Inverclyde Health and Social Care Partnership

Outline Business Case

Greenock Health and Care Centre

24 July 2017

CONTENTS PAGE

Appendices

1. **Site Selection Report**

2. **Design Statement**

3. **Schedule of Accommodation**

4. **HAI Scribe**

5. **Project Programme**

6. **Stakeholder Communication Plan**

7. **Benefits Realisation**

8. **Risk Register**

9. **Statement of Support Letter**

10. **Service Change Plan**

Executive Summary

1. Background

1.1 Greenock is the largest town within Inverclyde, and like much of the West of Scotland, is characterised by persistent socio-economic deprivation and poor health outcomes. The development of the Inverclyde Health and Social Care Partnership (HSCP) builds on established joint working that was fostered under the previous CHCP arrangements, but the new HSCP also affords an opportunity for us to take stock of progress to date and our priorities for the future.

1.2 Over the past four years work has been ongoing to take stock of health and social care services with a view to improving outcomes and mitigating the health inequalities that stubbornly exist through service reconfiguration.

1.3 An Outlines Business Case has been developed, and this document details our thinking in terms of the most important issues that shape our strategic priorities. Health inequalities are central, and some of the most notable negative consequences of these are highlighted. We know that many of the people who need health or social care support are often disinclined to approach or engage with our services, and only accept support when their condition(s) are quite advanced. This means that opportunities for supported self-management or health improvement at an earlier stage of disease progression can often be missed.

2. Current Facilities

2.1 The current facilities at Greenock Health and Care Centre are of poor quality and are seen as unwelcoming. Staff tell us that the current building is not able to accommodate the new ways of working afforded by multidisciplinary team approaches, in terms of layout, spatial relationships and general fabric. We also know that patients attending Greenock Health and Care Centre will often be expected to attend other locations to access services that are part of their overall care package or approach. If patients choose not to attend another location, then their treatment plan is at risk of being compromised. If we are to make a real difference to improving lives in Greenock and Inverclyde, we need to radically re-think our approach to how we organise and deliver health and social care services in a way that maximises our impact, nurtures and supports self-management, makes the patient journey as straightforward as possible, and recognises carers and third sector contributors as equal partners. We also need to ensure that we refine our relationship with Acute Sector services in ways that optimise effectiveness and efficiency, and support care and treatment being delivered from primary care settings whenever appropriate. This is in the best interests of patients and staff alike.

2.2 We have considered the negative points of the current building alongside the positive joint working that has steadily grown over the years within the Greenock Health and Care Centre. There is much to celebrate and any future change should aim to preserve the positives as well as address the negatives. Recognising this, we have considered various options including refurbishing, upgrading or expanding the existing facilities. For various reasons that are noted, once all of our options had been reviewed, we concluded that the best option for Greenock is a new-build Health Centre that enables bringing together the key supports from a range of professions to tackle health inequalities, improve health and contribute to social regeneration.

2.3 There has already been significant rationalisation of public sector buildings in Inverclyde to modernise delivery options and streamline the citizen's journey. The next logical step is to modernise health and social care premises and create opportunities to further improve access to services, integrating the wider Community Planning Partnership aspirations of improved outcomes, won through social and economic regeneration that increases the life opportunities and health outcomes of those most vulnerable to experiencing inequalities of all kinds.

2.4 This paper sets out a proposal and outline costs for the development of a health and social care facility for Greenock and the wider community of Inverclyde. The development will be led by the Health and Social Care Partnership, which is responsible for the provision of all health and social care services in Inverclyde.

2.5 The current Greenock Health and Care Centre is the base for four GP practices serving a population of 29,000 as well as providing a range of other services, and was designed almost 40 years ago. The population and expectations have changed significantly since it was built, and the centre is no longer fit for purpose. It is of poor fabric, is functionally unsuitable and does not have the space to deliver services that can and should be expected from a modernised National Health Service.

3. Strategic Case

3.1 NHS Greater Glasgow & Clyde (NHSGGC) is the largest NHS Board in Scotland and covers a population of 1.2 million people. The Board's annual budget is £2.8 billion and it employs over 40,000 staff. Services are planned and provided through the Acute Division and six Health and Social Care Partnerships, working with six partner Local Authorities.

3.2 NHSGGC provides strategic leadership and direction for all NHS services in the Inverclyde area and works with partners to improve the

health of local people and the services they receive. This approach recognises that good health outcomes are achieved through much more than just clinical services, important thought these are.

3.3 NHSGGC's purpose, as set out in the Board's Corporate Plan 2013 – 16 is to "*Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.*" This is entirely in line with NHSScotland's strategic priorities, particularly in relation to the 2020 Vision and the Quality Strategy. From the HSCP perspective, our planning is underpinned by the five strategic themes.

- Early intervention and preventing ill-health
- Shifting the balance of care
- Reshaping care for older people
- Improving quality, efficiency and effectiveness
- Tackling inequalities.

3.4 Inverclyde HSCP is responsible for the planning and delivery of all community health and social care services within the local authority area based on these five themes. The scope of HSCP services includes the delivery of services to children, adult community care groups, mental health, addictions, criminal justice, homelessness and health improvement activity. Having responsibility for this full range of provision presents real opportunities to address the issues relating to the five strategic themes.

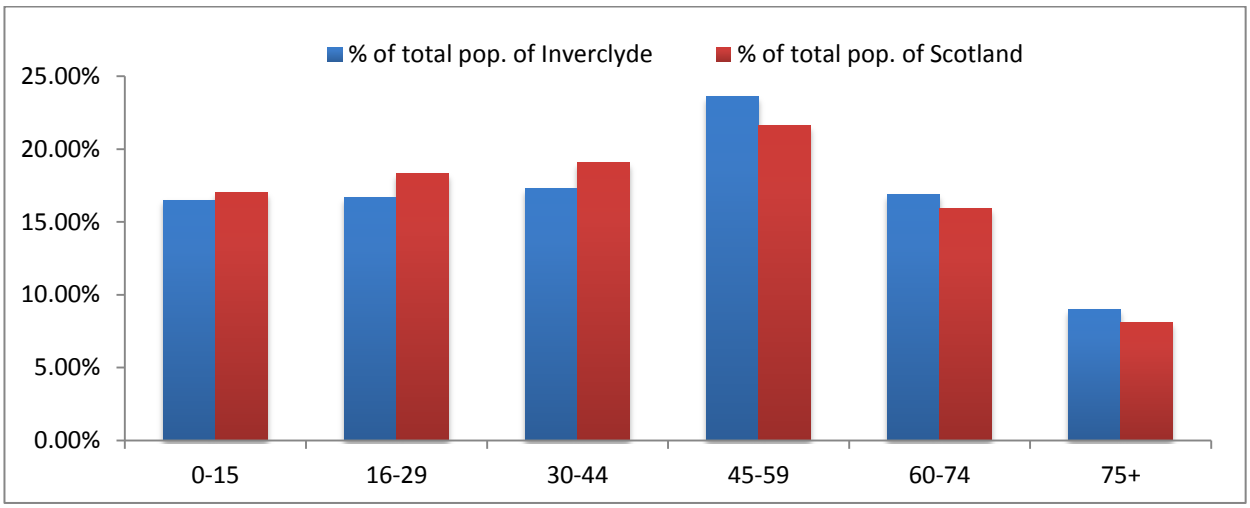
4. Demographic Profile

The 2014 population for Inverclyde is 79,860, accounting for 1.5 per cent of the total population of Scotland. **52%** are Female and **48%** are Male.

4.1 In Inverclyde, 16.5% of the population are aged 0-15 years, and 16.7% are aged 16 to 29 years (which is smaller than Scotland where 18.3% are aged 16 to 29 years). People aged 60 and over make up 26% of the Inverclyde population compared to the Scotland figure of 24%. Table 1 below shows that Inverclyde's population overall is skewed more towards older age groups than the Scottish averages. This means a potentially smaller proportion of working aged people against a higher proportion of older people who are likely to have greater health and social care needs given the health inequalities experienced in Inverclyde.

4.2 Greenock Health and Care Centre currently serves 29,000 patients, which is just over 36% of the Inverclyde population.

Table 1: Estimated Population of Inverclyde and Scotland, by age group, 2014



Source: Mid-Year Population Estimates, NRS Scotland, 2014

4.3 Current Arrangements

The current Health Centre building is no longer fit for purpose and cannot serve the population to best effect due to constraints of space, poor condition of the estate and lack of flexibility in how the existing building is able to be used. In assessing our options we have considered refurbishment and expansion, but the location, design and land footprint mean that this is not a feasible option. In considering improved ways of working to deliver better outcomes, the premises from which we operate are an important factor. The current arrangements do not support the changes we aim to make, and the most economical and sustainable option to emerge from the assessment is for a new-build facility.

This document therefore goes on to articulate the investment and design quality objectives; the risk management strategy and the benefits realisation plan.

5. Economic Case

In scoping the options, the Project Board has considered that the future model of service provision needs to be delivered from premises that are fit for purpose. The premises need to support the level of integrated

working required to make a more positive impact on reducing unequal health outcomes and supporting self-management, particularly in regard to multi-morbidities. The current facilities have been assessed as not meeting the basic needs, so the "Do Nothing" option is not viable. The poor repair and ongoing maintenance of the building mean that from a repairs perspective it is "money hungry". There is a current maintenance backlog of £888k which will only grow in the future. The asbestos that is integral to the building's structure means that even relatively simple repairs become extremely costly as measures need to be put in place to protect staff and the public from the dangers of displaced asbestos fibres or dust. The preferred solution is therefore a new-build facility, to be delivered within an overall funding envelope of £21.2M.

5.1 Commercial, Financial & Management Cases

In discussions with the Scottish Government and Scottish Futures Trust this Project will be developed based on the hub revenue financed model.

A high level time line has been produced, see below:

OBC Consideration\Approval	Sept 2017
FBC Consideration\Approval	Sept 2018
Financial Close	Sept 2018
Completion date	June 2020
Services Commencement	August 2020

The Governance and Project Management arrangements are based on previous Hub approved schemes, and experience from the developments such as Eastwood and Maryhill will help us improve these areas.

Financial Case

Output	Option 4 – New Build Wellington Street
Capital Expenditure (capex & development costs	£21,196,240
Annual Service Payment	£1,983,165

The overall cost position has increased from £18,998,742 at IA stage to £21,196,241. There has been a minimal increase in the building area of 15m2 since IA. A number of changes have increased costs. These include technical matters, site issues and design development. The most significant items include a compliance requirement for cold water systems to be chilled, a requirement for an additional adjacent site to deliver car parking numbers, confirmation of contamination of existing ground, additional retaining and cut/fill due to level changes, confirmation of presence of shallow rock and obstructions. Some of this has been addressed by utilising risk allowances included at IA stage, an element of value engineering and a reduction in inflation allowances based on published BCIS indexes. The overall costs have been examined by the Board's technical advisers who have confirmed that the costs represent value for money.

Discussions took place with Scottish Government in September 2016, when the requirement for additional site was identified and then in March 2017 when the further increases became apparent. Following upon this, confirmation was provided by Scottish Government that the Board should proceed with the submission of an OBC on this basis.

5.2 Summary of Objectives

The proposal for a new Greenock Health and Care Centre is therefore vitally important in terms of tackling health inequalities, promoting supported self-management, fostering the principles of multi-disciplinary anticipatory approaches and maximising effectiveness in how we work with colleagues in the Acute Sector. It will also contribute to local economic generation and the wider Council and Community Planning Partnership objectives of improving population health and valuing citizens by providing modern, well-equipped public spaces and buildings.

Workshops undertaken with staff and patients over the past two years have helped us to define some specific objectives that we would like to achieve by changing how and where we work if we are to meaningfully tackle the health inequalities that have characterised Inverclyde for so long. Five key themes came up time and again.

- Interagency and interdisciplinary working is central, and we have already shown with some of our social care premises that this is supported through co-location. The current health centre is not big enough to support the extent of our ambition, therefore our first investment objective is to **increase accommodation capacity**.

- In Inverclyde, related services are sometimes delivered out of different buildings meaning bus, car or taxi journeys for patients between these services. This can be costly and time-consuming, therefore our second investment objective is to **improve access for public and service users.**
- Our local partnership working has highlighted that improved patient outcomes are sometimes achieved through welcoming non-traditional health service partners onto the care pathway. Supporting the full integration of Third Sector and Community Planning Partners will help improve holistic care, preventative approaches and more appropriate referrals. Our third objective is therefore to **enable speedy access to modernised services**.
- Although co-location is helpful in supporting joint working, we recognise that this needs to be about more than just being in the same building. We also need to support continuous learning and development of clinical and non-clinical staff if we are to recruit high-quality expertise into Inverclyde in the future, so replacement premises must have physical capacity for this, but in a way whereby the spatial arrangement of development space is logical in terms of the teams and relationships that need to be supported. Our fourth objective is to have **better integrated teams and additional services.**
- As we look to the future, we are keen to reduce our carbon footprint in line with the Government's 2020 target. We also see the cost benefits of reducing energy bills, thereby freeing up resources towards clinical or support services. Our fifth objective is to **improve the safety and effectiveness of our accommodation**.

6. Strategic Background

6.1 In considering new ways of working we have considered who is affected by our proposal and worked to engage their views at an early stage. We have also considered how our objectives align with and help to deliver the wider strategic NHS priorities, both at national and NHSGGC levels. Finally, we have taken account of the key external factors that influence or are influenced by our proposal.

6.2 We are confident that the anticipated benefits described above and throughout the Outline Business Case will be realised, and that this will deliver genuinely improved outcomes for the people of Greenock and Inverclyde.

Transforming Care in Greenock

Strategic Case

June 2016

1. Setting the Context

1.1 Existing Greenock Health and Care Centre.

Greenock Health and Care Centre is a two storey building of clasp framed construction with a flat roof, which opened in 1978. The accommodation is now nearing the end of its useful life in terms of suitability for service provision.

Our Vision for the future

The new development will provide**:**

- the opportunity to provide an effective health & social care services and extend integrated working.
- Promotion of a patient/person centred service.
- Meeting local needs with easy and equitable access to services.
- Delivering a high quality of physical environment for patients and staff.
- Facilitating the introduction of new ways of working and in particular effective collaborative/partnership working, including optimising use of shared space wherever possible
- Providing a flexible, sustainable and adaptable property solution.
- Addressing health inequalities
- Modern fit for purpose accessible facility

1.2 The 2020 Vision for Health and Social Care report highlights over the next few years the demands for health and social care and the circumstances in which they will be delivered will be radically different. With a new development we will be able to provide the high quality health and care services the people expect. Securing the best possible outcomes for people from the care and support they receive.

1.3 These include Scotland's public health record and level of inequalities, our ageing population, the increasing expectations arising from new drugs, treatments and technologies and the specific impact of inflation on the health service. The new development will enable us to pursue opportunities to work with other public sector and business partners, help us to identify particular areas for accelerated improvement and enhanced roles in unscheduled and emergency care, in primary care, and in services for people living with multi-morbidities providing a whole system response to improve the patient pathway in order to reduce pressure on A&E departments.

1.4 The main purpose of the Strategic Case at OBC stage is to confirm that the background for selecting the preferred strategic / service solution(s) at Initial Agreement stage has not changed. It will do this by revisiting the Strategic Case set out in the Initial Agreement; and responding to the following questions:

- Have the current arrangements changed?
- Is the case for change still valid?
- Is the choice of preferred strategic / service solution(s) still valid?

1.5 Fundamentally, there have been no material changes to the strategic case since the Initial Agreement was prepared and approved – and so

in essence, the answer to the first question is “no”; and the answer to the second and third questions are “yes”. However further to helpful feedback from the Scottish Government’s Capital Investment Group, we have developed our narrative on benefits realisation to highlight the important contribution the project will make to the significant regeneration work that is currently underway in Greenock, and in the immediate locale of the preferred site.

1.6 Site Selection

In accordance with Scottish Capital Investment Manual (SCIM) guidelines the development of any new infrastructure project requires a full site options appraisal. This consists of a qualitative assessment and a financial assessment to arrive at the best value for money option.

During April 2015 NHS Greater Glasgow & Clyde appointed hub West Scotland to carry out options appraisals on a series of sites identified as suitable to accommodate a new health and social care facility for Greenock. The five sites under consideration had been shortlisted from a long list using criteria identified and agreed by the Project Board chaired by Brian Moore, the then Chief Officer of Inverclyde Health & Social Care Partnership (HSCP), retired April 2017. The Long list consisted of:

- Existing Site
- Brougham Street
- Cartsburn Business Park
- Eldon Street
- East India Docks
- Greenock Academy
- Greenock High School
- Hector McNeil Swimming Pool
- Ravenscraig Hospital
- Regent Street
- Wellington Street

Following a workshop with key stakeholders in September 2015 a series of detailed costs were developed for each of the sites under consideration. Each of the sites had a variety of abnormal costs which created a very wide range of development costs. Taking this into account a ranking was developed using the standard cost/benefit point process and this is detailed as follows:

	Option 1 Wellington Street	Option 2 Brougham Street	Option 3 East India Quay	Option 4 Ravenscraig Hospital	Option 5 Regent Street
Non Financial benefits score (a)	43.0%	67.5%	77.3%	53.0%	45.5%
Rank	**5**	**2**	**1**	**3**	**4**
NPV results £'000 (b)	30,617	34,514	34,440	37,201	34,706
Cost per benefit point (b/a)	**£71,202**	**£51,132**	**£44,554**	**£70,190**	**£76,278**
Ranked	**4**	**2**	**1**	**3**	**5**

The highest scoring option on this process was the East India Quay site. This site had been included, but was contentious since the Local Authority had an established development plan for the area which did not envisage a health and social care use. Following further discussion Inverclyde Council wrote to NHS GG&C on 15th December 2015 and confirmed that the site would not be made available, due to the wider plans that were already in place.

Ideally the highest scoring site from those remaining options would be selected, based on the normal cost/benefit analysis, demonstrating value for money. However because the project had an initial maximum funding cap of £19m (since increased to £21.2m due to extraordinary site costs), differing levels of accommodation can be afforded on each site, arising from the wide range of site abnormal costs. A further model was run to determine how much accommodation could be provided within the original cap on each site. The impact of this has been examined to establish whether the provision of an integrated services facility would be achievable on each site.

Site	Area (m2)	Cost (£000)
Wellington St	5,905	£18,998
Brougham St	5,079	£18,999
East India	5,380	£18,998
Ravenscraig	2,850	£18,919
Regent Street	4,260	£18,995

Of the two viable sites, Brougham Street and Wellington Street, the former scored well for accessibility but costs, based on desktop site information, indicate it can only deliver circa 5,079m2 of accommodation. Whilst this is larger than the current health centre, it is insufficient to provide the level of co-location and service integration that underpins the Initial Agreement. Wellington Street, whilst scoring less for accessibility, can deliver 5,846m2 of accommodation. The difference of 767m2, allows the inclusion of The Centre for Independent Living and Children's and Adolescent Mental Health Services. The inclusion of these allows rationalisation of some of the poorer physical estate and allows transfer of revenue support to help support the integrated solution.

Ideally the project would be funded to deliver the service improvements and investment objectives on the best value for money site. However, unless there are any opportunities for additional funding, there is a balance to be struck between accessibility vs service integration. After discussion with the HSCP and the Project Board, the preference is to develop the Wellington Street site, since it allows the best opportunity to deliver single access point for users, the highest degree of service integration, and maximises the opportunity for rationalisation of the current estate. Further information referred to in the Economic Case at paragraph 3.7, see also Appendix 1 for full report.

2. Have the current arrangements changed?

As detailed within the Initial Agreement, Inverclyde as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. According to the most recent *Scottish Public Health Observatory Health and Wellbeing Profile* for the area (published 2016):

- Life expectancies in 2011, at 73.7 years for males and 79.9 years for females, were lower than the Scottish average of 76.6 years for males and lower than the Scottish female average of 80.8 years.
- Cancer registration in 2011–2013 was, at 667, higher than Scotland's overall rate of 634.
- The rate for patients hospitalised with asthma in 2011–2013, at 123, was higher than the Scottish rate of 91.
- The rate for emergency hospitalisations in 2011–2013, at 8,874, was higher than the rate for Scotland (7,500).
- In 2014, the rate for alcohol-related hospital stays was 1,151, significantly higher than the Scottish rate of 664.
- In 2014, the rate for drug-related hospital stays was 280, more than double the Scottish rate of 133.
- The percentage of people prescribed medication for anxiety, depression or psychosis in 2014/15 was, at 21.4%, higher than Scotland overall (17%).
- The rate for adults aged 65 years and over with multiple hospital admissions in 2011–2013, at 6,259, was higher than that in

Scotland (5,160).

2.1 Overall, Inverclyde has a worse general level of health than the Scottish average – this is also the picture within Greenock. Greenock has high levels of poverty and an increasing elderly population, high numbers of whom have long term conditions. This is driving growing demand for health and social care services alongside an increasing imperative to co-locate teams, integrate services and deliver seamless care.

2.2 The current arrangements have not changed materially since the Initial Agreement was developed and approved. The current Greenock Health and Care Centre is the base for four GP practices serving a population of 29,000 (which is just over 36% of the Inverclyde population). Community health services in Greenock currently operate from a number of dispersed sites including Cathcart Centre (Cathcart Street); Larkfield Children and Family Centre (Larkfield Road), and Inverclyde Centre Independent Living (Gibshill Road).

2.3 All of the services across these community sites have been and are being developed as increasingly integrated health and care arrangements. However, the scope to fully realise those potentials continues to be significantly limited by the constraints of the existing facilities in which they operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support. On completion of a new health and care centre, the bases detailed above would co-locate into the new centre.

2.4 There have been no negative changes to the strategic background since the Initial Agreement was prepared and approved – as summarised in the table below.

Response to strategic background	**Status Confirmation**
Who is affected?	*The range of stakeholders affected by this proposal remains the same since the Initial Agreement was approved.*
Links to NHSScotland's strategic priorities	*The proposal's links with NHSScotland's strategic priorities remain the same since the Initial Agreement was approved.*
Links to other policies and	*The proposal's links with other policies and*

Response to strategic background	Status Confirmation
strategies	*strategies have been further strengthened since the Initial Agreement was approved.*
Influence of external factors	*External factors influencing this proposal remain the same since the Initial Agreement was approved.*
Service Activity Changes	*Service activity remains the same since the Initial Agreement was approved.*
Changes to service model	*The service model remains the same since the Initial Agreement was approved.*

2.5 As acknowledged within the above table, there have been a number of new policies and strategies that have reinforced the strategic case for the project – these are summarised as follows.

2.6 The *National Clinical Services Strategy* (2016) sets out a framework for the development of health services across Scotland for the next 10 to 15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy emphasises the importance of:

- Taking a person centred approach
- Ensuring services are safe, sustainable, efficient and adaptable over time
- Ensuring care is provided closer to home wherever possible
- Ensuring services are integrated between primary and secondary care
- Providing affordable solutions to utilise available funding as effectively as possible.

2.7 That Strategy highlights the need for effective integrated working between primary and community care; and across health and social care. For that reason, it promotes an objective to increasingly arrange for co-location of primary and community care services, in a way that enables them to work as manageably sized, close-knit teams with excellent inter-professional communication, and “one-stop” access for people.

2.8 The *National Health & Social Care Delivery Plan* (2016) emphasises that community and hospital-based care needs to be integrated and rebalanced to ensure that local health services are more responsive and supportive to the needs of individuals, not least those with chronic conditions who would be better supported in primary and community care. That requires reforming the latter to deliver a stronger, better resourced and more flexible service for people.

2.9 *Realising Realistic Medicine: The Chief Medical Officer for Scotland Annual Report 2015/16* asserts that the people receiving health and care should be at the centre of clinical decision-making; and highlights the imperatives for reducing harm and waste; tackling unwarranted variation in care; managing clinical risk; and innovating to improve.

2.10 Building on the above and its own *Clinical Services Strategy* (2015), NHSGGC's Acute Services Committee agreed an approach to planning the changes required to transform Acute Services in line with the direction set by these initiatives – *Transforming Delivery of Acute Services Programme* (2017). This included:

- An appreciation that while there continue to be increasing amounts of money spent on the NHS, that the growing demands from patients and the changing health needs of the population will only be met by shifting resources from acute hospitals to the community.
- A commitment that more support will be developed in the community to enable people to stay locally and out of acute hospitals unless necessary.
- An expectation that new approaches to the effective delivery of care and support for people with multiple health conditions will result from better integration and investment.

2.11 All of the above are reflected within and reinforce the strategic commissioning themes detailed within the *Inverclyde Health & Social Care Partnership's Strategic Plan 2016-19* – namely:

- Employability and meaningful activity
- Recovery and support to live independently
- Early intervention, prevention and reablement
- Support for families
- Inclusion and empowerment

The design quality objectives and Design Statement articulated within the Initial Agreement have remained unchanged through the development process – with the design for the new facility:

- To be clearly accessible for the communities that it is designed to serve.
- To be straight forward to navigate for all, with clear way finding and lines of sight.

- To foster a safe and calming environment, including through good use of natural light and ventilation.
- To promote a sense of community amongst staff within and across disciplines/services, encouraging dialogue, collaborative working and joint learning.
- To convey a welcoming and considerate impression, internally and externally – to express a "civic feel".

3. Is the case for change still valid?

3.1 The case for change (as summarised in the table below) has not changed materially since the Initial Agreement was developed and approved – if anything, it has only been strengthened given the more recent policies and strategies summarised in above.

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
Future service demand	Existing capacity is unable to cope with current or future projections of demand. There is no natural flow between clinical areas to maximise a multidisciplinary approach.	Multidisciplinary working has been impeded by the constraints of the layout. Patient demand cannot be met due to constraints of accommodation.
Dispersed service locations	Existing service arrangements affect service access and travel arrangements. Currently managing the upkeep and backlog maintenance of old buildings, most of which are no longer fit for purpose.	Service access is currently fragmented for this locality when compared with other catchment areas.
Ineffective service arrangements	The current Greenock Health and Care Centre was built at a time when the NHS was more focused on less complex episodes of illness and treatment; and less recognition of the need for privacy, respect and dignity as integral to the delivery of health services. It is no longer acceptable to have key services on upper floors if the lifts are unreliable, for example and while we have this situation, some sections of our communities have poorer access to services.	More integrated approaches are not supported by dispersed teams, particularly when the patient has to navigate across a number of sites and locations to access the range of supports needed.
Service arrangements	The existing Health Centre facility does not have interior	People will be discouraged from

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
not person centred	flexibility to re-shape clinical areas and accommodate related teams or services. This means that patients need to navigate an often complex array of locations to receive multi-disciplinary support. As more and more people are living with multiple long term conditions and wishing to be more active in the management of their own health, our existing service arrangements present more barriers than solutions.	engaging with our services as it can be complicated and expensive. This increases the risks of individuals coming to services late in their disease progression; treatment options being more limited, and outcomes being less good than they could have been.
Accommodation with high levels of backlog maintenance and poor functionality	Increased safety risk from outstanding maintenance. Greenock Health and Care Centre is now nearing the end of its useful life in terms of suitability for service provision. There has been a programme of works to address the need to remove asbestos, and therefore more routine works have had to be de-prioritised, further adding to the backlog (backlog maintenance is currently costed at £888k)	There is currently no room to expand the facility due to footprint of the building and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern primary care health provision.

3.2 The investment objectives (as summarised in the table below) have also not changed materially since the Initial Agreement was developed and approved – and again, if anything, their appropriateness has only been heightened given the more recent policies and strategies summarised in above.

Effect of that cause on the orga3nisation	What needs to be achieved to overcome this need? (Investment Objectives)
Existing capacity is unable to cope with future projections of demand.	Our vision for the future is to have a hub of health and social care that brings all the key services (both statutory and voluntary) under one roof so that patients can access the right support, from the right person and at the right time, to maximise their outcomes. To achieve this we need accommodation that can bring these services together in a way that maximises key service relationships and is easy for the patient to navigate.

Effect of that cause on the orga3nisation	What needs to be achieved to overcome this need? (Investment Objectives)
	INVESTMENT OBJECTIVE 1: increase accommodation capacity.
Existing service arrangements affect service access and travel arrangements	Our current arrangements have developed based on the location of buildings rather than the natural flow of services and how they should be used. Patients frequently have to travel between locations to access the full range of support they need, and staff use up valuable clinical time traveling between these locations too. The location of the current health centre means that traveling by car is the most convenient mode for most, and for those without access to a car, taxis or patient transport are often the only feasible options if there are mobility issues. This is costly, and can disproportionately affect those most vulnerable to poor health outcomes. To overcome this, we require improved access to primary care and associated services that are patient centred, safe and clinically effective. In relation to transport to and from the new health centre the HSCP will develop arrangements to ensure that we are making full use of existing HSCP recurrently funded community transport arrangements. Costs of providing a shuttle bus service within another HSCP have already been gathered to provide indicative costings and options for what is deliverable locally. This will be factored into the transport planning process locally. The IJB is committed to ensuring that mitigation measures are in place to ensure that the services provided are accessible to the population, for the full life time of the facility. *INVESTMENT OBJECTIVE 2: improve access for public and service users.*
Inefficient service performance	Since our new integrated arrangements commenced in 2015 there has been a much greater emphasis on joint working. This has not just been with the Council, but also the wider Community Planning Partnership (CPP) and local voluntary sector organisations. Through this approach we are beginning to see some improvement in the more persistent behavioural or cultural themes that have an impact on health outcomes (for example, no smoking bus stations and play parks; separate alcohol zones where

Effect of that cause on the orga3nisation	What needs to be achieved to overcome this need? (Investment Objectives)
	children are not allowed, such as the local Highland Games). Local Registered Social Landlords (RSLs) now encourage their tenants to have smoke-free homes, and the Financial Inclusion Partnership now actively encourages people to seek money advice before problems become overwhelming, and threaten mental health. These measures help tackle inequalities by reinforcing a consistent message that some behaviours are or should not be socially acceptable, but also that circumstances should not lead to stigmas. It is in this way that we hope to change deep-rooted negative cultures. To help us build on this approach, key services (including but not restricted to health services) need to be located together, and their relationships with good overall health and wellbeing made explicit. *INVESTMENT OBJECTIVE 3:* *enable speedy access to modernised services*
Service is not meeting current or future user requirements	Current arrangements dispersed over a number of locations do not meet modern requirements or expectations for good, supportive care that promotes independent living. To meet user requirements for equitable and clear service pathways and connections, we need facilities that can provide a natural flow of services, and reinforce the services' relationships with each other. To achieve this, we need a modern fit for purpose accessible facility that will facilitate and promote interagency and interdisciplinary working, and address health inequalities by having better integrated teams. GPs and other primary care professionals need access to Continued Professional Development (CPD) and training, and facilities to support this would be built into new arrangements. *INVESTMENT OBJECTIVE 4:* *better integrated teams and additional services.*
Increased safety risk from outstanding maintenance and inefficient service performance	Improved safety and effectiveness of accommodation by providing accommodation that will deliver improved energy efficiency, reducing CO2 emissions in line with the Government's 2020 target and contributing to a reduction in whole life costs. Meet statutory requirements and obligations for public buildings e.g. with regards to DDA. The current backlog maintenance is compounded due to the asbestos in the current building, making repairs so costly that there is insufficient capital funding to undertake most repairs. The roof leaks in many places and parts of the interior drop off from time to time, occasionally causing

Effect of that cause on the orga3nisation	What needs to be achieved to overcome this need? (Investment Objectives)
	injury to patients or staff. *INVESTMENT OBJECTIVE 5: improve the safety and effectiveness of our accommodation.*

4 Is the choice of preferred strategic solution still valid?

4.1 The preferred strategic solution described and confirmed within the Initial Agreement is still valid - and again, if anything, its appropriateness has only been heightened given the more recent policies and strategies summarised in above.

4.2 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so a Do Nothing option is not viable. The poor repair and ongoing maintenance of the main Greenock Health and Care Centre in particular mean that from a repairs perspective it is "money hungry". The asbestos that is integral to the building's structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £21.2 million. NHSGGC has made provision within its capital resource limit for such a project dependant on confirmation of Hub funding, with the revenue costs calculated as break even at this time.

4.3 A replacement health and care centre build would enable the co-location of multi-disciplinary services - including integrated health and social care teams - within a new facility giving one stop access and improved accessibility for patients to an increased range and improved quality of services (including additional acute outreach clinics); a considerably improved working environment for staff; space for community and third sector partners and carer's organisations involved in the co-production of supported self care; meeting and training space for all our staff (supported by a commitment to shared and agile technology for staff) and local community groups.

4.4 As described within the Initial Agreement, the development of a new and enhanced health and care centre has already been identified as a key contribution that NHSGGC can make to the wider regeneration of Greenock.

4.5 As confirmed within the Initial Agreement, considerable progress has been made in the regeneration of public sector premises across Inverclyde. Health Service estate now falls well below the new public sector norm, in that our partners have risen to the NHS challenge that high quality premises and public spaces are important in fostering good mental wellbeing. Unfortunately the NHS has not been able to match this commitment from our partners so far.

4.6 The preferred location for this new facility is on Wellington Street in the Broomhill area of Greenock. This is a key regeneration area with significant investment already taking place under the Broomhill Project banner. A new Health and Care Centre would be at the heart of that area as the main focal point of the regeneration.

4.7 The Broomhill Project aims to provide a better environment for the people of Greenock and importantly to attract new residents and families to a regenerated location. More importantly, such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Greenock area more broadly.

Transforming Care in Greenock

Economic Case

June 2016

5. Economic Case –

The main purpose of the Economic Case at OBC stage is to undertake a detailed analysis of the costs, benefits and risks of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the Initial Agreement.

5.1 The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services. This analysis includes the following steps:

- Identify a short-list of implementation options.
- Identify and quantify monetary costs and benefits of options.
- Estimate non-monetary costs and benefits.
- Calculate Net Present Value of options.
- Present appraisal results.

5.2 The approach taken to developing the economic appraisal for this project reflects the requirements of the new Scottish Capital Investment Manual (SCIM) guidance and was also informed by best practice recommendations from Audit Scotland[1] and the National Audit Office[2]. A fundamental principle has been that options be appraised on their costs and benefits, not on personal preferences of key stakeholders or individuals.

5.3 The process built on the highly participative approach to stakeholder engagement that has been a hallmark of the project and that was detailed within the Initial Agreement; and informed by all of the engagement and deliberations undertaken since the inception of the project. All of that intelligence has been considered and reflected upon by the multi-stakeholder Project Board. A specific and formal option appraisal exercise was undertaken by the Project Board on the 3rd May 2017, with the outcomes then further tested with a variety of service user/patient representatives throughout May 2017 prior to this Outline Business Case being finalised.

6. Identify a short-list of implementation options

As detailed within the Initial Agreement, in scoping the options for re-provision of services, it has been confirmed that the future model of service provision needs to be delivered from premises that are fit-for-purpose; and through a development that delivers on the following business objectives:

- Improve local access to a greater range of modernised services.
- Increase integration of multi-disciplinary teams and services.

- Improve safety and quality of facilities in which services delivered and based.
- Increase capacity and adaptability of facilities in which services delivered and based.
- Contribute to economic regeneration of Greenock as a whole.

As detailed within the Initial Agreement, four options have been investigated:

- Do nothing.
- Extend existing facilities within constraints of existing site.
- New Health and Care Centre on existing site.
- Develop new build integrated facility on new site.

6.1 The substantial limitations to delivering necessary new ways of working associated with the Do Nothing option were identified within the approved Initial Agreement. The specific limitations have been considered and detailed at AEDET workshops (Achieving Excellence Design Evaluation Toolkit), and a range of solutions have since been discussed at the Project Board, based on the investment objectives and the parameters defined SCIM. Agreement stage has not changed. Moreover, as confirmed within earlier within this OBC, fundamentally there have been no material changes to the strategic case since the Initial Agreement was prepared and approved: both the case for change and the choice of preferred strategic / service solution(s) are still valid. The work undertaken at OBC stage has consequently further validated the position articulated within the Initial Agreement, i.e. that to Do Nothing is <u>not</u> a feasible option, due to the poor repair of the existing building; its considerable and growing backlog maintenance; and the growing needs of the local population. However, as per the SCIM guidance, the Do Nothing option has been included in the economic appraisal detailed here.

6.2 As detailed within the Initial Agreement, with respect to the third and fourth options above a review of potential sites was undertaken by key stakeholders from NHS Capital Planning, Inverclyde Health & Social Care Partnership leaders and leads from Inverclyde Council's's planning and technical team. Six potential sites were identified the existing Health Centre site (expanded); Brougham Street; East India Harbour; Wellington Street, Regent Street and Ravenscraig Hospital Site.

6.3 All of the six were examined for capacity to accommodate the physical requirements, and checks were undertaken to establish suitability, availability and costs of the sites. Upon reviewing the available sites it became clear that the existing Health Centre site does not have a big enough footprint of land to accommodate a new Health and Care Centre that could deliver the full extent of our ambition. The Brougham Street and East India Harbour sites were in private ownership and would have

been prohibitively expensive to purchase. Brougham Street can only deliver circa 5,079m2 of accommodation which is insufficient to provide the level of co-location and service integration required. Additionally, East India Harbour had already been zoned for different purposes by the Council's Planning Committee, so would not have been usable for this purpose even if it had been within our means to purchase. The Ravenscraig Hospital site was already in NHS ownership so would not have incurred a purchase cost, however early review indicated that the abnormals on this site would have meant that the remaining budget for the build would have delivered a Health and Care Centre that was considerably smaller than the existing Greenock Health and Care Centre. This left Wellington Street as the only really feasible option, but fortunately the site had the potential to meet the benefits realisation requirements; is close to the existing Health Centre, and is also within the Broomhill Regeneration area, so would contribute significantly to the major regeneration of Greenock. See Appendix 1 Site Selection Report

The following site selection criteria were then utilized (which aligned with the benefit criteria):

- Public and Staff Access – 35%.
- Co-location with other public services – 15%.
- Contribution to regeneration – 15%.
- Environmental Quality – 20%.
- Future Expansion – 15%.

6.4 Broomhill is a key regeneration area within Greenock, with significant planned investment in housing. River Clyde Homes new office block will be close to the new development as well as from the Inverclyde Association for Mental Health. The collective aim is to provide a better environment for the people of Greenock and importantly to attract new residents and families to a regenerated location. The location of the town's principle health and care facility in this location is seen as the final fundamental investment to consolidate what has been committed to date.

6.5 The Wellington Street site will be remediated and levelled as much as possible by the developer, which would reduce hub development costs. Importantly, Inverclyde Council has provided the Wellington Street site to the NHS free of charge.

7. Monetary costs and benefits of options

Tables below set out the initial capital and revenue cost inputs to the GEM model related to each option. They are expressed as an undiscounted annual recurring cost for each category.

Capital Cost Implications

Initial Cost Implications:	Option 1: Do Nothing £'000	Option 2: Extend existing facilities within constraints of existing site. £'000	Option 3: New Health Centre on existing site. £'000	Option 4: Develop new build integrated facility on new (Wellington Street) site. £'000
Opportunity Costs	300	300	300	0
Initial Capital Costs	0	14,100	21,191	21,708
Transitional Period Costs	0	0	0	0
Cost of Embedded Accommodation	0	0	0	0
Total of Initial Cost Implications	300	14,400	21,491	21,708

Opportunity costs have been added for options 1,2 and 3 as we would not be selling the land that the current Health Centre sits.

Initial capital costs have been derived from benchmarking of previous projects for options 2 and 3 and 4 has been taken from Stage 1 Addendum cost at Q3 2018.

Transitional costs are considered to be nil.

Cost of embedded accommodation is considered to be nil.

Revenue Cost Implications

Revenue costs over 25 years

Revenue Cost Implications:	Option 1: Do Nothing £'000	Option 2: Extend existing facilities within constraints of existing site.	Option 3: New Health Centre on existing site.	Option 4: Develop new build integrated facility on new (Wellington

		£'000	£'000	Street) site. £'000
Life Cycle Costs	18,187	18,887	2,506	2,506
Clinical Service Costs	N/A	N/A	N/A	N/A
Non-clinical Support Service Costs	3,466	4,166	4,092	4,092
Building Related Running Costs	8,169	9,767	9,343	9,343
Net Income Contribution	N/A	N/A	N/A	N/A
Revenue Costs of Embedded Accommodation	N/A	N/A	N/A	N/A
Displacement Costs	N/A	N/A	N/A	N/A
Total recurring revenue cost implications	**29,822**	**32,820**	**15,942**	**15,942**

Lifecycle Costs have been calculated for options 1 and 2 are from using the information from our VFA capital planning system which details replacements over that period. For Option 3 and 4 the figure is from Stage 1 report.

Clinical service costs are not affected.

Non-clinical service costs are costs for domestic services

Building related running costs include heat, light and power and rates

8 Non-monetary costs and benefits of options

The results of the non-financial benefits appraisal exercise are presented in the table below:

Benefit Criteria	Weighting (%)	Weighted Score			
		Option 1: Do Nothing	Option 2: Extend existing facilities within constraints of existing site.	Option 3: New Health Centre on existing site.	Option 4: Develop new build integrated facility on new (Wellington Street) site.
Contribute to economic regeneration of Greenock	20%	40	120	120	280

as a whole.					
Promote integrated working between primary care, community health services, social work services, acute and specialist children's services.	25%	50	175	175	525
Enable speedy access and improved patient and service user experience, with modernised and integrated primary care and community health services.	25%	*75*	200	200	525
Promote a greater focus on prevention and anticipatory care, increasing the use of anticipatory care planning, thereby improving the overall health and wellbeing of people in the area and reducing health inequalities.	20%	40	200	200	300
Improve Safety and effectiveness of accommodation with a more energy efficient building, reducing C02 emissions and contributing to a reduction in whole life costs.	10%	10	50	90	90
Total Weighted Score:		215	745	785	1720
Rank:		*4*	*3*	*2*	***1***

The benefit criteria were developed at an early stage at a facilitated AEDET (Achieving Excellence Design Evaluation Toolkit) workshop, and were used to define the project objectives within the Initial Agreement (with the inclusion of the contribution to local regeneration of Greenock, in light of helpful feedback received from the Scottish Government's Capital Investment Group). The weights and scores were derived from the original AEDET workshop, and updated by stakeholders using the AEDET methodology on 18th April 2017. Stakeholders were asked to score the options and benefit criteria based on the categories below.

Category	**Score**	**Definition**
Excellent	10	The option performs **exceptionally well** in relation to the benefit criterion.
Very Good	8 or 9	The option performs **very well** in relation to the benefit criterion.
Good	6 or 7	The option performs **well** in relation to the benefit criterion.
Satisfactory	5	The option performs **satisfactorily** in relation to the

		benefit criterion.
Poor	3 or 4	The option performs **poorly** in relation to the benefit criterion.
Very Poor	1 or 2	The option performs **very poorly** in relation to the benefit criterion.

The scores were aggregated and then an average score was calculated for each section. The average score was then multiplied by the weighting to ascertain overall scoring in relation to the importance of each of the benefit criteria.

The table below presents the results of the non-financial risk appraisal for the project.

Risk	Impact Score	Risk Score (Impact x Probability)							
		Option 1: Do Nothing		Option 2: Extend existing facilities within constraints of existing site.		Option 3: New Health Centre on existing site.		Option 4: Develop new build integrated facility on new (Wellington Street) site.	
		Prob	Score	Prob	Score	Prob	Score	Prob	Score
Failure to contribute to improving Health Inequalities	*9*	*10*	*90*	*9*	*81*	*5*	*45*	*5*	*45*
Treatment pathways disrupted due to disparate service locations	*6*	*8*	*48*	*6*	*36*	*5*	*30*	*3*	*18*
Duplication of infrastructure and or resources	*6*	*9*	*54*	*8*	*48*	*5*	*30*	*4*	*24*
Service is not meeting current or future user requirements	*8*	*10*	*80*	*7*	*56*	*3*	*24*	*3*	*24*
Increased safety risk from outstanding maintenance and facility inflexibility	*6*	*9*	*54*	*7*	*42*	*2*	*12*	*2*	*12*
Total Risk Score:		*326*		*263*		*141*		*123*	
Rank:		*4(highest risk)*		*3*		*2*		*1(lowest risk)*	

9 Calculate Net Present Value (or Cost) and assess uncertainties

9.1 Net Present Value

In line with the Optional Appraisal Guide, the NPV or NPC for each

option can be calculated using discounted cash flow techniques on the capital and revenue costs associated with each option as entered into the GEM model. The outcomes of these calculations can be summarised in the exemplar table below:

	Option 1: Do Nothing £'000	Option 2: Extend existing facilities within constraints of existing site. £'000	Option 3: New Health Centre on existing site. £'000	Option 4: Develop new build integrated facility on new (Wellington Street) site. £'000
Net Present Value / Cost (£)	18,886	33,963	31,110	31,028

Assessing Uncertainty

Sensitivity analysis of both the Net Present Value / Cost and non-financial benefits of each option has been undertaken to assess how reactive these results are to changes in underlying assumptions.

Section 5.2 of the SCIM Option Appraisal Guide provides a list of potential uncertainties that could be analysed. For the purposes of this assessment, land receipts, capital and revenue costs have been flexed to assess the sensitivity.

The NPV results have been summarised in the table below:

Sensitivity Scenario	Option 1: Do Nothing		Option 2: Extend existing facilities within constraints of existing site.		Option 3: New Health Centre on existing site.		Option 4: Develop new build integrated facility on new (Wellington Street) site.	
	NPV (£m)	Rank	NPV (£m)	Rank	NPV (£m)	Rank	NPV (£m)	Rank

Scenario 1: no changes	18,886	-	33,963	3	31,628	2	31,028	1
Scenario 2: delay in land receipt for existing site	18,886	-	33,963	3	31,628	2	31,067	1
Scenario 3 10% increase in new build capex price	18,886	-	35,273	3	33,710	2	33,110	1
Scenario 4: 5% increase in Wellington site cost	18,886	-	33,963	3	31,628	1	32,069	2
Scenario 5: 10% increase in revenue costs	18,886	-	35,252	3	32,679	2	32,079	1

Although the Do Nothing option 1 has been assigned an NPV in the economic case, it has not been included in the Economic Case NPV sensitivity analysis as it is not an option that would be taken forward. The analysis has sought to assess the impact of changes in costs to the other 3 options.

Scenario 2 – This has assessed the impact of a delay in the land receipt for the existing site in the new build Wellington Street option. This scenario does not change the ranking of the NPVs.

Scenario 3 – The scenario assesses the impact of a 10% increase in construction costs in the options. This scenario does not change the ranking of NPVs.

Scenario 4 – this assesses a 5% increase in capital costs in the preferred option only. The result of this scenario is that the Option 3 (New build on existing site) becomes the first ranked NPV option only marginally from the Wellington Street option. When this is combined with the non-financial benefit scores Wellington Street remains the most economically advantageous site and therefore the preferred option. The construction costs at the Wellington Street site would need to increase by over 150% to reverse the combined economic ranking of Wellington Street first and new build on the existing site second.

Scenario 5 – this scenario assesses a 10% increase in running costs across the sites. This option does not change the ranking of the NPVs.

Non-financial benefits Sensitivity	Option 1		Option 2		Option 3		Option 4	
	Weighted Score	Rank	Weighted Score	Rank	Weighted Score	Rank	Weighted Score	Rank

Scenario								
Scenario 1: no changes	215	4	745	3	785	2	1720	1
Scenario 2: Equal weight	200	4	720	3	800	2	1600	1
Scenario 3: Exclude top rank score	140	4	545	3	585	2	1195	1
Scenario 4: Mid-range	210	4	700	3	800	2	1500	1

9.2 Assessing Uncertainty

Options 1, 2 and 3 were ruled out or rejected at IA stage. In addition, the NPCs when combined with the quality scores above show option 4 is significantly better than the previously rejected options. The above scenario testing does not alter this conclusion in any of the combined NPV and non-financial benefit scenarios.

9.3 Identifying the Preferred Option

	Option 1: Do Nothing £	Option 2: Extend existing facilities within constraints of existing site. £	Option 3: New Health Centre on existing site. £	Option 4: Develop new build integrated facility on new (Wellington Street) site. £
Net Present Cost (£'000's) per weighted benefit score	£188,862	£94,341	£77,775	£38,785

The combined NPC per weighted benefit score figures clearly identify Option 4 as the preferred option. Although Option 1 has the lowest Net Present Cost, it scores poorly in the quality factors and is not an option for the Board. Options 2 and 3 also score relatively poorly on the quality criteria compared to Option 4.

The table below shows the rankings of both the economic appraisal and of the risk appraisal exercise which has been undertaken for each of the options.

The table shows that the ranking of the options is the same under both the economic and risk appraisal with option 4 being ranked 1st and the Do Nothing Option 1, ranking last.

10 Appraisal Results

Evaluation Results (out of 100)	Option 1: Do Nothing	Option 2: Extend existing facilities within constraints of existing site.	Option 3: New Health Centre on existing site.	Option 4: Develop new build integrated facility on new (Wellington Street) site.
	Rank	Rank	Rank	Rank
Economic Appraisal	4	3	2	1
Risk Appraisal	4	3	2	1

It is clear from the appraisal work undertaken that Option 4 is a preferred option that should be taken forward from the economic case and assessed under the commercial and financial cases.

Although the Net Present Costs of options 2, 3 and 4 were similar, Option 2 and 3 were rejected at IA stage and Option 4 clearly delivers greater qualitative benefits when assessed. Areas where Option 4 scored more highly than the other options included:

- Ability to best integrate service delivery;
- Opportunity for preventative and anticipatory care;
- Reduction in Carbon emission impacts; and
- Economic benefit to local area

11. ECONOMIC APPRAISAL TEMPLATE (Included in sections above)

Transforming Care in Greenock

Commercial Case

June 2016

12. Commercial Case

13. Determine the Procurement Strategy

13.1 Procurement Route

The replacement of Greenock Health and Care Centre will be delivered using the hub procurement initiative, as procurement of NHS projects are mandated to be delivered through this Partnership arrangement . The project which is revenue funded accordingly will be delivered via a Design Build, Finance Maintain. (DBFM) contract.

13.2 Procurement Plan

The hub initiative has been established in Scotland to provide a strategic long-term programme approach in Scotland to the procurement of community-focused buildings that derive enhanced community benefit.

Greenock Health and Care Centre is located within the West Territory. A Territory Partnering Agreement (TPA) was signed in 2012 to establish a framework for delivery of this programme and these benefits within the West Territory. The TPA was signed by a joint venture company, hub West Scotland Limited (Hws), local public sector Participants (which includes NHS GGC and GCC), Scottish Futures Trust (SFT) and a Private Sector Development Partner (PSDP).

The New Greenock Health and Care Centre project will be bundled with the New Clydebank Health & Care Centre, and the Stobhill Mental Health Facility – the purpose of this approach and the benefits are outlined in the stand-alone paper which accompanies this and the Clydebank & Stobhill OBCs.

The TPA prescribes the stages of the procurement process including:

- New Project Request;
- Stage 1 (submission and approval process);
- Stage 2 (submission and approval process); and
- conclude DBFM Agreement (financial close)

Since this project includes design, construction and certain elements of hard Facilities Management services, the TPA requires that DBFMco (a special purpose company) enters into SFT's standard form Design, Build, Finance and Maintain Agreement for hub projects.
The main Contractor appointed for this project by Hws is BAM Construction , this contractor is also appointed on the Clydebank and Stobhill projects.

13.3 External Advisers

The External Advisers to support the HSCP/NHS GGC Capital Planning team for this project and the two other projects which are part of this bundled group i.e. Clydebank Health & Care Centre and Stobhill Hospital Mental Health Projects, have been appointed, utilising the Public Contracts Scotland for procurement, and where applicable the OJEU process.

The Advisers appointed are:

- Technical Advisers – Currie & Brown
- Legal Advisers – CMS
- Financial Advisers – Caledonian Economics
  Awareness of the need to clearly manage quality control during the construction phase of projects has been heightened by the recent publication of the Cole Report (Edinburgh Schools). In addition to the quality management responsibilities of DBFCo, a Building Monitor is being appointed by NHS GGC to provide an independent opinion of the quality of construction/

Scope and Content of Proposed Commercial Arrangements

14 Proposed scope and services

14.1 Existing Arrangements

Greenock Health and Care Centre is a Clasp Building constructed in the 1970's and is located on Duncan St, some half a mile from the Wellington St site. The Health Centre accommodates GP Practices, Community Dental, Podiatry, Physiotherapy, Out –Patient Clinics, Treatment Rooms, District Nursing\Health Visiting etc. All the existing services will transfer to the new facility, with additional services, such as Inverclyde Centre for Independent Living (ICIL).

14.2 The Site

The preferred site is located within the Broomhill area of Greenock, close to the existing Greenock Health Centre. The site was formerly the location of Wellington Academy which was demolished in 2012. At this time the site has a number of contaminants which will require to be cleared or remediated, prior to construction commencing in Summer 2018 .

A further site for additional car parking spaces (Former Football pitch for Wellington Academy) adjacent to the main site and also in the ownership of Inverclyde Council is required to meet parking requirements identified in discussions with Inverclyde Council, Roads Department.

The two areas of land are currently under the ownership of Inverclyde Council, and are being transferred to the NHS as part of their contribution

to providing a new Health Centre in Greenock. The transfer of land between both organisations is on – going from a legal perspective. However, Inverclyde Council at their full Council meeting held on 1st September 2016 approved the transfer. It is acknowledged that the transfer will be fully completed prior to Financial Close.

A Schedule of Accommodation (SOA) has been arrived at following a number of meetings with the users and project team and totals a floor area of 5,846m2. The design reports are included in Appendix 2 and a copy of the SOA is included as Appendix 3 which details all the services to located within the new facility. These include General Practitioners, Community Dental, CAMHS, Physiotherapy, Podiatry, Sandyford Sexual Health, Social Work etc.

14.3 Site Access, Constraints and Orientation

It is not anticipated that there will be any access issues on to the site. To support the proposed design, site investigations and topographical surveys have been undertaken by hub West to determine the full extent of the ground conditions and any possible contaminants on the site. As pockets of Asbestos have been identified on the Wellington St site a Remediation Plan is presently being developed, and will be presented to the Pollution Officer

14.4 Design Development

The design has been developed by using the Eastwood Health and Care Centre as the reference point. The objective of the reference project was to develop and test two different creative responses to the integrated services agenda and to demonstrate that “Excellent design is achievable within good value Affordability Caps.”

The outputs from Reference Designs delivered high quality design solutions that are sustainable, competitively priced and meet current healthcare design guidance. The Reference Designs are also consistent with the Policy on Design Quality for NHS Scotland and hubco’s commitments to design quality.

The Reference Design process used the Eastwood site at Drumby Crescent and hubco have arranged for both Architectural Practices for the Greenock & Clydebank Health & Care Centre DBFM projects to meet on a regular basis, to enable sharing of best practice, lessons learnt, commonality and consistency of approach.

14.5 NHS Scotland Design Assessment Process (NDAP)

As part of the embedding of the design process in the various business case stages, the Scottish Government has, in addition to BREEAM assessments, advocated a formalised design process facilitated by Architecture and Design Scotland (A&DS) and Health Facilities Scotland (HFS). NHS GGC has taken steps to consult with A&DS in the development of the design of the new Health and Care Centre.
An initial Design Statement has been prepared on behalf of NHS GGC in conjunction with the project team, PSCP and their architects, and is included in this OBC as Appendix 2 This has been used as the key control document to measure the developing design against the project's design objectives.

14.6 HAI-Scribe

An HAI-Scribe Stage 1 infection control assessment of the preferred option site was carried out on 29th March 2017 with NHS GGC Infection Control. The Stage 1 Strategy and Risk Assessment was completed at this meeting and is included in Appendix 4.

14.7 Clinical and Design Brief

The Health Planner for the project has attended the Delivery Group meetings and met with various stakeholders to look at the operational policy documents provided by NHS GGC and to review the accommodation requested. A full report was produced by the Health Care Planner and presented to the Project Board on 28th June 2016.

14.8 Staff to be accommodated in the new facility

The number of staff (including Social Care) to be accommodated in the new facility is summarised in the table below:

Staff numbers

Services	Estimated No of Staff
GP Practices	45
Treatment Suite	4
Sandyford Sexual Health	3
Health Visiting\School Nursing	27
District Nursing	50
Physiotherapy	7
Community Dental	7
Podiatry	11
CAMHS	26
Speech & Language Therapy	10
Pharmacy	5
HSCP Staff – Business Support	45

Social Work – Assessment & Care	18
Social Work – ICIL	52
Social Work – Homecare	26

14.9 Surplus Estate

The OBC is predicated on the basis that the existing Greenock Health Centre, Boglestone Clinic, CAMHS Building, ICIL, and Cathcart Centre, which are not fit for purpose, will be disposed of once the new facility becomes available. Following disposal, any resultant capital receipt will be accounted for in line with recommendations contained in CEL 32 (2010).

14.10 Commercial Arrangements

GP Practices

In respect of GP Practices Inverclyde HSCP using the agreed methodology for GPCharges, has provided each of the Practices with an estimate of their Rent & Other Charges for their New Accommodation within the New Facility based on the approved Schedule of Accommodation. These costs will be confirmed/adjusted and agreed prior to completion of the building.

Pharmacy

There will be a requirement for NHSGGC to negotiate a lease with the Pharmacy Contractor located within the existing Health Centre prior to the move to the New Facility. This will be in conjunction with the Pharmacy Directorate and the District Valuer. It is imperative that a lease is agreed with the Pharmacy provider, prior to the New Greenock Health & Care Centre opening.

15. Risk Allocation

15.1 Transferred Risks

Inherent construction and operational risks are to be transferred to the Sub-hubco. These can be summarised as follows:

15.2 Risk Allocation

	Risk Category	Potential Allocation		
		Public	Private	Shared
1	Design risk		Yes	
2	Construction and		Yes	

	Risk Category	Potential Allocation		
		Public	Private	Shared
	development risk			
3	Transitional and implementation risk		Yes	
4	Availability and performance risk		Yes	
5	Operating risk			Yes
6	Variability of revenue risks		Yes	
7	Termination risks			Yes
8	Technology and obsolescence risks			Yes
9	Control risks	Yes		
10	Residual value risks	Yes		
11	Financing risks		Yes	
12	Legislative risks			Yes

15.3 Shared Risks

Operating risk is shared risk subject to NHS GGC and Sub-hubCo responsibilities under the Project Agreement and joint working arrangements within operational functionality.

Termination risk is shared risk within the Project Agreement with both parties being subject to events of default that can trigger termination.

While Sub-hubCo is responsible for complying with all laws and consents, the occurrence of relevant changes in law as defined in the Project Agreement can give rise to compensate Sub-hubCo.

16. Payment Structure

NHS GGC will pay for the services in the form of an Annual Service Payment.
A standard contract form of Payment Mechanism will be adopted within the Project Agreement with specific amendments to reflect the relative size of the project, availability standards, core times, gross service units and a range of services specified in the Service Requirements.

NHS GGC will pay the Annual Service Payment to Sub-hubCo on a monthly basis, calculated subject to adjustments for previous over/under

payments, deductions for availability and performance failures and other amounts due to Sub-hubCo.

The Annual Service Payment is subject to indexation as set out on the Project Agreement by reference to the Retail Price Index published by the Government's National Statistics Office. Indexation will be applied to the Annual Service Payment on an annual basis. The base date will be the date on which the project achieves Financial Close.

Costs such as utilities and operational insurance payments are to be treated as pass through costs and met by NHS GGC. In addition NHS GGC is directly responsible for arranging and paying all connection, line rental and usage telephone and broadband charges. Local Authority rates are being paid directly by NHS GGC.

17. Contractual Arrangements

The hub initiative in the West Territory is provided through a joint venture company bringing together local public sector participants, Scottish Futures Trust (SFT) and a Private Sector Development Partner (PSDP). The hub initiative was established to provide a strategic long term programmed approach to the procurement of community based developments. To increase the value for money for this project it is intended that the Greenock Health and Care Centre will be bundled with the similarly timed new Clydebank Health Centre, and the Stobhill Mental Health Project. This will be achieved under a single Project Agreement utilising SFT's standard "Design Build Finance and Maintain (DBFM) Agreement".

This bundled project will be developed by a DBFMco. DBFMco will be funded from a combination of senior and subordinated debt and supported by a 25 year contract to provide the bundled project facilities.

The senior debt is provided by a project funder that will be appointed following a funding competition and the subordinated debt by a combination of Private Sector, Scottish Futures Trust and Participant Investment.

DBFMco (Design, Build, Finance and Maintain) will be responsible for providing all aspects of design, construction, ongoing facilities management and finance through the course of the project term with the only service exceptions being wall decoration, floor and ceiling finishes.

Soft facilities

Soft facilities management services (such as domestic, catering, portering and external grounds maintenance) are excluded from the Project Agreement.
Group 1 items of equipment, which are generally large items of permanent plant or equipment will be supplied, installed and maintained by DBFMco throughout the project term.

Equipment

Group 2 items of equipment, which are items of equipment having implications in respect of space, construction and engineering services, will be supplied by NHS GGC, installed by DBFMco and maintained by NHS GGC.
Group 3 items of equipment are supplied, installed, maintained and replaced by NHS GGC.

The agreement for New Greenock Health and Care Centre will be based on the SFT's hub standard form (DBFM) contract (the Project Agreement). The Project Agreement is signed at Financial Close. Any derogations from the standard form position must be agreed with SFT.

DBFM

DBFMco will delegate the design and construction delivery obligations of the Project Agreement to its building contractor under a building contractor. A collateral warranty will be provided in terms of other sub-contractors having a design liability. DBFMCo will also enter into a separate agreement with a FM service (FES) provider to provide hard FM service provision. The term will be for 25 years. Termination of Contract – as the NHS will own the site; the building will remain in ownership of the NHS throughout the term, but be contracted to DBFMco. On expiry of the contract the asset remains with NHS GGC.

Service level specifications will detail the standard of output services required and the associated performance indicators. DBFMco will provide the services in accordance with its method statements and quality plans which indicate the manner in which the services will be provided.

NHS GGC will not be responsible for the costs to DBFMCo of any additional maintenance and/or corrective measures if the design and/or construction of the facilities and/or components within the facilities do not meet the Authority Construction Requirements.

Not less than 2 years prior to the expiry date an inspection will be carried out to identify the works required to bring the facilities into line with the hand-back requirements which are set out in the Project Agreement. DBFMCo will be entitled to an extension of time on the occurrence of a Delay Event and to an extension of time and compensation on the occurrence of Compensation Events.

NHS GGC will set out its construction requirements in a series of documents. DBFMCo is contractually obliged to design and construct the facilities in accordance with the Authority's Construction Requirements.

NHS GGC has a monitoring role during the construction process and only by way of the agreed Review Procedure and/or the agreed Change Protocol will changes occur. Sub-hubCo will be entitled to an extension of time and additional money if NHS GGC requests a change.

NHS GGC and DBFMCo will jointly appoint an Independent Tester who will also perform an agreed scope of work that includes such tasks as undertaking regular inspections during the works, certifying completion, attending site progress and reporting on completion status, identifying non-compliant work and reviewing snagging.

NHS GGC will work closely with DBFMco to ensure that the detailed design is completed prior to financial close. Any areas that do remain outstanding will, where relevant, be dealt with under the Reviewable Design Data and procedures as set out in the Review Procedure.
The Project Agreement details the respective responsibilities towards malicious damage or vandalism to the facilities during the operational terms. NHS GGC has an option to carry out a repair itself or instruct Sub-hubCo to carry out rectification.
Compensation on termination and refinancing provisions will follow the standard contract positions.

Personnel Implications

As the management of soft facilities management services will continue to be provided by NHS GGC there are no anticipated personnel implications for this contract.

No staff will be required to transfer to a new employer and therefore the alternative standard contract provisions in relation to employee transfer (TUPE) have not been used.

Transforming Care in Greenock

Financial Case

June 2016

18 Financial Case: Introduction

18.1 Overview

It is proposed that the Greenock Health and Care Centre project will be one of three schemes contained within the Greenock, Clydebank & Stobhill Design, Build, Finance and Maintain (DBFM) bundle being procured through hub West Scotland by NHS Greater Glasgow & Clyde (NHSGGC)

The financial case for the preferred option, option 4 New Build Greenock Health and Care Centre at Wellington Street Site sets out the following key features:

- Revenue Costs and associated funding
- Capital Costs and associated funding.
- Statement on overall affordability position
- Financing and subordinated debt.
- The financial model
- Risks
- The agreed accounting treatment

The overall cost position has increased from £18,998,742 at IA stage to £21,196,241. There has been a minimal increase in the building area of 15m2 since IA. A number of changes have increased costs. These include technical matters, site issues and design development. The most significant items include a compliance requirement for cold water systems to be chilled, a requirement for an additional adjacent site to deliver car parking numbers, confirmation of contamination of existing ground, additional retaining and cut/fill due to level changes, confirmation of presence of shallow rock and obstructions. Some of this has been addressed by utilising risk allowances included at IA stage, an element of value engineering and a reduction in inflation allowances based on published BCIS indexes. The overall costs have been examined by the Board's technical advisers who have confirmed that the costs represent value for money.

- Discussions took place with Scottish Government in September 2016, when the requirement for additional site was identified and then in March 2017 when the further increases became apparent. Following upon this, confirmation was provided by Scottish Government that the Board should proceed with the submission of an OBC on this basis.

18.2 Revenue Costs & Funding

18.3 Revenue Costs and Associated Funding for the Project

18.4 The table below summarises the recurring revenue cost with regard to the Greenock Health and Care Centre scheme.

18.5 In addition to the recurring revenue funding required for the project, non-recurring revenue and capital investment will also be required for demolition of existing Health Centre (£891.4k) equipment (£1,271.8k) and subordinated debt investment (£176.1k) Details of all the revenue and capital elements of the project together with sources of funding are presented below:

Recurring Revenue Costs

First full year of operation	2020/21
Additional Recurring Costs	**£'000**
Unitary Charge	[redacted]
Depreciation on Equipment	127.2
IFRS – Depreciation	847.8
Heat, Light &Power, Rates & Domestics services	452.6
Client Facilities Management (FM) Costs	31.0
Total Additional Recurring Costs	[redacted]

19 Unitary Charge

The Unitary Charge (UC) is derived from both the hub West Scotland Stage 1 submission dated 28th April 2017 and the Financial Model Health Bundle 20170511 and represents the risk adjusted Predicted Maximum Unitary Charge of [redacted] pa based on a price base date of April 2016 and Capex figure of £21,196k

The UC will be subject to variation annually in line with the actual Retail Price Index (RPI) which is estimated at 2.5% pa in the financial model. The current financial model includes a level of partial indexation [redacted] and this will be optimised prior to financial close.

19.1 Depreciation

Depreciation of £127.2k relates to a 6% allowance assumed for capital equipment equating to £1,271.8k including VAT and is depreciated on a straight line basis over an assumed useful life of 10 years.

19.2 Heat, Light & Power, Rates & Soft FM Costs

Heat, Light & Power costs are derived from existing Health Centre costs and a rate of £27.00/m2 has been used.

Rates figures have been provided by external advisors and an allowance for water rates of £19.00/m2 has also been included.

Soft FM costs are derived from existing Health Centre costs and a rate of £28.00/m2 has been used.

19.3 Client FM Costs

A rate of £5.29/m2 has been provided by the Boards technical advisors based on their knowledge of other existing PPP contracts.

19.4 Costs with regard to Services provided in new Health Centre

NHS staffing and non-pay costs associated with the running of the health centre are not expected to increase with regard to the transfer of services to the new facility.

19.5 Recurring Funding Requirements – Unitary Charge (UC)

A letter from the Acting Director – General Health & Social Care and Chief Executive NHS Scotland issued on 22nd March 2011 stated that the Scottish Government had agreed to fund certain components of the Unitary Charge as follows:

100% of construction costs;

100% of private sector development costs;

100% of Special Purpose Vehicle (SPV) running costs during the construction phase;

100% of SPV running costs during operational phase;

50% of lifecycle maintenance costs.

Based on the above percentages the element of the UC to be funded by SGHD is [redacted] which represents 92% of the total UC, leaving NHSGGC to fund the remaining [redacted] (8%). This split is tabled below:

Unitary Charge split

UNITARY CHARGE	Unitary Charge £'000	SGHD Support %	SGHD Support £'000	NHSGGC Cost £'000
Capex inc group1 equipment (Net)	1,780.5	100%	1,780.5	0
Life cycle Costs	[redacted]	50%	[redacted]	[redacted]
Hard FM	[redacted]	0%	[redacted]	[redacted]
Total Unitary Charge including Risk	[redacted]		[redacted]	[redacted]
			92%	**8%**

19.6 Sources of NHSGGC recurring revenue funding

The table below details the various streams of income and reinvestment of existing resource assumed for the project.

Sources of revenue funding

NHSGGC Income & Reinvestment	£'000
Existing Revenue Funding	631.4
IFRS – Depreciation	847.9
Additional Revenue Funding –GPs & Pharmacy	70.2
Council Revenue Contribution	61.6
Total Recurring Revenue Funding	**1,611.1**

19.7 Depreciation

Annual costs for depreciation outlined above relate to current building and capital equipment. The budget provision will transfer to the new facility.

19.8 Heat, Light & Power, Rates & Soft FM Costs & GP's Contribution

All heat, light & power, rates and domestic budget provision for current buildings will transfer to the new facility. This is reflected above in the NHSGGC contribution.

Current budget provision for rent / rates of existing GP premises will also transfer to the new facility as reflected above.

20. Additional Revenue Funding

This relates to indicative additional annual revenue contributions from GPs and Pharmacy within the new facility.

20.1 Summary of revenue position (Summary of conventional capital costs and funding requirements)

In summary the total revenue funding and costs associated with project are as follows:

20.2 Summary revenue position

Recurring Revenue Funding	**£'000**
SGHD Unitary Charge support	[redacted]
NHSGGC recurring funding per above	1,611.1
Total Recurring Revenue Funding	[redacted]
Recurring Revenue Costs	**£'000**
Total Unitary charge(service payments)	[redacted]
Depreciation on Equipment	127.2
Facility running costs	483.4
IFRS – Depreciation	847.9
Total Recurring Revenue Costs	[redacted]
Net surplus at OBC stage	**0**

The above table highlights that at OBC and Stage 1 Submission stage, the project revenue funding is cost neutral. This will be reviewed during FBC stage.

20.3 Capital Costs & Funding

Although this project is intended to be funded as a DBFM project i.e. revenue funded, there are still requirements for the project to incur capital expenditure. This is detailed below:

Capital costs and associated funding for the project

Capital Costs	£'000
Land purchase & Fees	0.0
Group 2 & 3 equipment Including VAT	1,271.8
Sub debt Investment	176.1
Total Capital cost	**1,447.9**
Sources of Funding	
NHSGGC Formula Capital	1,447.9
Total Sources of Funding	**1,447.9**

20.4 Land Purchase

The land is currently under the ownership of Inverclyde Council, and is being transferred to the NHS at no cost.

20.5 Group 2 & 3 Equipment

An allowance of £1,271.8k including IT equipment and VAT has been assumed for the Greenock Project. An equipment list is currently being developed which will also incorporate any assumed equipment transfers. It is therefore anticipated the current equipment allowance of £1,271.8k will reduce at FBC stage.

20.6 Sub Debt Investment

Sub Debt was reviewed after ESA10 and at this stage of the project it is assumed that the Board will be required to provide the full 10% investment. Confirmation will be requested from the other participants during the stage 2 process (the PSDP, SFTi and HCF). The value of investment assumed at OBC stage is £176.1k for which NHSGGC has made provision in its capital programme.

20.7 Non Recurring Revenue Costs

There will be non-recurring revenue costs estimated below:

Non Recurring Revenue Costs	£'000
Advisors Fees	103.5
Demolition	891.4
Decommissioning incl IT & Telecoms	112.4
Commissioning	30.0
Security (6months)	90.0
Total Non-Recurring Revenue Costs	**1,227.3**

These non-recurring revenue expenses will be recognised in the Board's financial plans.

20.8 Disposal of Current Health Centre and Clinics

The OBC is predicated on the basis that the existing Greenock Health and Care Centre, Boglestone Clinic and Cathcart Centre, which are not fit for purpose, will be disposed of once the new facility becomes available. There will be a non-recurring impairment cost to reflect the rundown of the facilities. The net book value's as at May 2017 is, Greenock HC £1,071k, Boglestone Clinic £140k and Cathcart Centre £1,389k. Following disposal, any resultant capital receipt will be accounted for in line with recommendations contained in CEL 32 (2010). CAMHS service will vacate Larkfield Children's and Families Centre which will then be available for another service to occupy.

20.9 Statement on Overall Affordability

The current financial implications of the project in both capital and revenue terms as presented in the above tables confirm the projects affordability. The position will continually be monitored and updated as we progress towards Full Business Case (FBC).

20.10 Financing & Subordinated Debt

20.11 hubco's Financing Approach

hub West Scotland (Hws) will finance the project through a combination of senior debt, subordinated debt and equity. The finance will be drawn down through a DBFMCo special purpose vehicle that will be set-up for the three projects.

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

20.12 Current finance assumptions

The table below details the current finance requirements from the different sources, as detailed in the Greenock financial model submitted with hubco's Stage 1 submission.

Current finance assumptions

	Greenock
Senior Debt (£000)	20,248
Sub debt (inc rolled up interest) (£000)	176
Equity (£000)	0.01
Total Funding	20,424

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

20.13 Subordinated debt (Summary of revenue financed capital costs and funding requirements)

Our expectation is that subordinated debt will be provided in the following proportions: [redacted] 10% NHS Greater Glasgow & Clyde [redacted]

The value of the required sub debt investment is as follows:

Subordinated debt

	NHS GG&C	SFT	HCF Investments	hubco	Total
Proportion of sub debt	10%	[redacted]	[redacted]	[redacted]	100%
£ sub debt	176,105	[redacted]	[redacted]	[redacted]	1,761,050

NHS Greater Glasgow & Clyde confirms that it has made provision for this investment within its capital programme.

It is assumed the sub-ordinated debt will be invested at financial close, and therefore there would be no senior debt bridging facility.

20.14 Senior Debt

hubco has assumed that the senior debt will be provided by NORD. Hubco's review of the funding market has advised that NORD currently offers the best value long term debt for the projects. This is principally because of:

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

SFT tenders the funder opportunities on an annual basis. It is always a best value appointment via a competitive process.

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

Senior debt

Metric	Terms
Margin during construction	[redacted]

Margin during operations	[redacted]
Arrangement fee	[redacted]
Commitment fee	[redacted]
Maximum gearing	[redacted]

A NORD term sheet, or confirmation of NORD's terms have not yet been received from hubco, though NHS GG&C's financial advisors confirm that these terms modelled are in line with NORD's approach in the market currently.

20.15 Financial Model

The key inputs and outputs of the financial model are detailed below:

Financial model key inputs and outputs

Output	Greenock
Total Annual Service Payment (NPV)	[redacted]
Nominal project return (Post Tax)	[redacted]
Nominal blended equity return	[redacted]
Gearing	[redacted]
All-in cost of debt (including 0.5% buffer)	[redacted]
Minimum ADSCR[3]	[redacted]
Minimum LLCR[4]	[redacted]

The all-in cost of senior debt includes an estimated swap rate of 2.0% and an interest rate buffer of 0.50%. The buffer protects against interest rate rises in the period to financial close. Recent swap rates for an average loan life of around 15 years were trading at around 1.45%

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

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

therefore the interest rate buffer 1.0% of adverse movements, given the current model's average loan life of 16.14 years.

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

20.16 Financial efficiencies through project bundling

A separate paper has been provided that outlines the financial efficiencies through project bundling.

20.17 Risks

The key scheme specific risks are set out in the Greenock Health and Care Centre Risk Register, which is held at Appendix 8 to this OBC. This has been developed by joint risk workshops with hub West Scotland and totals £523,800. The risk register risks according to their likely impact (red, amber, green). It is anticipated that the majority of these risks will be fully mitigated, or mitigated to manageable levels in the period prior to FBC submission and financial close.

The unitary charge payment will not be confirmed until financial close. The risk that this will vary due to changes in the funding market (funding terms or interest rates) sits with NHS GG&C. This is mitigated by the funding mechanism for the Scottish Government revenue funding whereby Scottish Government's funding will vary depending on the funding package achieved at financial closed.

A separate, but linked, risk is the risk that the preferred funder will withdraw its offer. This is a risk which needs to be considered when the funding market for revenue projects is difficult. This will be monitored by means of on-going review of the funding market by NHS GG&C's financial advisers and periodic updates from hubco and its funders of the deliverable funding terms (through the Funding Report). This will incorporate review of the preferred lender's commitment to the project as well. This will allow any remedial action to be taken as early in the process as possible, should this be required. Hubco's financial model currently includes a small buffer in terms of the interest rate which also helps mitigate against this price risk adversely impacting on the affordability position.

At financial close, the agreed unitary charge figure will be subject to indexation, linked to the Retail Prices Index. This risk will remain with NHS GG&C over the contract's life for those elements which NHS GG&C has responsibility (100% hard FM, 50% lifecycle). NHS GG&C will address this risk through its committed funds allocated to the project.

The affordability analysis incorporates that funding will be sought from GP practices who are relocating to the new health centre. This funding will not be committed over the full 25 year period and as such is not

guaranteed over the project's life. This reflects NHS GG&C's responsibility for the demand risk around the new facility.

The project team will continue to monitor these risks and assess their potential impact throughout the period to FBC and financial close.

20.18 Accounting Treatment and ESA10

This section sets out the following:

- the accounting treatment for the Greenock scheme for the purposes of NHS GG&C's accounts, under International Financial Reporting standards as applied in the NHS; and
- how the scheme will be treated under the European System of Accounts 2010, which sets out the rules for accounting applying to national statistics.

20.19 Accounting treatment

The project will be delivered under a Design, Build, Finance and Maintain (DBFM) service contract with a 25 year term. The assets will revert to NHSGGC at the end of the term for no additional consideration.

The Scottish Future Trust's paper, "Guide to NHS Balance Sheet Treatment" 5 states:

" under IFRS [International Financial Reporting Standards], which has a control based approach to asset classification, as the asset will be controlled by the NHS it will almost inevitably be regarded as on the public sector's balance sheet".

The DBFM contract is defined as a service concession arrangement under the International Financial Reporting Interpretation Committee Interpretation 12, which is the relevant standard for assessing PPP contracts. This position will be confirmed by NHS GGC's auditors before the Full Business Case is adopted. As such, the scheme will be "on balance sheet" for the purposes of NHS GG&C's financial statements.

NHS GG&C will recognise the cost, at fair value, of the property, plant and equipment underlying the service concession (the health centre) as a non-current fixed asset and will record a corresponding long term liability. The asset's carrying value will be determined in accordance with International Accounting Standard 16 (IAS16) subsequent to financial close, but is assumed to be the development costs for the purposes of internal planning. On expiry of the contract, the net book value of the asset will be equivalent to that as assessed under IAS16.

[5] http://www.scottishfuturestrust.org.uk/publications/guide-to-nhs-balance-sheet-treatment/

The lease rental on the long term liability will be derived from deducting all operating, lifecycle and facilities management costs from the unitary charge payable to the hubco. The lease rental will further be analysed between repayment of principal, interest payments and contingent rentals.

The overall annual charge to the Statement of Comprehensive Net Expenditure will comprise of the annual charges for operating, lifecycle and maintenance costs, contingent rentals, interest and depreciation.

The facility will appear on NHSGGC's balance sheet, and as such, the building asset less service concession liability will incur annual capital charges. NHSGGC anticipate it will receive an additional ODEL IFRS (Out-with Departmental Expenditure Limit) allocation from SGHD to cover this capital charge, thereby making the capital charge cost neutral.

20.20 ESA10 (European System of Accounts 2010)

As a condition of Scottish Government funding support, all DBFM projects, as revenue funded projects, need to meet the requirements of revenue funding. The key requirement is that they must be considered as a "non-government asset" under ESA10.

The standard form hub DBFM legal documentation has been drafted such that construction and availability risk are transferred to hubco. On this basis, it is expected that the Greenock scheme will be treated as a "non-government asset" for the purposes of ESA 10. Following clarification and the provision of guidance "A guide to the statistical treatment of PPPs" by EUROSTAT on 29 September 2016 SFT have engaged the various parties and made amendments to the standard documentation that allow hub schemes to be considered as a "non-government asset" under ESA10.

20.21 Value for Money

The Predicted Maximum Cost provided by Hubco in their Stage 1 submission has been reviewed by external advisers and validated as representing value for money.

The costs have been compared against other similar comparators with adjustment to reflect specific circumstances and industry benchmarks, compliance with method statements and individual cost rates where appropriate. The Health care scorecard as contained within the SCIG manual has been completed and this demonstrates that the project as designed and costed is meeting the required value for money metrics

For Stage 2, Hubco are expected to achieve further value for money through market testing.

20.22 Composite Tax Treatment

In line with other hub DBFM projects, composite trade tax treatment has been applied in the financial model, where a combined trade of the development, construction, financing and maintenance of the asset is undertaken. This is accepted practice by HMRC and will not require an advanced clearance.

As with other DBFM projects, the Financial Model assumes Hws will charge VAT on the Service Payment and will reclaim VAT incurred in its own development and operational costs.

21. Assessing Affordability - as described above

22. Confirming Stakeholder(s) Support – See Appendix 9

Transforming Care in Greenock

Management Case

June 2016

23 Management Case: Overview

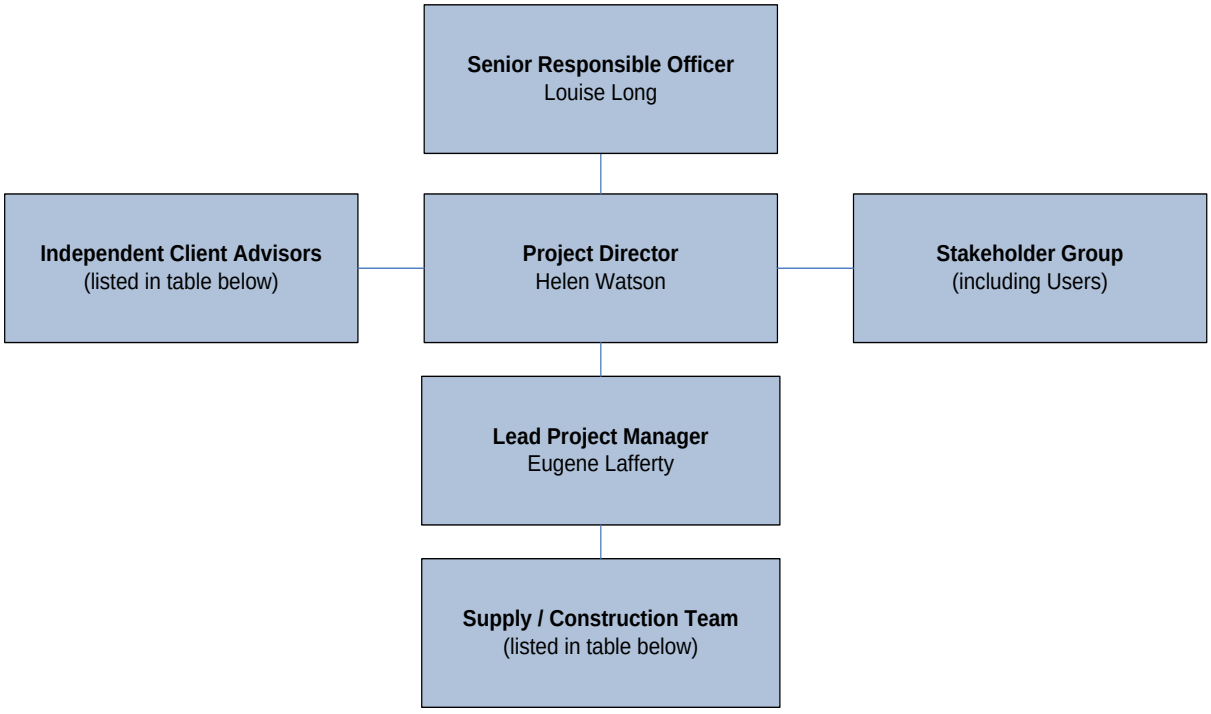
The NHS Greater Glasgow & Clyde hub Project Steering Group has established governance and reporting structures which will be implemented to deliver these three projects. The Greenock, Clydebank and Stobhill Project Boards report and approve through to the hub Steering Group to the NHS Capital Planning Group and then the NHS Board.

The Inverclyde Project Board reports to the NHSGGC Hub Steering Group which oversees the delivery of all NHSGGC hub projects, through the HSCP Director. The Group is chaired by Louise Long, Chief Officer Inverclyde HSCP and includes representatives from other Project Boards within NHSGGC, Facilities, Finance and Hubco. Louise also chairs the Greenock Health and Care Centre Project Board for Inverclyde.

This section summarises the planned management approach setting out key personnel, the organisation structure and the tools and processes that will be adopted to deliver and monitor the project In particular, it summarises the approach to the project to date, as well as looking forward to the management arrangements during the delivery and operation of the new facility.

24 Project Management Proposals

24.1 Reporting structure and governance arrangements



24.2 Key roles and responsibilities

The **Senior Responsible Officer (SRO)** Louise Long - Chief Officer for Inverclyde Health and Social Care Partnership

The **Project Director –** Helen Watson, Head of Strategy and Support Services, Inverclyde Health and Social Care Partnership

The **Lead Project Manager** – Eugene Lafferty, Project Manager, Capital Planning, NHSGGC

Project / Programme Board Members:		
Project role & main responsibilities:	**Named person:**	**Experience of similar project roles:**
Organisation's senior business / finance representative - Representing the organisation's business & financial interests.	Helen Watson, Head of Strategy and Support Services, Inverclyde HSCP	Helen has responsibilities for a number of major primary care and capital planning projects. Helen has prepared business cases and secured funding for Inverclyde Council/ Inverclyde HSCP.
	Marion Speirs, Hub Accountant	Marion has acted as Financial Lead on all NHSGGC hub projects to date. These have included completed projects (Maryhill H&CC and Eastwood H&CC), projects currently on site (Inverclyde Integrated Care, Woodside H&CC and Gorbals H&CC) and projects currently in development (Greenock H&CC, Clydebank H&CC and

		Stobhill Mental Health Wards. Lesley has had responsibility for Estate development and capital planning in a number of her previous roles. Most recently she was Project Board member representing Finance for the £50M North Ayrshire SFT/HUB development of a new Largs schools campus.
Senior service representative - Representing the end user interests.	Jeanette Hawthorn, Head of Business Support	As Head of Business Support Jeanette has been involved a number of projects involving Office Rationalisation and leads on elements of the HSCP Property Asset Management Plan assisting the Chief Officer. Jeanette will ensure that the project produces the required products, will liaise and negotiate with all services and stakeholders and manage the day to day managements of the project and dedicated project resources.
Senior Technical / Estates / Facilities representative - Representing the technical aspects of the project	John Donnelly, General Manager Capital Planning	John has acted as Technical Lead on all NHSGGC hub projects to date. These have included completed projects (Shields Centre, Maryhill H&CC, Eastwood H&CC), projects currently on site (Inverclyde Integrated Care, Woodside H&CC and Gorbals H&CC) and projects currently in development (Greenock H&CC,

		Clydebank H&CC and Stobhill Mental Health Wards
Stakeholder representative(s) - Representing stakeholders' interests:	Dr Hector MacDonald	Hector is the HSCP's clinical director and has been a General Practitioner in Inverclyde for 17 years. He will champion the needs of stakeholders in the process and ensure productive communication takes place between stakeholders and the project board

Independent Client Advisors:	
Project role:	**Organisation & Named lead:**
Project Director & Business Case author:	Helen Watson, Head of Strategy and Support Services
Health and Social Care - Project Manager	Jeanette Hawthorn, Head of Business Support
Clinical / service lead:	Dr Hector MacDonald, Clinical Director
Technical advisor:	Currie and Brown
Financial advisor	Caledonian Economics
Legal advisor	CMS
IM&T advisor	David Daly, IT Manager NHSGGC, David Murphy, IT NHSGGC
Medical equipment advisor	n/a
Commissioning advisor	Tbc
Other advisors:	Hoskins Architects

24.3 Project recruitment needs

NHS Greater Glasgow and Clyde have extensive experience managing Hub Projects. The New Greenock Health & Care Centre Project will be Property & Capital Planning's sixth such development.
The Project Structure is a tried and tested process as per detailed in section . Should there become resource gaps within the Project Structure; these will be reported to the Project Board and immediate action will be taken to fill roles which would have an impact on the Project, Programme or both.
Should any gaps be identified, the opportunity to work and share resources with other NHS Boards will be explored, in the first instance, thereafter, the normal recruitment process will be followed, with any interim requirements being covered, where appropriate by the Property & Capital Planning Department.

24.4 Project plan and key milestones - See Appendix 5

OBC Consideration\Approval	July-September 2017
Stage 2	June-July 2018
FBC Consideration\Approval	September 2018
Financial Close	October 2018
Completion date	June-July 2020
Services Commencement	July-August 2020

25 Change Management Arrangements

To achieve successful change management outcomes key staff will continue to be involved in a process of developing detailed operational policies and service commissioning plans that will be incorporated into the benefits realisation plan.

25.1 Operational and service change plan - See Appendix 10

A number of service meetings have taken place with all teams and GP practices moving into the new development. The first set of meetings took place in May 2016 where meetings were held with every service and discussed their accommodation requirements at length. Follow up meetings were arranged to clarify details. There have been monthly Project Board meetings scheduled since 5th May 2015 and regular bi monthly Delivery Group meetings where officers have discussed the new

ways of working mobile /agile working and this will be explored further at future workshops. The Arts Strategy Group was established in May 2016. That group will provide strategic direction to enable a co-ordinated and inclusive approach to the integration of therapeutic design, art and ongoing creative and performing arts activity influencing health and wellbeing at the New Greenock Health and Care Centre, and local area.

25.2 Facilities change plan

The new development has presented opportunities to rationalise some elements of the HSCP estate and bring related services together at a single location. There is also a wider piece of work ongoing to complete an accommodation plan within the HSCP incorporating both local authority and community health buildings. A key driver for the development is for it to be revenue neutral.
The new development will not only assist with the new Health and Social Care Partnership working but will enable full engagement for GP practices to be involved in the integration agenda.

The new development will be one of the HSCP key sites with integrated teams co-located, and through the rationalisation of the HSCP estate this will result in the decommissioning of 1 local authority and 4 health buildings which will release revenue for re-investment in the new centre. As part of the rationalisation process the following sites are incorporated within the final options:-

- Relocating local authority and community health staff from Inverclyde Centre for Independent Living to the new development in Greenock.
- Staff currently based in the CAMHS building adjacent to current hospital site would also be relocated to the Greenock new health and care centre development.
- Speech and Language Therapy staff currently based in Port Glasgow Health Centre would also relocate to the Greenock new development. This would create some space capacity within the Port Glasgow Health Centre. Learning Disability and Drugs Service Teams from Cathcart Centre will relocate to other HSCP accommodation.

A clear change management approval process is in place with full discussion of costed change requests being discussed and agreed at the Project Board prior to any changes being implemented.

25.3 Stakeholder engagement and communication plan – See Appendix 6

With the integration of Health and Social Care services, the new centre will provide the opportunity to provide high quality integrated primary and community health and social care services to people living in Greenock and beyond. In addition, the Centre will provide a community resource to be shared and used by the wider community and third sector organisations. The Project development should not only enhance and improve the health inequalities of experienced by local people, but also help to address some of the economic regeneration in the area.

Background and aims

NHS Boards have a statutory duty to involve patients and the public in

the planning and development of Health services. Scottish Government guidance sets out how this should be done CEL 4(2010) Informing, Engaging, and Consulting People in developing Health and Community Care. With a major service change, such as the development of the new Health and Care Centre, extensive consultation with the community will be required around issues such as sites, service delivery and design to name but a few areas.

Aims of the Consultation Process:-

- We will involve patient and carer representation as well as community councillors and community representatives in the planning process throughout all stages of the development.
- We will also engage with third sector partners in the planning and consultation stages.
- Our People Involvement Network, is supported by staff at Your Voice the patient body. This is the local organisation, which consults with patients, carers and service users, as well as the wider community, about issues relating to health and social care. The organisation then feeds these issues into the HSCP through our People Involvement Framework.

26 Benefits Realisation – See Appendix 7

The benefits identified within this OBC will be monitored and evaluated during the development of the project to maximise the opportunities for them to be realised and measurable indicators will be reviewed on a quarterly basis at the Project Board.

27 Risk Management - See Appendix 8

The main project risks and mitigation factors are identified at a high level at the OBC stage. As the project develops through the FBC stages a more detailed and quantified risk register will be prepared. The main risks at this stage are highlighted in Appendix 8. The Risk Register will be continually be reviewed and discussed at the Project Board.

28 Commissioning

Technical Commissioning

The NHSGGC Property & Capital Planning Project Manager will be responsible for overseeing the final stages of the project including all training needs for the new building and final commissioning certificates. They will liaise with the Main Contractor and other specialist contractors, along with the Commissioning Group to ensure a smooth transition to the

New Facility.

Non-Technical Commissioning

A Transition and Commissioning Group will be established during the construction stage with membership from the various stakeholders in the project including, amongst others, Clinical User representation, Non Clinical User representation, IT, Telecoms, Estates, Procurement, Facilities Management, Estates and input from Infection Control. The Group will be led by the in-house Commissioning Team drawing on experience of previous new builds including the Queen Elizabeth University Hospital to develop an agreed Commissioning programme in conjunction with users.

The group will also be responsible for the development of a migration programme for the service move to the new facility and co-ordination of all the service teams to achieve the migration timescale, in line with the contract programme.

As many of the new ways of working as possible will be implemented prior to the move albeit taking into account the restrictions of the current facilities. Agile working and paperlite will be promoted and a back scanning exercise is already underway, this will create not only less storage requirement but provide more secure data storage.

29 Project Evaluation

Post Project Evaluation will be undertaken in line with the SCIM guidelines to determine the project's success and identify lessons to be learnt.

In more detail there will be an evaluation during the Construction Phase in the form of monitoring the project with regards to time, cost, the procurement process contractors performance, and any initial lessons learnt.

Six to twelve months after commissioning of the facility a more wide ranging evaluation (Stage 3) will take place. This will assess, amongst other factors: how well the project objectives were achieved; was the project completed on time, within budget and according to specification; whether the project delivered value for money; How satisfied patients, staff and other stakeholders are with the project results and the lessons learnt about the way the project was developed, organised and implemented. The Post Project Report will also provide information on key performance indicators.

A key focus will be sharing the information gathered so that the lessons

to be learned is made available to others.

Longer term outcomes (Stage 4) will be evaluated 2 to 5 years post migration to the new facility as by this stage the full effects of the project will have materialised. The evaluation will be undertaken by the in-house Post Project Evaluation team and both quantitative and qualitative data will be collected during stages 3 and 4 evaluation through the use of questionnaires and workshops.