has assumed that the distribution of all revenue risk impacts approximate to a triangular distribution (i.e. that the average of the minimum, most likely and maximum values equals the mean risk value).

9.8.3 The resulting expected values of the quantified risks, expressed in cash values and their corresponding NPC, over a 30 year appraisal period, is shown below for each option. Further details are provided in **Appendix E3**

Figure 9-4: Mean risk cash value for short-listed options £000

Risk	Impact	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
1.4 Incorrect demand and capacity planning assumptions	Increased revenue costs	163	145	145	134
3.6 Recurring revenue costs underestimated	Increased revenue costs	1,358	1,207	1,207	1,119
5.2 Incorrect planning assumptions resulting in delays in commissioning of facilities	Increased transitional costs	0	15	18	18
Total undiscounted over 30 year appraisal period		**1,521**	**1,367**	**1,371**	**1,272**
Discounted NPC		**877**	**854**	**858**	**796**

9.8.4 It can be seen that the Preferred Way Forward has the lowest expected risk and Status Quo the highest as any increased demand is likely to have the biggest impact on existing arrangements since it is the least flexible and most unsustainable solution.

9.8.5 The discounted value quantified risks are subsequently applied to the results of the economic appraisal to derive the full expected NPC of the options.

9.9 Qualitative Risks

9.9.1 For those risks which could not be quantified a qualitative assessment was carried out whereby each risk was assessed for both impact and likelihood using the scoring scale outlined below.

Figure 9-5: Impact / likelihood scoring scale

Score	Impact Scale	Likelihood Scale
1	Very minor	Rare
2	Minor	Unlikely
3	Moderate	Possible
4	Major	Likely
5	Catastrophic	Almost certain

9.9.2 The product (by multiplying together) of the assessment of the potential impact and the likelihood of occurrence gives rise to an overall analysis of the risk e.g. low to high as detailed below.

Figure 9-6: Analysis of qualitative risk levels figure

Impact	*Likelihood*				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Very minor (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Key:		Low Risk (1-3)		Moderate Risk (4-9)		Significant Risk (10-14)		High Risk (15-25)

9.9.3 This provides a useful indicator in determining the areas requiring the greatest degree of risk management effort.

9.10 Results of Assessment

9.10.1 All risk areas were assessed across all options and the results presented. A summary of these are provided in the table below. Full details of the risk assessment are summarised in **Appendix E4.**

Figure 9-7: Results of the qualitative risk assessment

Ref	Risk Heading	Option 1	Option 2	Option 3	Option 4
1	***Capacity & Demand Risks***				
1.1	Facilities not flexible enough to respond to changes in service and demand	15	12	9	3
1.2	Changes to population demographic impact on service requirements	20	20	12	8
1.3	Insufficient facilities on Barra resulting in more transfers off island	25	20	15	10
2	***Staffing Risks***				
2.1	Staff are not able to develop and retain skills required for new ways of working	20	16	12	8
2.2	Staff are not adequately supported through changes in procedures	20	16	8	8
2.3	Loss of key personal or staffing resources or specialist knowledge base that could impact upon the project work load; key events or milestones.	16	12	12	8
2.4	availability of carers to support the social care model	20	12	12	12
3	***Operational Risks***				
3.1	Failure to deliver required levels of quality	15	12	9	3
3.2	Inadequate patient environment	15	12	6	3
3.3	Facility does not meet stakeholder expectations	15	12	9	3
3.4	Disruption to on-going delivery of clinical and non-clinical services.	15	15	9	6
3.5	Partners are unable to agree and implement model of service	15	12	6	3
4	***Reputational & Policy Risks***				
4.1	Lack of clear links between the project and the organisation's key strategic priorities, including agreed measures of success	15	9	9	3
4.2	Lack of clear senior management ownership and leadership	6	6	6	3
4.3	Lack of ministerial ownership and leadership	12	12	8	4
4.4	Communication and Stakeholder involvement inadequate	8	8	8	8
4.5	Adverse publicity resulting from failure to justify levels of investment	15	12	9	3
4.6	Lack of clear delivery strategy	12	16	16	8
5	***Timing & Disruption Risks***				
5.1	Accidental loss of engineering services to existing facilities	25	20	5	5
6	***Funding Risks***				
6.1	Capital envelope available does not support	5	20	20	25
7	***Technology Risks***				
7.1	Unable to integrate health & social care (and other partners) information systems	16	12	12	8
8	***Commercial Risks***				
8.1	Limited market interest causes delay in procurement process	8	12	12	12
	Total Risks	***328***	***283***	***224***	***149***
	Ranking	***4***	***3***	***2***	***1***

9.11 Analysis of Results

9.11.1 From the data presented it is clear that the overall results indicate a number of key risks with a significant number within the red indicator (score 15-25).

9.11.2 There should be further work to review and update the risk assessment at Full Business Case when further information is available and some risks reduced.

9.11.3 The Status Quo option has the highest level of risk reflecting the limited extent to which it meets the overall investment objectives.

9.11.4 The level of risk remains relatively high for Options 2 and 3 largely because by providing new facilities that are not co-located the risks associated with lack of integration are not addressed.

9.11.5 Option 4, Preferred Way Forward, presents the lowest level of qualitative risk.

9.12 Summary of the Risk Assessment

9.12.1 The table below summarises the net present cost of revenue risks and summarises the results of the qualitative assessment undertaken.

Figure 9-8: Summary of risks for short-listed options

Option	Expected value of quantified revenue risks (Discounted NPC)	Ranking (Quantified)	Qualitative assessment (total risk points)	Ranking (Qualitative)
Option 1 – Status Quo	£877k	4	328	4
Option 2 – Do Minimum A	£854k	2	283	3
Option 3 – Do Minimum B	£858k	3	224	2
Option 4 – Preferred Way Forward	£796k	1	149	1

9.12.2 The quantifiable capital (optimism bias and contingency) and revenue risks are used in the economic appraisal chapter to risk adjust the net present costs of the short-listed options.

9.13 Risk Mitigation

9.13.1 At this stage no assumptions have been made regarding the mitigation of the risks identified above. As the project progresses it is anticipated that a number of these risks will be able to be mitigated.

9.14 Risk Management Plan

9.14.1 NHS Western Isles and CnES are currently developing a risk management plan that will enable effective management of the risks identified in this analysis.

9.14.2 The response for each risk can 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 project.
- **Reduction**, where the actions either reduce the likelihood of the risk developing or limit the impact on the business or project 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.
- **Acceptance**, where the Project 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.

9.14.3 A detailed risk action plan will be developed in relation to the preferred option and should detail, as a minimum:

- A description of each key risk;
- The timeframe over which the risk is present;
- The early warning signs that a problem is occurring;
- Mechanisms for spotting the early warning signs; and
- The person responsible for taking corrective action.

9.14.4 In summary, whilst there are a number of significant risks involved with each of the options, there are means to mitigate and manage them all. This process needs to be built in to the overall Project Management as the preferred option is taken forward.

9.14.5 Details of the Project Board risk management plan are set out in Section 18 of the OBC.

9.15 Conclusion

9.15.1 This section outlines the methodology used to identify and assess the risks. Where appropriate those risks that can be quantified have been valued. Risks which cannot be readily quantified have been the subject of a qualitative assessment.

9.15.2 The quantified risks associated with each of the short-listed options will be subsequently incorporated into the economic appraisal to ensure that the analysis properly reflects the risk differentials across the different options. The risk scoring exercise highlighted some of the key risks inherent in each option which need to be mitigated.

10 ECONOMIC APPRAISAL

10.1 Introduction

10.1.1 This purpose of this section is to undertake a detailed analysis of the monetary costs and benefits of the shortlisted options in order to identify the option that is likely to offer the best value for money.

10.1.2 This is undertaken by:

- Identifying and quantifying the monetary costs and benefits of options; and
- Calculating the Net Present Cost of options.

10.1.3 The economic appraisal process utilises a number of key outputs from other parts of the OBC process, namely workforce planning, capacity planning and design in establishing the capital and revenue implications of each option.

10.2 Capital costs

10.2.1 The Project Board and its appointed cost advisors, in conjunction with the hub North Scotland, has prepared the capital costs based on an appraisal of the capital requirements of each of the four shortlisted options.

10.2.2 These are derived primarily from the schedules of accommodation, reflecting the key features described in the table below, with appropriate adjustments to reflect the total costs of delivering the options to the point facilities become operational.

Figure 10-1 Capital requirements of options

Dimension	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Health facilities	Refurbish existing hospital	**Standalone re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Mortuary	**Standalone re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Mortuary • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage	**Re-provision of health facilities** • 3 x 72-hour beds (NHS) • 2 x resuscitation and retrieval bays • Multi-purpose consulting rooms • Primary care • Dental • Mortuary • Ambulance station • Shared admin/office facilities (for health and social care) • Shared storage
Supported accommodation	Refurbish existing care home	**Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Standalone provision of housing with extra care** • 8 x fixed (tenanted) units	**Co-located provision of housing with extra care** • 8 x fixed (tenanted) units • 2 x flexible units

10.2.3 The main assumptions used in calculating costs are listed below.

Figure 10-2 Capital cost assumptions

Core assumptions

- Construction cost calculated by hub North Scotland cost consultant Turner Townsend using benchmark projects for cost per m2. Includes allowances for:
  - Abnormals e.g. Demolition inc temporary works/phasing, excavation in rock, upgrade access& off site utilities)
  - Preliminaries
  - Risks based on design development and post contract risk
  - Professional team fees in relation to PFC, Stage 1 & Stage 2, building warrant and planning consent
  - Main contractor overheads and profit (4.5%)
  - Location adjustment (30%)
  - Inflation to financial close as per Hubco agreement (2Q2018). Allowances within risk register for construction inflation
  - Hubco management
  - Strategic partnering service including Site investigations, architects, Acoustic survey, Asbestos survey , Transportation Impact Assessment, Drainage Impact Assessment
- Fees in relation to project management, business case development and Technical Advisor/Legal Advisor.
- Non-works costs include Croft reimbursement (current estimate £100k) and land purchase (£40k) less proceeds from old GP house (£100k) and current GP premises (£100k)
- NHS equipment estimated at 15% of total cost (based on Prime Cost, Prelims and Risk) assuming all equipment is purchased and minimal transfer of existing items. The phasing of the equipping costs is in line with the construction spending. CnES equipment has been estimated at £150k.
- VAT is allowed for at 20% however there has been an element of VAT reclaim on Fees. No VAT has been included for the CnES element of capital cost. There is ongoing engagement with Caledonian Economics to establish how the differing VAT treatment for NHS and CnES can be managed contractually.
- Optimism bias based on the analysis set out in section 9.3 (Calculated on Construction Cost, Fees and Non-Work Costs but not Equipment).
- Phasing of the capital costs is based on the current project plan for each of the shortlisted options.
- Costs included to target BREEAM excellent rating. A date for the initial assessment is currently being scheduled.

Option 1 - Status Quo

- Do minimum cost estimates reflect the work required to address the backlog maintenance and minor changes to storage.

Option 2 - Do Minimum A

- Health costs calculated based on the core assumptions set out above for a standalone health facility including the re-provision of areas with the most severe compliance risks (i.e. hospital, dental, and mortuary).
- Standalone housing with extra care construction costs provided by CnES for the development of 8 units and adjusted to include risk, inflation, fees, non-works

costs, equipment, location factor, and optimism bias using the core assumptions set out above.

Option 3 - Do Minimum B

- Health costs calculated based on the core assumptions set out above for a standalone health facility
- Standalone housing with extra care construction costs provided by CnES for the development of 8 units and adjusted to include risk, inflation, fees, non-works costs, equipment and optimism bias using the core assumptions set out above.

Option 4 - Preferred Way Forward

- Calculated based on the core assumptions set out above

10.2.4 Based on this methodology, the capital cost of each option has been calculated. Supporting analysis is provided through OB1 forms which are attached in Appendix F1. This is summarised in the tables below.

10.2.5 The tables show the costs associated with the health specific areas, local authority areas, and the overall total.

Figure 10-3: Capital costing summary (£'000)

Health specific areas	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Construction	156	8,210	10,319	9,909
Fees		150	150	107
Non works		(60)	(60)	(100)
Equipment costs		742	929	904
Optimism bias	14	664	833	793
Health total excluding VAT	**170**	**9,706**	**12,170**	**11,614**
VAT	34	1,746	2,204	2,126
Health total including VAT	**204**	**11,452**	**14,373**	**13,740**

Local Authority specific areas	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Construction	154	2,218	2,218	3,836
Fees		0	0	43
Non works		0	0	40
Equipment costs		150	150	150
Optimism bias	14	177	177	314
Local Authority total excluding VAT	**169**	**2,545**	**2,545**	**4,383**
VAT				
Local Authority total including VAT	**169**	**2,545**	**2,545**	**4,383**

Total	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Construction	310	10,428	12,536	13,745
Fees		150	150	150
Non works		(60)	(60)	(60)
Equipment costs		892	1,079	1,054
Optimism bias	29	841	1,010	1,107
Total excluding VAT	**339**	**12,251**	**14,715**	**15,996**
VAT	34	1,746	2,204	2,126
Total including VAT	**373**	**13,997**	**16,919**	**18,122**

Source: OB1 forms

10.2.6 Capital expenditure will be incurred over a number of years. The phasing of this, excluding VAT, is outlined in the table below.

Figure 10-4 Phasing of capital costs (£000)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Year 1	317	321	349	308
Year 2	22	1,692	2,013	2,111
Year 3	0	6,322	7,627	8,379
Year 4	0	3,917	4,726	5,198
Total capital costs per OB1 forms (excluding VAT)	**339**	**12,251**	**14,715**	**15,996**

Source: OB1 forms (Cash Flow Worksheet)

10.2.7 In addition to the initial capital investment, there will be lifecycle costs associated with replacing individual elements of an asset during the appraisal period which have reached the end of their useful life. The Project Board and its appointed cost advisors, in conjunction with the hub North Scotland, has estimated the lifecycle costs using the assumptions set out below.

Figure 10-5 Lifecycle cost assumptions

Option 1 - Status Quo

- Gross internal floor area (GIFA) of 2250 m2 at an average cost of £50 per m2 for each year of the appraisal period

Option 2 - Do Minimum A

- GIFA of 1991 m2 (1146 m2 = health facility; 520 m2 = 8 housing with extra care units) at an average cost of £18 per m2 for each year of the appraisal period

Option 3 - Do Minimum B

- GIFA of 2179 m2 (1659 m2 = health facility; 520 m2 = 8 housing with extra care units) at an average cost of £18 per m2 for each year of the appraisal period

Option 4 - Preferred Way Forward

- GIFA of 2329 m2 (1659 m2 = health facility; 670 m2 = 10 housing with extra care units) at an average cost of £18 per m2 for each year of the appraisal period

10.2.8 Total lifecycle costs over a 30 year appraisal period are estimated for each of the options in the table below.

Figure 10-6 Total 30-year lifecycle costs (£'000)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Total lifecycle costs over 30 year appraisal period (undiscounted)	3,263	779	1,019	1,132

10.3 Transitional costs

10.3.1 Transitional costs are likely to be incurred for the programme implementation team; the assumptions for which are outlined below.

Figure 10-7 Transitional cost assumptions

Core assumptions

- Programme management team incorporating 1.0 Band 8a Programme Manager and 1.0 Band 5 Support Officer
- Salaries at mid-point of 2016/17 Agenda for Change pay scale and including 30% on costs

Option 1 - Status Quo

- No programme implementation team required.

Option 2 - Do Minimum A

- 80% of Preferred Way Forward

Option 3 - Do Minimum B

- 100% of Preferred Way Forward

Option 4 - Preferred Way Forward

- Year 1 = 0.5 year cover; Year 2 = full time cover; Year 3 = full time cover; Year 4 = 0.5 year cover

10.3.2 Estimated transitional costs for each option are outlined in the table below.

Figure 10-8 Total transitional costs (£'000)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Programme implementation team	0	214	268	268

10.4 Recurring revenue costs

10.4.1 Recurring revenue costs have been estimated for each of the four shortlisted options with consideration for:

- Baseline recurring revenue costs for delivering services on the island including the impact of growing demand;
- The impact of cash releasing benefits; and
- The impact of non-cash releasing benefits on the wider system.

10.5 Baseline recurring revenue costs

10.5.1 The table below provides an overview of 2016/17 baseline revenue costs, excluding depreciation. This represents the current annual budgeted cost of delivering health and social care services on the island of Barra and Vatersay under existing arrangements.

Figure 10-9 Baseline revenue costs at 2016/17 prices (£'000)

	Health £'000	Social Care £'000	Total £'000
Pay costs	781	475	1,256
Non pay costs	146	70	216
Income	0	(67)	(67)
Total baseline costs (2016/17)	**927**	**478**	**1,405**

10.5.2 As outlined in the Strategic Case, it is anticipated that forecast population changes will result in growing demand for health and social care services. The assumptions for estimating the cost of this are provided below.

Figure 10-10 Growing demand assumptions

Estimating the cost of increasing demand for services

- Although the movement in the overall Barra and Vatersay population is anticipated to be minimal in future years, the proportion of older people (over 65) is forecast to increase by 23% between 2016 and 2030.
- It is assumed that this increase in older people is likely to increase the number of people suffering from Long Term Conditions requiring care, while the corresponding reduction in the size of the working age population will constrain the availability of carers.
- On this basis, it is assumed that demand for health and social care services is likely to increase significantly over the next fifteen years.
- Although the way in which these services is delivered is undergoing a number of changes – specifically with the recent focus on delivering more care at home or closer to home – this increase in demand is likely to result in the need for increased resource overall.
- Since the changes to the model of care are still under discussion, it is difficult to quantify the likely impact of this on workforce costs. Therefore for the purposes of the Outline Business Case, it is assumed that the pay costs associated with health and social care staffing (In 2016/17 this equates to a cost of £685k p.a. for health and £386k p.a. for social care) will increase in line with the over 65 population.

10.5.3 The baseline cost of service delivery is therefore expected to increase year on year to reflect this. The adjusted annual cost is provided in the table below.

Figure 10-11 Baseline costs including the impact of growing demand

Year	Health £'000	Social Care £'000	Total £'000
2016/17	927	478	1,405
2017/18	939	485	1,424
2018/19	966	500	1,466
2019/20	975	505	1,480
2020/21	979	507	1,486
2021/22	995	516	1,510
2022/23	1,004	521	1,525
2023/24	1,006	522	1,528
2024/25	1,022	531	1,553
2025/26	1,042	543	1,584
2026/27	1,053	549	1,602
2027/28	1,070	559	1,629
2028/29	1,074	561	1,634
2029/30	1,096	573	1,669
2030/31	1,086	567	1,653

10.5.4 A steady states is anticipated from 2031/32 onwards.

10.5.5 For the purposes of the economic appraisal, each of the options starts from this baseline position. Cost movements are applied accordingly to reflect the changes arising under each option. As such the economic costs are presented in total rather than as increments from the baseline.

10.5.6 The economic appraisal establishes the movement in monetary cash flows. The impact of non-cash items such as capital charges and depreciation is assessed within the Financial Appraisal (Section 13) to ascertain the total income and expenditure impact of the preferred option as part of assessing the affordability of the project.

10.6 Direct costs and benefits of options

10.6.1 This section considers any features of each of the shortlisted options that directly impact the recurring revenue budget for delivering services on the island of Barra and Vatersay.

10.6.2 The only feature directly impacting in this case are the financial benefits associated with the productivity improvements expected to arise as a result of moving to a more integrated workforce. This is considered to be a cash releasing benefit which will reduce recurring revenue expenditure, thereby mitigating the cost pressure associated with growing demand.

10.6.3 The assumptions used to estimate these indirect costs and benefits is provided below.

Figure 10-12 Indirect costs and benefits assumptions

Cash releasing benefit – Improved productivity from workforce integration

- Since the future model of care is still under discussion at this stage it is not possible to provide a detailed workforce costing, therefore for the purposes of the Outline Business Case a percentage productivity target has been used.
- The Status Quo and Do Minimum options involve no changes to the structure of the workforce and so no productivity saving is estimated.
- The Preferred Way Forward option involves a co-located multi-disciplinary team who will work flexibly between the hub and the community. It is estimated that this will result in a productivity saving of 10% on baseline workforce costs.

10.6.4 The impact on recurring revenue costs of cash releasing benefits for each of the options is provided below between 2016/17 and 2030/31, the period that population forecasts are available.

10.6.5 It is assumed that from 2031/32 onwards the saving of £150k p.a. will be retained.

Figure 10-13 Direct cash releasing benefit – productivity improvement (£'000)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
2016/17	0	0	0	0
2017/18	0	0	0	0
2018/19	0	0	0	0
2019/20	0	0	0	0
2020/21	0	0	0	(134)
2021/22	0	0	0	(136)
2022/23	0	0	0	(138)
2023/24	0	0	0	(138)
2024/25	0	0	0	(140)
2025/26	0	0	0	(144)
2026/27	0	0	0	(145)
2027/28	0	0	0	(148)
2028/29	0	0	0	(149)
2029/30	0	0	0	(152)
2030/31	0	0	0	(150)

10.7 Indirect costs and benefits of options

10.7.1 This section considers any features of each of the shortlisted options that impact the wider system. While these costs and benefits will not directly impact on the recurring revenue costs for delivering services on the island of Barra and Vatersay and so are not considered in the Finance Case in section 13, they need to be considered in the economic appraisal in terms of considering public value for money.

10.7.2 Recurring revenue costs have been calculated based on the assumptions outlined in the table below.

Figure 10-14 Indirect cost and benefit assumptions

Increased costs - Impact on inpatient bed days of continuing with existing arrangements

- Continuing with existing arrangements means that there will continue to be pressure on off island inpatient bed days.
- Off-Island bed days figure for Barra/Vatersay residents (postcodes HS9) for 2014/15 of 1239 bed days. This includes Acute/General activity (SMR01), Obstetrics (SMR02) and Psychiatry activity (SMR04).
- For the purposes of the Outline Business Case it is assumed that bed days will increase in line with the forecast growth in over 65 population for the Status Quo option.
- Cost per occupied bed day for NHS Scotland of £214 per day (Source: *Delayed Discharges in NHS Scotland: Annual Summary of Occupied Bed Days and Census Figures*, 28 June 2016, NHS Scotland Information Services Division)
- The Do Minimum and Preferred Way Forward options are expected to mitigate the risk of this increase through delivery of the new model of care and so no cost is included.

Non cash releasing benefit – impact of housing with extra care model

- A three-year study undertaken by the Extra Care Charitable Trust and Aston University identified the financial benefits of the Extra Care Housing model including:
- A reduction in NHS costs associated with primary, community and acute care delivered to an Extra Care resident of £1,115 p.a. This figure has been used for the purposes of the Outline Business Case.
- A reduction of the cost of delivering social care to an Extra Care resident depending on the level of care (for instance £1222 p.a. for lower level care and £4556 for higher level care). For the purposes of the Outline Business Case the average that is quoted in the study of £1222 p.a. for lower level care is used.

Non cash releasing benefit – impact of including 2 flexible units within housing with extra care

- The provision of 2 additional flexible units for step up and step down care is likely to reduce avoidable admissions and delayed discharges, thereby having a positive impact on the cost of off-island bed days.
- For the purposes of this Outline Business Case, a target reduction of 5% cost saving on the current off-island inpatient bed days has been included for the Preferred Way Forward.

10.7.3 The economic impact of the additional costs within the wider system associated with each of the shortlisted options is provided below between 2016/17 and 2030/31, the period that population forecasts are available.

10.7.4 It is assumed that from 2031/32 onwards the saving of £62k p.a. will continue.

Figure 10-15 Indirect additional costs – inpatient bed days (£'000)

Indirect annual increased costs	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
2016/17	0	0	0	0
2017/18	5	0	0	0
2018/19	15	0	0	0
2019/20	19	0	0	0
2020/21	20	0	0	0
2021/22	26	0	0	0
2022/23	30	0	0	0
2023/24	31	0	0	0
2024/25	37	0	0	0
2025/26	44	0	0	0
2026/27	49	0	0	0
2027/28	55	0	0	0
2028/29	57	0	0	0
2029/30	65	0	0	0
2030/31	62	0	0	0

10.7.5 The annual economic impact of the non-cash releasing benefits within the wider system associated for each of shortlisted options is provided below. It is anticipated that this will be realised from 2020/21 onwards.

Figure 10-16 Indirect non cash releasing benefits (£'000)

Indirect annual non cash releasing benefits	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Non cash releasing benefit of housing with extra care model	0	(19)	(19)	(19)
Non cash releasing benefit of including 2 flexible units within housing with extra care	0	0	0	(13)
	0	**(19)**	**(19)**	**(32)**

10.8 Preparing the economic appraisal

10.8.1 A discounted cash flow for each of the options has been undertaken over 30 years using a discount rate of 3.5% for years 0 to 30 in line with the requirements of HM Treasury to calculate the Net Present Cost (NPC) of each option.

10.8.2 The main assumptions used to prepare the economic appraisal are listed below.

Figure 10-17 Key assumptions used in the economic appraisal

- Costs and benefits are calculated for a 30 year appraisal period
- Costs and benefits use real base year prices - Year 0 relates to 2016/17 prices.
- The following costs are excluded from the economic appraisal:
  - Exchequer 'transfer' payments, such as VAT;
  - General inflation;
  - Sunk costs; and
  - Depreciation, impairment and capital charges.
- A discount rate of 3.5% is applied to the economic appraisal.

10.9 Results of the economic appraisal

10.9.1 Based on the assumptions outlined in the previous sections, the results of the economic appraisal are presented in the table below.

Figure 10-18 Net Present Cost over 30 year appraisal period (£'000)

	Option 1 Status Quo £000	Option 2 Do Min A £000	Option 3 Do Min B £000	Option 4 PWF £000
Initial capital costs	326	11,787	14,157	15,390
Total lifecycle costs	3,139	779	1,019	1,089
Total capital costs	**3,465**	**12,566**	**15,176**	**16,479**
Transitional costs	0	214	268	268
Total one-off revenue costs	**0**	**214**	**268**	**268**
Current baseline costs	43,552	43,552	43,552	43,552
Impact of growing demand	6,050	6,050	6,050	6,050
Revised baseline costs	**49,602**	**49,602**	**49,602**	**49,602**
Productivity savings from integrated workforce	0	0	0	(3,980)
Direct cash releasing benefits	**0**	**0**	**0**	**(3,980)**
Impact on off-island inpatient bed days of continuing with existing arrangements	1,499	0	0	0
Indirect additional costs	**1,499**	**0**	**0**	**0**
Reduction in NHS costs for Extra Care residents	0	(241)	(241)	(241)
Reduction in social care costs for Extra Care residents	0	(264)	(264)	(264)
Impact on off-island inpatient bed days of flexible units	0	0	0	(358)
Indirect non cash releasing benefits	**0**	**(505)**	**(505)**	**(863)**
Total recurring revenue costs including direct and indirect costs and benefits	**51,101**	**49,097**	**49,097**	**44,760**
Undiscounted Net Present Cost	**54,566**	**61,878**	**64,541**	**61,507**
Rank	**1**	**3**	**4**	**2**
Discounted Net Present Cost (NPC)	**33,653**	**41,725**	**44,063**	**42,754**
Risk adjustment	877	854	858	796
NPC risk adjusted	**34,530**	**42,579**	**44,921**	**43,551**
Rank	**1**	**2**	**4**	**3**

10.9.2 The initial results from the economic appraisal indicates that the Status Quo option has the lowest Net Present Cost (NPC) overall since the level of upfront investment is minimal.

10.9.3 However, to assess the relative value for money a comparison of the NPC per benefit point has been calculated for each of the shortlisted options using the risk adjusted NPC from Figure 10-18 above divided by the weighted non-financial benefits score from section 8. The results are shown in the table below.

Figure 10-19 Net present cost per benefit point

	Option 1 Status Quo	Option 2 Do Minimum A	Option 3 Do Minimum B	Option 4 Preferred Way Forward
Net Present Cost (NPC) £'000	34,530	42,579	44,921	43,551
Weighted benefits score	215	532	628	795
NPC ratio to benefits score £'000	**161**	**80**	**72**	**55**
Rank	**4**	**3**	**2**	**1**

NPC values reflect risk adjustments

10.9.4 The results show that when comparing the relative costs and benefits of the alternative solutions, Option 4, Preferred Way Forward, has the lowest overall cost per benefit point, indicating this option delivers the best value for money of the shortlisted options.

10.10 Conclusion

10.10.1 A thorough economic analysis in compliance with HM Treasury and SCIM requirements has been performed. This has concluded that Option 4, Preferred Way Forward, offers the best combination of costs and benefits and therefore offers the best value for money.

11 PREFERRED OPTION

11.1 Overview

11.1.1 This section describes the preferred option relating to the development of the Health and Social Care Hub based on the island of Barra and explains the key factors from the appraisal process that supports its selection. The key features and benefits of the preferred option are also highlighted.

11.1.2 No overriding factor or measure has been used to determine which option is most likely to meet the objectives of the project and as such no single measure, qualitative or quantitative. The selection of the preferred option has been based on a broad assessment of the outcome of all aspects of the option appraisal and a balanced view of the solution which is deemed to offer the optimal balance across its core elements.

11.1.3 As such the preferred option is deemed to reflect the solution that is best able to deliver the key outcomes and benefits, minimise the risks and address the constraints and dependencies identified. This has been rigorously tested against the investment objectives and Critical Success Factors (CSFs) to ensure that the preferred option is most suited to meeting the business needs and associated scope of the project on a sustainable basis.

11.2 Option Appraisal Results

11.2.1 As demonstrated in the Economic Case each option offers a different range of features, both positive and negative however, the option appraisal undertaken as part of the business case measures and contrasts these in quantifiable terms.

11.2.2 The following table summarises the results of the benefits appraisal, economic appraisal and risk assessment. A comparison of risk adjusted Net Present Cost per benefit point is also included.

Figure 11-1 Option appraisal results

Option Appraisal Measure	Option 1: Status Quo	Option 2: Do Minimum A	Option 3: Do Minimum B	Option 4: Preferred Way Forward
Initial capital cost including optimism bias and VAT (£000)	373	13,997	16,919	18,122
Annual recurring revenue costs by 2030/31 (£000)	1,715	1,635	1,635	1,471
Net Present Cost (£000)	34,530	42,579	44,921	43,551
Non-financial benefit points	215	532	628	795
Net Present Cost per benefit point (£000)	**161**	**80**	**72**	**55**
Qualitative risk assessment score	328	283	224	149

NPC values reflect impact of quantified risks

11.3 Analysis of the Option Appraisal Results

Option 1 – Status Quo

11.3.1 The Status Quo option, which involves addressing the backlog maintenance of the existing facilities, offers the lowest Net Present Cost when discounted over a 30 year appraisal period due to the low level of upfront investment required. However, it does not generate any financial benefits and it has the highest ratio of costs to benefits, indicating it does not represent value for money. Overall, it does not represent a feasible option due to the high level of compliance risk, particularly related to hospital, care home, and dental facilities.

Option 2 – Do Minimum A

11.3.2 Option 2, which involves providing new health facilities for those areas with the most severe compliance risks (hospital and dental) and developing housing with extra care on a separate site, offers the next lowest New Present Cost when discounted over a 30 year appraisal period. This is because the level of investment required is slightly lower than the alternative options. However, it generates limited financial benefits, meaning recurring revenue costs remain at a similar level to the Status Quo option, and has a relatively high ratio of costs to non-financial benefits. Furthermore, the level of risk associated with this option remains high because of the limited opportunities for integrated working. Given the scale of investment remains relatively high at £14m but the solution generates only minimal financial and non-financial benefits and does not adequately mitigate risks, this option does not offer value for money.

Option 3 – Do Minimum B

11.3.3 Option 3, which involves providing new facilities for all areas but developing health facilities and housing with extra care on separate standalone sites, offers the highest Net Present Cost, since the level of investment required is relatively similar to Option 4 at £17m and results in fewer benefits and a higher level of risk due to limited opportunities for integrated working. This option does not offer value for money.

Option 4 – Preferred Way Forward

11.3.4 Option 4, which involves new co-located facilities with a fully integrated workforce, offers the best value for money despite requiring the highest level of upfront investment of £18m. This is because it provides fit for purpose facilities which support integrated working and the delivery of safe, high quality, patient-centred care. This minimises risk and results in the highest level of non-financial benefits. In addition, to this it offers the most efficient solution with recurring revenue costs estimated to be 11% lower than the Status Quo option. This option is therefore considered to offer the best value for money.

11.4 Conclusion

11.4.1 Following a robust option appraisal process involving a wide range of stakeholders, the Project Board has determined that its preferred option for this scheme is Option 4. This solution provides the optimal value for money whilst addressing the key constraints of the programme to develop a health and social care hub on the island of Barra.

11.4.2 The preferred option delivers a wide range of benefits which are complementary with local and national service requirements as well as the delivery of a range of short and long term objectives in improving the provision of services.

11.4.3 An overview of the key features of the option is provided below.

New purpose built co-located facilities on identified site that include

- Re-provide St Brendan's hospital (including 3 x 72-hour NHS beds, 2 x resuscitation and retrieval bays and multi-purpose consulting rooms), dental facilities, primary care facilities, and create an ambulance station;
- 8 x tenanted housing with extra care units and 2 x flexible units
- Fully integrated health and social care team

Main advantages

- Purpose built, fit for purpose compliant health facilities – reducing current risks to patients, staff, and service sustainability
- Co-location of all services promotes integration of teams, enabling the delivery of more co-ordinated care and improving patient / service user experience
- Creation of an ambulance station improving response times and providing storage
- Providing housing with extra care will support residents to live independently
- Flexible units provide opportunities to improve choice for services such as respite and palliative care
- Reduced risk when unable to evacuate patients from the island due to weather and transport failures (e.g. facilities will provide suitable place of safety for mental health patients)

11.4.4 Subsequent sections of the OBC will consider delivery arrangements for the preferred option including procurement, funding and project management arrangements.

COMMERCIAL CASE

12 PROCUREMENT ROUTE ASSESSMENT

12.1 Overview

12.1.1 The SCIM requires that, as part of the OBC development process, NHS Boards undertake an assessment to establish the procurement route for the project. This should consider the most likely route to deliver the best overall value for money including consideration of the potential for procuring capital investment projects through alternative financing arrangements under Public Private Partnership (PPP). Where PPP is assessed as not offering the best value for money procurement route for delivering the project, a clear justification should be provided.

12.1.2 In the event that a traditional procurement is adopted there is a range of options available to the Project Board in delivering the project and the assessment should again consider which of these is likely to best support the delivery of the requirements and offer the best value for money.

12.1.3 The Project Board sought to make this assessment at an early stage and , following the development of the IA, formally considered the options for procuring the requirements in relation to St Brendan's Community Resource Hub.

12.2 Hub Initiative

12.2.1 The SCIM guidance proposes that the default position for delivering a new build community development for the St Brendan's Community Resource Hub, having an equivalent capital value in excess of £750,000, should be via the Scottish Futures Trust hub initiative.

12.2.2 The Scotland-wide hub initiative which is led by Scottish Futures Trust (SFT) reflects a national approach to the delivery of new community infrastructure which is valued at more than £2bn over the next 10 years.

12.2.3 It brings community planning partners, including health boards, local authorities, police, and fire and rescue services together with a private sector development partner to form a hubCo, to increase joint working and deliver best value and all five areas have already been formally established in the South East, North, East Central, West and South West regions of Scotland.

12.2.4 Hub North Scotland, which incorporates the Western Isles area, is now operational and Alba Community Partnerships, comprising Miller Corporate Holding Limited ("Miller") and Sweett Investment Services Ltd, has been selected to help the public sector Participants to deliver real benefits in community and social care services to the people within the hub North Territory. Both NHS Western Isles and CnES are shareholders in hub North Scotland and signatories to the Territory Partnering Agreement.

12.2.5 The potential advantages to the public sector partners in using hub as an alternative to more traditional forms of procurement include faster and more efficient procurement timescales as well as cost savings through standardised processes and documentation.

12.2.6 Whilst hub North Scotland has the exclusive right to be the preferred provider for capital projects it will still be required to demonstrate value for money for each project through an open book approach, benchmarking and / or market testing.

12.2.7 Hub North Scotland can deliver projects either through a design and build route where participants wish to make contributions under a capital cost option or alternatively a design, build, finance and maintain solution where revenue contributions are the preferred funding route.

12.2.8 In light of the respective funding positions of NHS Western Isles and CnES, a capital cost option is the preferred option.

12.2.9 Other commercial aspects of the project to be considered will include:

- The acquisition of the adjacent land strip
- Disposal of the existing GP surgery
- Disposal of the vacant NHS property in Castlebay (old GP house)

13 PROPOSED CONTRACTURAL ARRANGEMENTS

13.1 Overview

13.1.1 This section describes the commercial details of the proposed contract between NHS Western Isles, CnES and hub North Scotland. Hub North Scotland will undertake a wide range of services and duties to assist and support NHS Western Isles and CnES through each of the business case stages, construction and commissioning of the new facility.

13.2 Required Services

13.2.1 The hub initiative was established to provide a strategic long-term programmed approach to the procurement of community based developments. Whilst one of the proposed uses of the hub is in Design, Build, Finance and Maintain (DBFM), it has been elected to proceed with this project as a Design and Build (D&B) project.

13.2.2 One advantage in proceeding with the hub initiative as a procurement model is to significantly reduce the procurement timescales, and to ensure that the project is delivered as soon as practical, dispensing with the additional time and expense of a standard procurement exercise.

13.2.3 The funding for this project will come from capital funding, and therefore there is no requirement for the establishment of a 'Sub-hubCo' arrangement as a Special Purpose Vehicle (SPV).

13.2.4 As this is a D&B project, all hard and soft assets, and equipment will be wholly owned by NHS Western Isles and CnES, excepting for those items of equipment that have been procured in lease agreements separate to this project. The contractual arrangements of any existing lease agreements will continue to be with NHS Western Isles / CnES.

13.2.5 The existing site is in joint ownership and it has been agreed by both NHS and CnES that the additional land purchase required for the new development will be in joint ownership.

13.3 Proposed Method of Payment

13.3.1 The method of payment will be that laid out in the standard Design and Build Development Agreement between hub North Scotland and NHS Western Isles & CnES. This document covers the obligations, frequency and timing of payments of the following:

- Project Development fees
- Application for payments including supporting documentation
- Manner of payments
- Retention amounts
- Late payments

13.4 Potential for Risk Transfer

13.4.1 This section provides an assessment of how the associated risks might be apportioned between NHS Western Isles & CnES and hub North Scotland. The

process for identifying, assessing and apportioning the project specific risks will be outlined in Section 6.

13.4.2 The general principle is to ensure that risks should be passed to "the party best able to manage them", subject to value for money (VFM).

13.4.3 Some risks will be clearly allocated to one party or the other; however, a number of risks will be shared between the parties and will require to be jointly managed through effective risk mitigation arrangements.

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

Figure 13-1: Risk allocation matrix

Risk Category	Potential Allocation		
	NHS WI / CnES	Shared	HUB Co
1. Design Risk		✓	
2. Construction & Development Risk			✓
3. Transition & Implementation Risk	✓		
4. Availability and Performance Risk	✓		
5. Operating risk	✓		
6. Variability of Revenue Risks	✓		
7. Termination Risks	✓		
8. Technology & Obsolescence Risks	✓		
9. Control Risks	✓		
10. Residual Value Risks	✓		
11. Financing Risks	✓		
12. Legislative Risks	✓		
13. Other Project Risks specified within the contract	✓	✓	

13.4.5 The project delivery risks are identified in an integrated risk register with inputs by the Project Board and hub North Scotland. The Project Manager will be responsible for updating the risk register and identifying key risks.

13.4.6 The risk register will be issued on a monthly basis by the Project Manager who will indicate on a simple matrix the changes to the risk register, ensuring all allocations of risk can be traced easily for audit purposes. Where there is movement of substantial

amounts of risk allocation shown on this matrix, further breakdown to this risk allowance will be shown and submitted on supporting sheets.

13.5 Proposed Key Contractual Clauses

13.5.1 The Design and Build Development Agreement forms the basis of the contract between hub North Scotland and NHS Western Isles & CnES for the development of this project. This is a standard, pre-prepared contract by SFT for the commercial arrangements of D&B projects delivered through the hub initiative.

13.5.2 Both organisations are currently seeking VAT advice from Caledonian Economics to establish the most appropriate contractual arrangements with hub North Scotland due to the different VAT liabilities. There is a range of options including single contract between hub North and NHS Western Isles with a separate agreement between NHS Western Isles and CnES or a single contract between hub North and CnES with a separate agreement between CnES and NHS Western Isles or two contracts one with hub North and NHS Western Isles and one with hub North and CnES. It is likely that the latter; two separate contracts one with hub North and NHS Western Isles and one with hub North and CnES will be required to ensure the most beneficial VAT position.

13.5.3 There has been no agreement between hub North Scotland, NHS Western Isles and CnES to alter any of the standard terms and clauses within this agreement. However, it is accepted that any attempt to do so must be done with approval from SFT.

13.6 FRS5 Accountancy Treatment

13.6.1 It is assumed that public funding will be allocated for this project and therefore the assets will be included on NHS Western Isles' and CnES' balance sheet. Refer to the Financial Case in Section **Error! Reference source not found.** for further details.

13.7 Agreed Personnel Implications

13.7.1 The proposed project is to be set out under a D&B arrangement. There will be no personnel implications such as transferring of staff under Transfer of Undertakings (Protection of Employment) regulations (TUPE).

13.8 Conclusion

13.8.1 Having concluded that capital finance is the procurement route offering the best overall value for money, the Project Board has chosen to deliver the project through the SFT hub initiative.

13.8.2 As part of the hub initiative, the development of the St Brendan's Community Resource Hub will follow the standard agreement for the hub Design and Build Development Agreement (DBDA).

13.8.3 Embedded within this contractual framework will be the arrangements for payment and risk allocation.

13.8.4 The proposed procurement route will result in the capital expenditure being incorporated on NHS Western Isles' SOFP and CnES' capital plan.

FINANCIAL CASE

14 FINANCIAL APPRAISAL

14.1 Overview

14.1.1 This section sets out the forecast financial implications of delivering the preferred option that was identified in the Economic Case.

14.1.2 The creation of a health and social care hub requires significant investment but provides the opportunity for sustainable improvements in clinical services for the population of Barra and Vatersay and allows for better use of existing resources across health and social care in the face of growing demand for services.

14.2 Capital implications

14.2.1 The preferred way forward requires total capital investment of £18.122m. This includes VAT for the proportion of the build related to health, as well as quantified risk and optimism bias. The breakdown of the capital requirements is provided below.

Figure 14-1 Capital requirements (£'000)

	NHS WI £'000	CnES £'000	Total £'000
Building and engineering works	7,576	2,937	10,513
Quantified risk	597	232	829
Location adjustment	1,737	667	2,403
Construction costs	**9,909**	**3,836**	**13,745**
Non works costs	(100)	40	(60)
Equipment costs	904	150	1,054
Total estimated cost before VAT and fees	**10,713**	**4,026**	**14,740**
VAT	1,967		1,967
Professional fees	107	43	150
Total including VAT	**12,788**	**4,069**	**16,857**
Optimism bias allowance	952	314	1,265
Estimated costs including optimism bias	**13,740**	**4,383**	**18,122**

14.2.2 The assumptions for this are outlined in section 10, the Economic Appraisal. However, it is recommended that professional advice is sought in relation to the treatment of VAT.

14.2.3 £2.9m of the funding required for the total capital investment will be met from the CnES capital plan. NHS WI seeks funding for the remaining £15.222m from Scottish Government Health and Social Care Directorates (SGHSCD) Capital Investment Group (CIG). A summary of this allocation is provided below.

Figure 14-2 Funding allocation (£'000)

	Funding allocation £'000
NHS WI capital allocation	15,222
CnES capital contribution	2,900
Total capital investment	**18,122**

14.3 Revenue implications

14.3.1 It currently costs £1,405k p.a. to deliver health and social care services on the island of Barra and Vatersay. This is based on 2016/17 budget excluding depreciation and capital charges.

14.3.2 As outlined in the Strategic and Economic Cases, this is expected to increase by £248k p.a. by 2030/31 if we are to continue to meet growing demand. This will result in annual recurring revenue costs of £1,653k by 2030/31, excluding the impact of inflation, if the model of care is continued to be delivered in the same way.

14.3.3 Implementing the preferred option will partly mitigate this cost pressure since it is expected to deliver £150k p.a. of cash releasing benefits by 2030/31 in relation to the productivity improvements of a fully integrated workforce model. This will result in recurring revenue costs of £1,503k p.a. by 2030/31.

14.3.4 The table below shows the annual impact of the changes, the assumptions for which are outlined in the Economic Appraisal in section 10.

Figure 14-3 Recurring revenue costs (£'000)

Year	Baseline including demand growth			Preferred Option			Movement
	Health £'000	Social Care £'000	Total £'000	Health £'000	Social Care £'000	Total £'000	
2016/17	927	478	1,405	927	478	1,405	0
2017/18	939	485	1,424	939	485	1,424	0
2018/19	966	500	1,466	966	500	1,466	0
2019/20	975	505	1,480	975	505	1,480	0
2020/21	979	507	1,486	895	457	1,352	(134)
2021/22	995	516	1,510	910	465	1,374	(136)
2022/23	1,004	521	1,525	918	469	1,388	(138)
2023/24	1,006	522	1,528	920	470	1,391	(138)
2024/25	1,022	531	1,553	934	479	1,413	(140)
2025/26	1,042	543	1,584	952	489	1,441	(144)
2026/27	1,053	549	1,602	962	494	1,457	(145)
2027/28	1,070	559	1,629	978	503	1,481	(148)
2028/29	1,074	561	1,634	981	505	1,486	(149)
2029/30	1,096	573	1,669	1,001	516	1,517	(152)
2030/31	1,086	567	1,653	992	511	1,503	(150)

14.4 Wider system implications

14.4.1 The introduction of the preferred option is also expected to deliver financial benefits within the wider system, due to the introduction of housing with extra care including the flexible units.

14.4.2 The estimated saving of £32k p.a. from 2020/21 onwards has been classified as non-cash releasing for the purposes of this business case as it is outside of the scope of the recurring revenue budgets for Barra and Vatersay.

14.4.3 A summary is provided in the table below, the assumptions for which are outlined in the Economic Appraisal in section 10.

Figure 14-4 Non cash releasing benefits (£'000)

	Health £'000	Social Care £'000	Total £'000
Reduction in NHS costs for Extra Care residents	(9)		(9)
Reduction in social care delivery for Extra Care residents		(10)	(10)
Impact on off-island inpatient bed days of flexible units	(13)		(13)
Non cash releasing annual benefits	**(22)**	**(10)**	**(32)**

14.5 Capital charges implications

14.5.1 Indicative capital charges associated with implementing the preferred option have been calculated based on:

- Initial capital investment requirements outlined in Figure 14-1 above including optimism bias but excluding impairment;
- Building depreciation based on asset life of current 90 year NHS and 40 years for CnES; and
- Equipment depreciation based on an average 10 year asset life.

14.5.2 It has been assumed that the construction costs will not be capitalised until the development is complete; depreciation will then be applied using the straight line method. The table below outlines the full value which will be incurred from 2020/21 onwards.

Figure 14-5: Capital charges impact (£'000)

	NHS WI £'000	CnES £'000	Total £'000
Buildings depreciation	141	106	246
Equipment depreciation	109	15	124
Total depreciation (Preferred Option)	**249**	**121**	**370**
Current depreciation	32	14	46
Depreciation impact	**217**	**107**	**324**

14.6 Summary

14.6.1 This section has set out the overall capital and revenue affordability for the preferred option. In summary:

- There is a capital investment requirement of £18.122m, which is expected to be funded by:
    - £2.9m from CnES capital plan;
    - NHS WI seeking approval from Scottish Government for central capital funding of £15.222m;
- £150k p.a. of cash releasing benefits are expected to be realised by 2030/31, which will partly offset the cost pressure caused by the forecast growing demand for services;

- £32k p.a. of non-cash releasing savings which are expected to benefit the wider system; and
- Increased capital charges of £324k p.a.

MANAGEMENT CASE

15 PROJECT MANAGEMENT & PROJECT IMPLEMENTATION TIMETABLE

15.1 Overview

15.1.1 This section of the OBC sets out the arrangements put in place to manage the project to successful delivery. The areas covered include:

- Project management strategy and methodology
- The project framework
- Project roles and responsibilities
- The project plan, showing the high level timetable for the project
- Project communication and reporting arrangements
- Gateway review

15.2 Project Management Strategy and Methodology

15.2.1 This project enthusiastically embraces the principles of project and programme management to ensure that the project is successfully delivered and all risks managed.

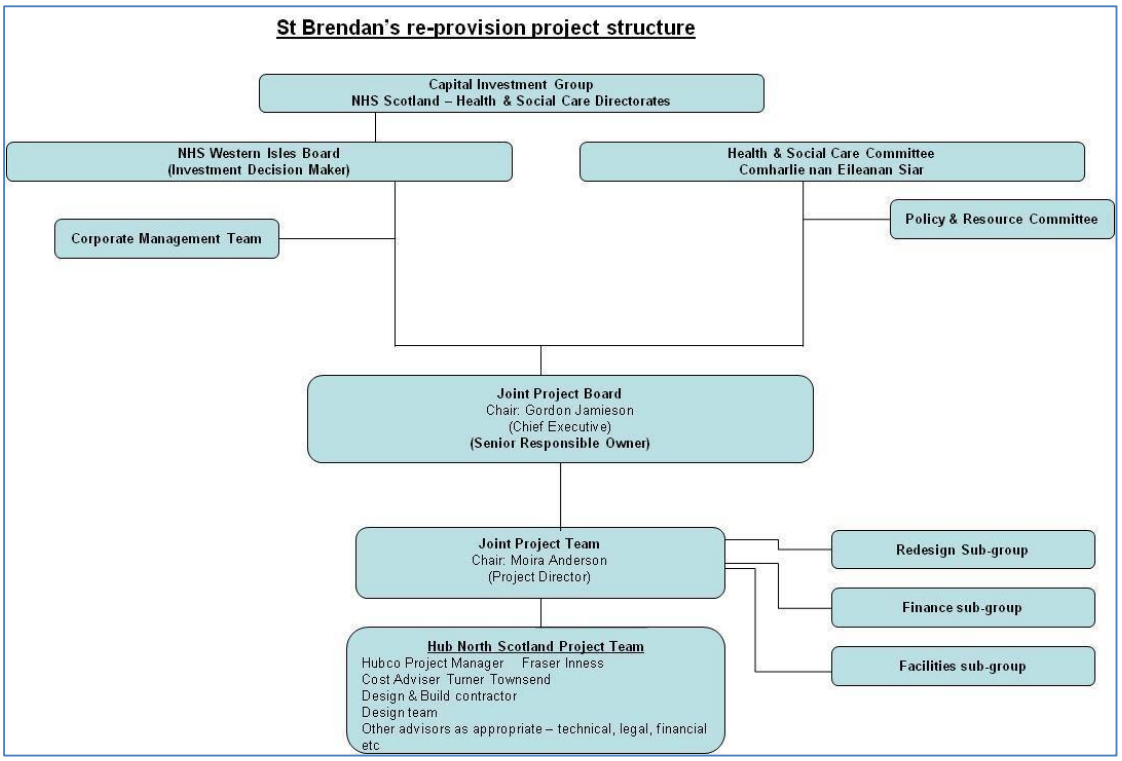
15.2.2 The approach to the management and methodology of the project is based on the overriding principles of the “hubco” initiative where NHS Western Isles and CnES will work in partnership with the appointed Private Sector Development Partner (hub North Scotland) to support the delivery of the project in a collaborative environment that the “*Territory Partnering Agreement*”, and “*DBDA Agreement*” creates.

15.3 The Project Framework

15.3.1 The diagram below sets out:

- The overall governance structure
- How the Project Board and the Project Teams fit into this structure and report back into the host organisations
- The key roles for the redevelopment e.g. the Senior Responsible Owner (SRO), and Project Director

Figure 15-1 Draft Governance Structure



15.3.2 The NHS Senior Responsible Owner (SRO) chairs the Project Board and reports to the NHS Western Isles Board. Senior CnES representatives on the Project Board report to the Health and Social Care Committee at CnES.

15.4 Project Roles and Responsibilities

Structures within the Project

15.4.1 The detailed roles and responsibilities of the Project Board and Teams within the project structure are set out in the table below.

Figure 15-2: Roles and responsibilities of Project Board and team

Team or Group	Responsibilities
Project Board	▪ Oversee the project ▪ Review the progress ▪ Approve the business case ▪ Resolve matters outside Project Team's delegated authority
Corporate Management Team (NHS Western Isles) **Policy & Resource Committee (CnES)**	▪ Deliver the service modernisation programme ▪ Develop vision of an overall services strategic direction ▪ Agree and prioritise the Capital Plan ▪ Maximise the integration of development opportunities across organisations and with external partners ▪ Ensure the Capital Plan is aligned to support service development priorities ▪ Monitor progress of programme against programme objectives

Team or Group	Responsibilities
	▪ Resolve issues which need the agreement of senior stakeholders to ensure progress of programme ▪ Provide recommendations to NHS Western Isles on Property Strategy ▪ Provide commitment and endorsement of programme at communication events ▪ Support the Senior Responsible Officer (SRO) ▪ Exercise leadership/ championing the redevelopment ▪ Confirm sign off at programme closure
Sub-groups leads for Finance, Facilities & Redesign	▪ 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. ▪ Agree the design proposals. ▪ Make recommendations for approval to the Project Board.

Individual roles and responsibilities

15.4.2 The key roles are those of the Investment Decision Maker, Senior Responsible Owner, Project Director and Project Manager. These are summarised in **Appendix I1**.

15.5 Project Plan

15.5.1 The dates detailed in the table below highlight the key milestones for the project.

Figure 15-3: Project milestones

	Action	Responsibility	Duration	Target Completion
1	Completion of OBC	Project Board	-	August 2017
2	Approval of OBC by Project Board and internal approvals as required	Project Board	Action 1 + 0 month	August 2017
3	Approval from Capital investment Group Scottish Government	Project Board	Action 1 + 3 month	November 2017
4	Preparation & approval of New Project Request	Project Board	Action 3 + 2 months	January 2018
5	hub North Scotland Stage 1	hub North Scotland	Action 4 + 5 months	June 2018
6	hub North Scotland Stage 2	hub North Scotland	Action 5 + 6 months	December 2018
7	FBC development	Project Team	Action 4 + 12 months	December 2018
8	FBC Submission to Scottish Government	Project Board	Action 8	December 2018
9	Conclude commercials	Project Board/ hub North Scotland	Action 8 + 3 months	March 2019
10	Enabling works	hub North Scotland	Action 10 + 1 month	April 2019
11	Construction commence	hub North Scotland	Action 10 + 1 month	May 2019
12	Construction complete	hub North Scotland	Action 11 + 12 months	May 2020
13	Commissioning of new buildings	Project Board	Action 12 + 1 month	June 2020
14	Demolition of existing buildings	hub North Scotland	Action 13 + 3 months	September 2020

15.6 Project Communication and Reporting Arrangements

15.6.1 A meeting schedule has been developed for the engagement and management of stakeholders. This includes details of all planned meetings in order to ensure effective communication.

15.6.2 A communications strategy has jointly been developed and approved by CnES and NHS Western Isles.

15.6.3 All formal communication between representatives shall be issued through the Project Manager or Project Director.

15.6.4 The main method of communication of records will be via e-mail. All e-mails will be copied to the Project Director for record purposes.

15.6.5 Regular meetings have been arranged in order to manage, control and monitor issues throughout the OBC process.

15.6.6 Minutes will be taken at all meetings to ensure the task-focus of the project. After each meeting, an agreed action list will be circulated.

15.6.7 NHS Western Isles and CnES have undertaken a progressive and constructive consultation process in developing this OBC and preparing for the redevelopment of St Brendan's campus.

15.6.8 The comments and output from these consultations have been considered throughout preparation of this Outline Business Case.

15.6.9 Staff, public and patient engagement is critical to the success of the project and a number of consultation events with the public as end users have been held. These have been utilised to:

- Establish the benefit criteria for the scheme
- Review all potential options
- Select a shortlist of options
- Score the non financial benefits
- Identifying the preferred option

15.6.10 There has been engagement evaluation in partnership with Scottish Health Council.

Local Authority

15.6.11 In development of the OBC The partner organisations have looked to identify and mitigate early on in the development any potential difficulties in obtaining planning permission and have covered topics such as:

- Restrictions that are likely to apply to the site given the current facilities
- Potential impact of any Tree Preservation Orders on the sites
- Impact of local conservations areas on the design and development
- Likely requirements for the provision of public transport facilities
- Parking requirements given the proposed scale of the development

15.7 Project Reporting Arrangements

15.7.1 The internal reporting arrangements and responsibilities including links with hub North Scotland are as follows:

15.7.2 All members of the Project Board / Project Team will have individual responsibilities for cascading project information through their respective service functions

15.7.3 The Project Director and coordinators will be responsible for producing a monthly progress report to their own organisations and to the Project Board on progress, opportunities, any potential problems and project risks

15.7.4 The Project Manager will produce a monthly progress report in advance of the monthly progress meeting including a summary of the current status of the project and any key issues that have arisen

15.7.5 The hub North Scotland Cost Consultant will produce a monthly report including a financial analysis of approved and forecast project expenditure for monthly progress meetings and Project Board Advisors' Meetings

15.7.6 The SRO will be responsible for producing formal Project Board Reports

15.7.7 The SRO will be responsible for producing ad hoc reports to the Project Board

15.7.8 Hard copies of all documents will be maintained by those parties responsible for the documents' preparation and management.

15.7.9 The external reporting arrangements and responsibilities are as follows:

- The Project Director will be responsible for the inclusion of the public in the proposed developments
- Any required media management will be in accordance with the Project Board's communications plan.

15.7.10 The Project Board will consider the production of a regular newsletter for internal and external communication purposes. Responsibility for production and frequency (if required) to be identified.

15.8 Conclusion

15.8.1 This section of the OBC shows that NHS Western Isles and CnES have developed a robust project management framework outlining the project strategy and methodology based on best practice, the roles and responsibilities of key project members, the project communication and reporting arrangements and the project plan including key project milestones.

16 CHANGE MANAGEMENT

16.1 Overview

16.1.1 This section of the OBC sets out the approach to change management and how it helps to deliver the preferred option, discussing:

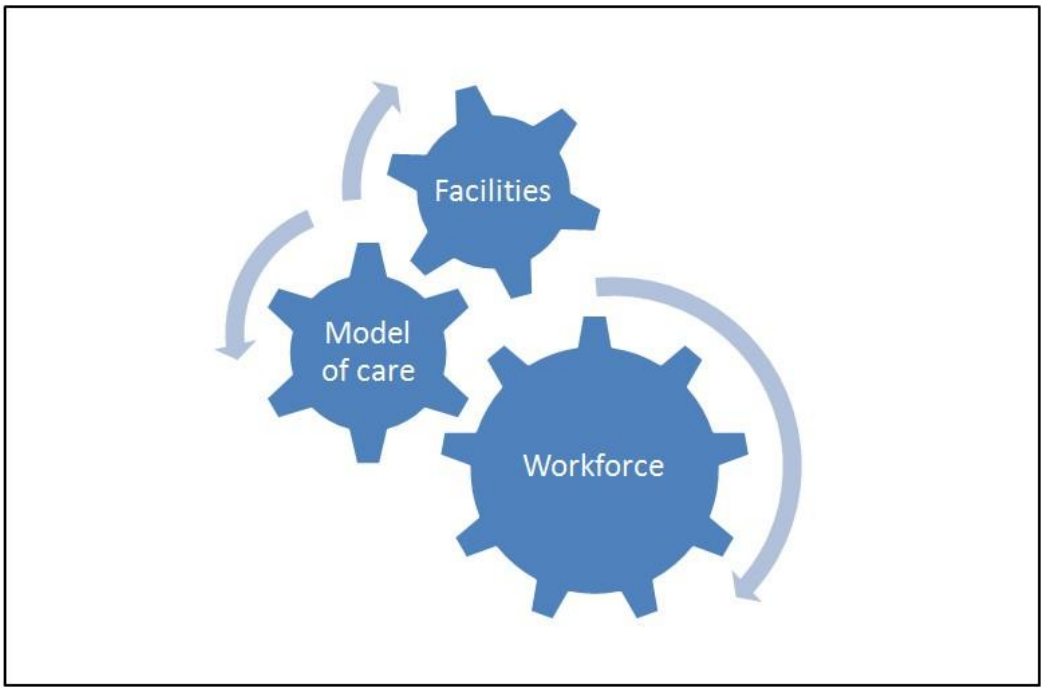
- Change management philosophy
- Change management principles
- The approach to change management
- The current change management plan

16.2 Change Management Philosophy

16.2.1 The redevelopment of St Brendan's hospital and care home represents a significant change point for NHS Western Isles and CnES. The change to the physical infrastructure is simply an enabler to a more fundamental change in the way that health and social care will be delivered for the residents of Barra and Vatersay.

16.2.2 The simplified diagram below shows the three key elements encompassed by the change.

Figure 16-1: Scope of change



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

Figure 16-2 Impact of change

Area	
Culture	The culture of the organisation will change from one where care is provided in a facilities focused silo to one where the person is seen as being at the centre of care, irrespective of the extent of the contribution of health and social care to the overall treatment and patient pathway. The need for improvements in quality will sit at the heart of these changes. These changes will impact upon culture and therefore staff right across NHS Western Isles and CnES.
Systems	Systems will be more responsive and geared to supporting the new models of care, both within the hospital and social care. In particular more emphasis will be placed on good communication and effective handover between acute and primary /community care to make the patient experience seamless.
Processes	New models of care will introduce new processes and change roles and responsibilities of staff. The emphasis of the clinical processes will be a speedier treatment without compromise on patient quality. The physical environment will also improve the way care is delivered and mean that some of the approaches adopted in the past because of restricted physical configuration will change.
People	There will be changes to roles and responsibilities. Some of this will arise from the changes in clinical process within the hospital, whereas other changes in roles will come from the way the focus of care will shift from purely acute to more pathway based care.

16.2.4 In the light of the impact of these changes, the change management philosophy is to:

- Recognise the significance of the change
- Embrace the change, taking the opportunity to improve the quality of healthcare and maximise the return on investment
- Implement the change in a structured and well managed way to maintain control of the change process

16.3 Change Management Principles

16.3.1 The Project Board has discussed the change process and has started to develop a series of principles that will underpin the change process. These principles will shape the way that the process is managed, reflecting the change management philosophy outlined above.

16.3.2 The principles agreed to date are to:

- **Recognise the need to maximise the benefits of the change** for patients, who should be at the heart of the changes made
- **Take advantage of the time required to complete the development** to start the change process immediately and avoid risks related to a 'big bang' approach

- **Test and prove the changes** through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned
- **Work in partnership with staff and other stakeholders** both within and outside the hospital to engage all those involved in the delivery of care in the change process
- **Focus on staff skills and development** required so staff are both capable and empowered to deliver healthcare effectively and to a high quality standard in the new facility through new models of care

16.3.3 Once the OBC has been approved, these principles will be revisited and confirmed. The change management philosophy and change management principles will be communicated to all staff as part of the launch of the change management process.

16.4 The Change Management Approach

16.4.1 The Project Board has designed a change management approach that encompasses the philosophy and principles outlined above.

16.4.2 It is likely that the implementation programme may start slowly, but will ramp up significantly before the FBC is approved. Once the FBC is approved, the programme will move swiftly into implementation.

16.4.3 Although the principles and processes are not yet fully signed off and in place, the Project Board has recognised and acted upon its responsibility for leading effective change management during the project. The paragraphs below set out the work completed to date, demonstrating the proactive approach to planning change management within this OBC.

16.5 The Current Change Management Plan

16.5.1 A core change management plan has been developed that sets out the key tasks for the project's change management plan. Once the OBC has been approved and the Change Management Champion identified, three actions will occur:

- The Core plan will be reviewed to identify other relevant areas that need to be included
- Detailed plans will be set up for each of the tasks in the core plan
- An overall timetable will be developed and the high level milestones communicated as part of the launch of the Change Management Plan

16.5.2 The table below sets out the Core plan and the main tasks identified to date.

Figure 16-3 Core change management plan

Area	Planned tasks
Planning phase	• Appoint key programme roles and Change Managers, confirming responsibilities and leadership • Revisit and agree philosophy and principles • Confirm stakeholders and interested parties both within and outside the hospital • Develop Core plan in more detail, identifying high level milestones for the change management plan, mapped to the overall project plan • Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	• Confirm communications lead and protocols (route and timing of approval of communications) • Develop communications routes, including face to face briefings (whole NHS Western Isles / CnES, individual groups, and 'surgeries'), bulletins, intranet pages • Formulate and agree key communications messages against high level milestones • Set up stakeholder map and engagement plan • Launch change programme • Ongoing communications work
Training and development	• Complete detailed workforce planning to identify 'shadow' structures, roles and competencies for those roles • Work with staff through workshops and other training to clarify the workings of the new models of care and how these will impact in practice • Identify training and development required to fulfill roles and competencies • Develop training plan, aligned to pilot work and overall milestones in implementation plan • Link training and development into communications plan
Piloting	• Identify and confirm areas where piloting of new models and practice will be implemented • Confirm schedule of pilot work, mapped against high level project and change management milestones • Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan • Execute pilots, feedback and report progress
Full Implementation	• Identify scheduling/phasing of full implementation at St Brendan's • Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing • Discussion and agreement with key staff • Execute implementation and transition plans

16.6 Conclusion

16.6.1 This section of the OBC shows that the Project Board has:

- A sound change management philosophy, underpinned by specific change management principles.
- Developed a clear approach to change management, whose simple structure will facilitate effective delivery.
- Already made progress in developing a Core change management plan to implement the changes required to make the redevelopments a success.

17 BENEFITS REALISATION PLAN

17.1 Introduction

17.1.1 NHS Western Isles and Comhairle nan Eilean Siar are committed to ensuring that a thorough and robust Post-Project Evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project and PPE is fully embedded in the project management arrangements.

17.1.2 A key element of PPE is to ensure that the range of benefits anticipated to be realised from the project actually materialise. Therefore, a Benefits Realisation Plan (BRP) has been developed. This report outlines the process undertaken in order to achieve this.

17.2 Background to the Benefits Realisation Process

17.2.1 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.

17.2.2 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).

17.2.3 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.

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

17.2.5 The plan for benefits needs to be integrated into or co-ordinated with the programme plan and should be very clear about handover and responsibilities for ongoing operations in the changed state (where the benefits will actually accrue).

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

17.3 Benefits Management

17.3.1 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 project during the delivery phase which impact on, or alter the anticipated benefits.

17.3.2 The benefits management approach is a cycle of selection, planning, execution and review. Further details of each stage are 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
- **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

17.4 The Benefits Realisation development

17.4.1 The benefits realisation development was undertaken by the Project Team on 23rd April 2014.

17.4.2 The session was structured into two main phases, namely:

- A review of the OBC benefit criteria, and
- The activities associated with actual development of the BRP

17.5 A Review of the OBC Benefit Criteria

17.5.1 As outlined in section 2 the non financial benefit criteria developed as part of the OBC always represent the starting point in terms of the development of the BRP. It is however necessary to review these to ensure that they remain valid.

17.5.2 Further details of the OBC benefit criteria including a summary of their key features is provided in section 8.3.

17.6 Process for Developing the BRP

17.6.1 As part of the workshop activities four work stages were identified in the development of the BRP process, namely:

- Defining the benefits
- Reviewing their key features
- Assessing how they will be delivered and measured
- Agreeing the best means of monitoring.

17.6.2 The first two stages were captured as part of the review of the OBC benefit criteria. Each criterion and its key features were initially reviewed and any issues clarified. It was felt beneficial at this stage to map each of the original benefit criteria to the six dimensions of quality; this is shown below:

Figure 17-1: Criteria Mapped to 6 Dimensions of Quality

Criterion	Definition	Quality Dimension
Clinical effectiveness, integration of service	The option should be able to allow for effective provision of health and social care services. It should allow for integration of services through providing an enabler to new ways of working.	**Effective**
Sustainability and safety of services	The option should be able to accommodate changes in patterns of care and the changing needs of the population over the longer term. It should enable optimal and efficient deployment of all types of resources including staff, facilities and equipment to meet the expansion or realignment of services in the future.	**Effective** **Efficient** **Safe** **Person centred**
Quality of care	The option should provide a safe service for all patients, users, carers, visitors and staff. Any clinical risks associated with the option should be assessed, managed and minimised so that	**Safe** **Person centred**

Criterion	Definition	Quality Dimension
	the provision of the service should do no harm and aim to avoid preventable adverse events.	
Staffing meets required needs	The option should provide a staffing level which meets the needs of health and social care in Barra supporting the recruitment and retention of staff.	**Effective** **Safe**
Quality of physical environment	The option should provide fit for purpose accommodation meeting all minimum sizing guidelines and standards.	**Safe** **Person centred**
Timing, phasing, disruption	Disruption to the work of the service should be minimised throughout the period of building and relocation. Minimal disruption to adjacent services should be considered.	**Timely** **Safe**

17.6.3 Following this and using these benefit criteria as the starting point, the remaining workshop activities were centred around three main aspects of BRP development, namely:

- Identification of any potential dis-benefits
- Actions necessary to realise the benefits
- Process for measurement and monitoring

17.7 Identification of Potential Dis-benefits

17.7.1 In realising a benefit it is recognised that as a consequence there is often a resulting negative impact or dis-benefit. Whilst these rarely outweigh the positive benefit it is important that dis-benefits are identified and any potential impact managed as part of the overall BRP.

17.7.2 For each benefit criteria considered, the group was tasked with identifying and documenting:

- What dis-benefits or problems could achieving the benefit cause?
- What negative impacts could there be on staff, patients or visitors?
- What impact could there be on organisational culture, strategy or structure?

17.8 Actions Necessary to Realise the Benefits

17.8.1 Generally speaking benefits can only be realised if there is a clear set of agreed actions in place which are fully signed up to by the appropriate stakeholders. In some cases this will require certain supporting systems to be in place and in others the focus will be more on interactions and communication.

17.8.2 It is critical that all actions necessary to realise benefits are captured and agreed in the BRP. Failure to achieve this will result in either sub-optimal benefits delivery or more critically not achieving some of the core project objectives. This could adversely impact upon some or all of the project stakeholders.

17.8.3 For each benefit criterion considered, the group was tasked with identifying and documenting:

- What specific actions are required to realise the benefits?
- Areas to consider include skills, structures, information, culture, systems, staff, stakeholders, patients.

17.9 Measurement and Monitoring

17.9.1 Measuring and then monitoring the delivery of benefits is key in assessing the extent to which they are being delivered against the plan.

17.9.2 In some cases measurement can be achieved through existing systems and information sources, however, in many cases this requires the establishment of new arrangements. It is therefore important that where new mechanisms are required, these are identified at an early stage.

17.9.3 Additionally it should be recognised that only a proportion of the benefits will be 'hard' or quantifiable (e.g. additional activity delivered or reduction in costs) with many requiring 'soft' or qualitative measures to assess their delivery. These qualitative measures are often the areas requiring the greatest level of bespoke development.

17.9.4 Finally, the frequency of benefit monitoring will be established as part of this process.

17.9.5 For each benefit criterion considered, each group was tasked with identifying and documenting:

- How would you know that the benefit has been achieved?
- Could both qualitative and quantitative measures be used?
- How will NHS Western Isles & CnES monitor the achievement of the benefit?

17.10 Summary of Outputs

17.10.1 The outputs of the three stages of group work were documented and used as the basis for populating the BRP.

17.10.2 A summary of these outputs is included at **Appendix J1**

17.10.3 Workshop participants should be asked to review these and to feedback any comments and / or amendments. This will allow the remaining aspects of the BRP to be developed.

17.11 Conclusion

17.11.1 The Project Board and CnES have developed a robust process for identifying, measuring and managing the benefits anticipated to result from the proposed investment in the St. Brendan's Community Resource Hub.

17.11.2 A draft Benefits Realisation Plan (BRP) has been developed and further activities identified to conclude the remaining aspects and finalise the plan.

17.11.3 This will be used to track, monitor and manage benefits over the lifetime of the project and, where necessary, take corrective action to ensure the anticipated benefits are realised.

18 RISK MANAGEMENT PLAN

18.1 Overview

18.1.1 This section of the OBC sets out NHS Western Isles' and Comhairle nan Eilean Siar's approach to risk management, in delivering the preferred option, discussing:

- Risk management philosophy
- Categories of risk
- The framework for risk management
- The current risk management plan

18.2 Risk Management Philosophy

18.2.1 NHS Western Isles' and CnES'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 organisations regard risk as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the project.

18.2.2 NHS Western Isles and CnES recognise the value of 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;
- Implement the right level of control to address the adverse consequences of the risks if they materialise;
- Having strong decision making processes supported by a clear and effective framework of risk analysis and evaluation.

18.2.3 Once risks are identified, 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 project.
- Reduction, where the actions either reduce the likelihood of the risk developing or limit the impact on the business or project to acceptable levels.
- Transfer, where 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.
- Acceptance, where the Project 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.

18.3 Categories of Risk

18.3.1 In developing the preferred solution, NHS Western Isles and CnES examined three categories of risks for each option. These are set out in the table below, together with a summary of how these were assessed.

Figure 18-1: Risk areas

Area	Description	How assessed
Capital risks	Capital risks relate to unknown or unidentifiable factors that increase the cost and time of the project construction	Qualitative and quantitative risks assessed by Quantity Surveyor
Optimism bias	Optimism bias is the demonstrated systematic tendency for appraisers to be over optimistic about key project parameters. This creates a risk that predicted outcomes do not fully reflect likely costs	Standard methodology to identify extent of optimism bias, with mitigating factors confirmed through Project Board assessment
Revenue risks	These are risks relating to everyday management encompassing cost and activity as well as external environmental factors	Risks identified, with quantitative and qualitative assessment through workshop

18.3.2 The risk values for the shortlisted options were identified and evaluated as part of the assessment process in choosing the preferred solution, shown in section 9. Although the focus of this section is on the approach to managing the risks of the preferred solution, the scope of risk management will continue to cover all three areas of risk.

18.4 The Risk Management Framework

18.4.1 NHS Western Isles and CnES have designed a simple risk management framework that focuses on effective identification, reporting and management of risks. There are only three roles in the risk management process that are summarised below.

Figure 18-2: Risk management roles

Role	Responsibility	Reporting & accountability
Risk management lead	Manages the process for identifying and addressing risk, maintaining the risk register on a day to day basis	SRO and Project Board
Risk management sub group	Brings together key risk owners to co-ordinate the identification and assessment of risks plus the management of key risks	Project Team and Project Board

Role	Responsibility	Reporting & accountability
Risk owner	Individual or group responsible for developing and implementing risk mitigation measures for individual risks they are responsible for	Risk management lead and Risk management sub group

18.4.2 The framework will be put in place once the OBC has been approved. Although these structures are not yet in place, NHS Western Isles and CnES have recognised and acted upon their responsibility for leading effective risk management throughout each stage of the project. This is particularly important at OBC stage, to ensure that the risks associated with the preferred solution have been identified and addressed.

18.4.3 The paragraphs below set out the work completed to date, demonstrating the proactive approach to risk management within this project.

18.5 The Current Risk Management Plan

18.5.1 NHS Western Isles and CnES are currently developing a risk register that will enable effective management of the risks identified in the risk analysis. The risk register covers all areas of risk, both those assessed and measured and wider project risks, and has been developed through a series of workshops, meetings and discussions with key project members to provide a mechanism for managing the projects risks even at this early pre approval stage.

18.6 Responsibility for managing the risk register

18.6.1 The responsibility for managing the risk register lies with the St. Brendan's scheme Project Director who will review the risk register and where necessary hold risk reduction meetings as and when required. Otherwise, the risk register will be issued on a monthly basis with updated changes.

18.7 The current risk register

18.7.1 The risk register is attached at **Appendix K1** and includes:

- A description and cause of the 19 risks that have been identified
- A description of the potential impact associated with each risk
- The risk assessment for each risk using a Probability x Impact score to categorise them;
  - **Red** (score >16)
  - **Amber** (score 10-16)
  - **Yellow** (score 4-9)
- Green (score <4)
- The risk action plan and progress
- The mitigation, status and due date
- Ranking order of the risks
- The risk owner and individual responsible for taking action - now identified for all risks

18.7.2 The risk register is already being regularly monitored to identify the change in the potential impact of the risk.

18.7.3 This is a normal risk pattern at this stage of the project and the active monitoring of risks will continue throughout the project. Where new risks are identified, these are communicated to the scheme Project Board and the risk register is updated.

18.8 Further development of the risk register after OBC approval

18.8.1 Further work is planned to provide additional detail in the risk register in terms of the cost of each risk showing best, likely and worst case scenarios.

18.9 Conclusion

18.9.1 This section of the OBC shows that NHS Western Isles and CnES have:

- A sound risk management philosophy that is based on effective risk management
- A clear risk management framework, whose simple structure will facilitate effective risk management
- Already made considerable progress in identifying, evaluating and addressing the risks for the preferred solution chosen in this OBC
- Further development of the risk register is required after the approval of the OBC in terms of the potential cost associated with each risk

19 ARRANGEMENT FOR POST PROJECT EVALUATION

19.1 Overview

19.1.1 This section of the OBC sets out the plans which NHS Western Isles and CnES have 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 four stages of PPE
- Management of the Evaluation Process
- The expected timing of the evaluation stages

19.2 The Requirement for Post-Project Evaluation

19.2.1 Post-project evaluation is a mandatory requirement by the Scottish Government Health Directorates (SGHSCD). The requirements are set out in detail within the SCIM Post Project Evaluation Manual.

19.2.2 For projects such as the one proposed in this OBC whose value exceeds £5m Post Project Evaluation Reports must be submitted to the SGHSCD. These reports are monitored with other key milestones in the project lifecycle. Information from summary and individual reports will be pulled together and issued as a key lessons document annually by SGHSCD to inform and support future project delivery.

19.2.3 The resources required for each PPE stage are still being assessed but will be finalised after the OBC has been approved.

19.3 Framework for Post-Project Evaluation

19.3.1 The Project 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 project.

19.3.2 The purpose of post project evaluation is to:

- Improve project appraisal at all stages of a project from preparation of the business case through to the design, management and implementation of the scheme. This is often referred to as the 'Post Project Evaluation" (PPE) and is typically carried out six months after completion.
- Provide a longer term assessment to appraise whether the project has delivered its anticipated improvements and benefits. This is often referred to as the 'Post Occupancy Evaluation' (POE) and can be carried out approximately 2-5 years after completion depending on the nature of the project.

19.3.3 If properly planned and resourced, evaluation can produce significant benefits, which are summarised in the table below.

Figure 19-1: PPE benefits

The benefits obtained	Who benefits
▪ Improve the design, organisation, implementation and strategic management of projects ▪ Ascertain whether the project is running smoothly so that corrective action can be taken if necessary ▪ Promote organisational learning to improve current and future performance ▪ Avoid repeating costly mistakes ▪ Improve decision-making and resource allocation (e.g., by adopting more effective project management arrangements) ▪ Improve accountability by demonstrating to internal and external parties that resources have been used efficiently and effectively ▪ Demonstrate acceptable outcomes and/or management action thus making it easier to obtain extra resources to develop healthcare services.	▪ NHS Western Isles / CnES – in using this knowledge for future projects including capital schemes ▪ Other key partners and local stakeholders – to inform their approaches to future major projects ▪ The NHS / CnESs more widely – to test whether the policies and procedures which have been used in this procurement are effective.

19.3.4 PPE also sets in place a framework within which the Benefits Realisation Plan set out in **Appendix I1** can be tested to identify which benefits have been achieved and which have not.

19.3.5 The SGHSCD has published guidance on PPE, which supplements that in the Scottish Capital Investment Manual (SCIM). The key stages applicable for this project are set out in the table below along with likely timing.

Figure 19-2: The four stages of PPE

Stage	Evaluation undertaken	When undertaken	Timing
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	Completed before submission of FBC and included within FBC costs and FBC submission
2	Monitor progress and evaluate the project outputs	On completion of the facility	Within six to eight weeks of the completion of the facility
3	Initial post-project evaluation of the service outcomes	Six months after the facility has been commissioned	Six months after commission of the new facility

Stage	Evaluation undertaken	When undertaken	Timing
4	Follow-up post-project evaluation (*or post occupancy evaluation - POE*) to assess longer-term service outcomes two years after the facility 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	Typically at intervals of 5-7 years.	Two years after the facility has been operative.

19.3.6 The detailed plans for evaluation at each of these four stages will be drawn up by NHS Western Isles and CnES in consultation with its key stakeholders. The paragraphs below set out the types of issues considered at each stage of the review and the timescales for each stage.

The Four Stages of PPE

19.3.7 The SCIM guidance on PPE identifies four stages in the PPE process, which are discussed in the paragraphs below.

Stage 1: The Evaluation Plan

19.3.8 The Evaluation Plan is a requirement for the FBC and will be completed before the FBC is submitted and form part of the FBC document. The Evaluation Plan will:

- Set out the objectives of the evaluation, confirming what type of information it is designed to generate and for what purpose
- Set out the scope of the evaluation to show the type of evaluation to be undertaken at the various stages of the project and the key issues to be addressed
- Define the success criteria for assessing the success or otherwise of the project
- Define performance indicators/measures for these criteria
- State the method(s) that will be used to obtain the information
- Set out the team and its membership - who will be responsible for undertaking the evaluation and their respective roles
- State the proposed membership of the Evaluation Steering Group
- Identify the resources and budget for the evaluation, including the need for written reports and dissemination activities
- Develop a dissemination plan for ensuring the results from the evaluation are used to re-appraise the project
- Clarify the timing of the evaluation, with expected start and finish dates

19.3.9 The Evaluation Plan will be developed in conjunction with the Benefit Realisation Plan and Risk Management Strategy, as all three strategies are closely related. This will help ensure that:

- The assessment of whether the benefits expected from the evaluation, including the risks of non-delivery of the benefits, have materialised

- Changes in the project objectives and other important parameters can be tracked and explicitly noted in the Evaluation Plan

19.3.10 The Evaluation Plan will be a live document and kept under constant review.

Stage 2: Evaluation requirements at the construction stage

19.3.11 The project will be monitored for time, cost and service performance. Other aspects of the project which will be subject to monitoring include:

- The management procedures
- The procurement process
- The design solution
- The contractor's performance during the building and operational stages of the project.

19.3.12 Monitoring reports will be produced at regular intervals to help the Project Director determine whether project objectives are being met. These reports will be produced on a monthly basis.

19.3.13 The key issues to address at this stage will include:

- Was the project completed on time?
- Was it completed within the agreed budget?
- What were the reasons for any delay?
- What action would management recommend to prevent future problems?
- Has the estate maintenance backlog been eliminated as planned?
- Functional suitability of the building?

19.3.14 When the building has been completed, its construction record and functional suitability will be reviewed.

19.3.15 The issues identified in the review process up to this point, will form the basis of the post-project evaluation report for this stage.

Stage 3: Evaluation requirement during the operational stage

19.3.16 Once services are being delivered in the new facility and a reasonable bedding-in period of some six to twelve months after commissioning of the facility has been allowed, a more wide-ranging evaluation of the costs and benefits of the project will be undertaken.

19.3.17 This evaluation will build on the work carried out in stage 2. It will involve reviewing the performance of the project in terms of the project objectives. These will have been defined clearly at stage 1 of the evaluation process.

Stage 4: Evaluating longer-term outcomes

19.3.18 Further post-project evaluation will be undertaken at a later stage to assess longer-term outcomes and/or the extent to which short- term outcomes are sustained over the longer term. By this stage, the full effects of the project including the clinical effects will have materialised.

19.3.19 As well as re-assessing the preliminary outcomes identified in the previous phase, the evaluation at this stage will address issues such as:

- Changes in operating costs
- Changes in maintenance costs

- Changes in risk allocation and transfer
- Changes in activity as expected
- Changes in bed occupancy rates, length of stay and other performance measures.

19.4 Management of the Evaluation Process

19.4.1 The Project Director will be responsible for ensuring that the arrangements have all been put in place and that the requirements for PPE are fully delivered. The Project Director will be responsible for day to day oversight of the PPE process, reporting to the SRO and Project Board.

19.4.2 The Project Director will set up an Evaluation Steering Group (ESG), which will:

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

19.4.3 A project manager will be appointed to co-ordinate and oversee the evaluation. It has not yet been confirmed whether the evaluation will be carried out by in-house staff, external advisers or a team comprising of both. Whichever configuration is chosen, the key principle will be that the evaluation is “arms length” and objective. Therefore the Evaluation Team will be unrelated to the project to promote a detached assessment.

19.4.4 The Evaluation Team will be multi-disciplinary and include the following professional groups, although the list is not exhaustive:

- Clinicians, including consultants, nursing staff, clinical support staff and Allied Health Professionals
- Social care representatives
- Healthcare Planners, Estates professionals and other specialists that have an expertise in facilities
- Accountants and finance specialists, IM&T professionals, plus representatives from any other relevant technical or professional grouping
- Patients and/or representatives from patient and public groups

19.4.5 The costs of the final post-project evaluation will be identified once the ESG and Evaluation Team are fully-established. These costs are therefore not currently included in the costs set out in this OBC.

19.5 Conclusion

19.5.1 NHS Western Isles and CnES have 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. These plans have not yet been costed, but will be fully developed and the costs identified for inclusion in the FBC.