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Outline Business Case

"St Kilda Integrated Care facility and development of the Brixham Hospital site"

Version 6: 22nd July 2014

Version Tracking

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Approvals

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Executive Summary

The Trust and Torbay Council have long standing commitments to the community of Brixham and the long stay residents of St Kilda to re provide and enhance the current facility which is no longer fit for purpose.

The local health and social care community has been successful in its bid to become a Pioneer site for integrated care, giving even greater emphasis to the existing multi-agency joint working and the continued success of the Torbay model. An important objective for the health and care system is to improve community and preventative services to respond to the challenge of an aging population, and the desire for people to remain in their homes and address conditions such as dementia. South Devon and Torbay CCG strongly supports this model of delivering joined up services to enable a reduction in 'bed-based' care through investment into community services.

The proposal to build a 36 bedded fully integrated care facility on the Brixham Hospital site is an innovative scheme that brings together NHS Community Hospital and Adult Social Care beds, including Intermediate Care and Rehabilitation, into a single flexible facility delivered through an integrated staffing model to allow safe, timely, sustainable and cost effective care and early discharge back into a community setting/home.

The building, named St Kilda, will be located on unused land on the Brixham Community Hospital site, the delivery of the facility is part of a wider c£7m site development that will resolve a number of estates challenges and allow the delivery of modern frail elderly and dementia friendly care beds; a base for all 3 Brixham GP practices on the site and the re-location of two Primary Care Practices to create an integrated health "hub" for the population of Brixham. The site will also include the Health and Social Care Team for the town, other patients consulting space, carers base, MIU, pharmacy and retail space.

The scheme delivers significant economies of scale and revenue budgetary savings as part of an efficient and flexible solution. It affords not only an enhanced re-ablement service but also the revenue consequences of a £6m loan to finance the capital costs of the new facility, and both the Adult Social Care ASC and Health efficiency savings for 2016/17.

This Business case is supported by a wide range of stakeholders including residents of St Kilda, Staff, Brixham League of Friends, commissioners, NHS England and Torbay Council and Brixham GP's. South Devon Healthcare NHS FT (SDHCT) are also supportive of and will endorse the business case as a legacy scheme to be managed by the proposed Integrated care Organisation (ICO) following approval by the SDHCT Board at its August meeting.

1. Strategic Case

1.1 Introduction

Torbay and Southern Devon Health and Care NHS Trust (TSDHC) is an integrated health and adult social care organisation providing community health services in Torbay and Southern Devon to around 375,000 people plus about 100,000 visitors at any one time during the summer holiday season. The Trust also provides and commissions adult social care services for Torbay Council, and has a joint management structure and partnership arrangement in place for social care in South and West Devon with Devon County Council. The Trust employs approximately 2000 staff including frontline health and social care staff, such as district nurses, occupational therapists and social workers, who operate from a range of different premises across Torbay and Southern Devon.

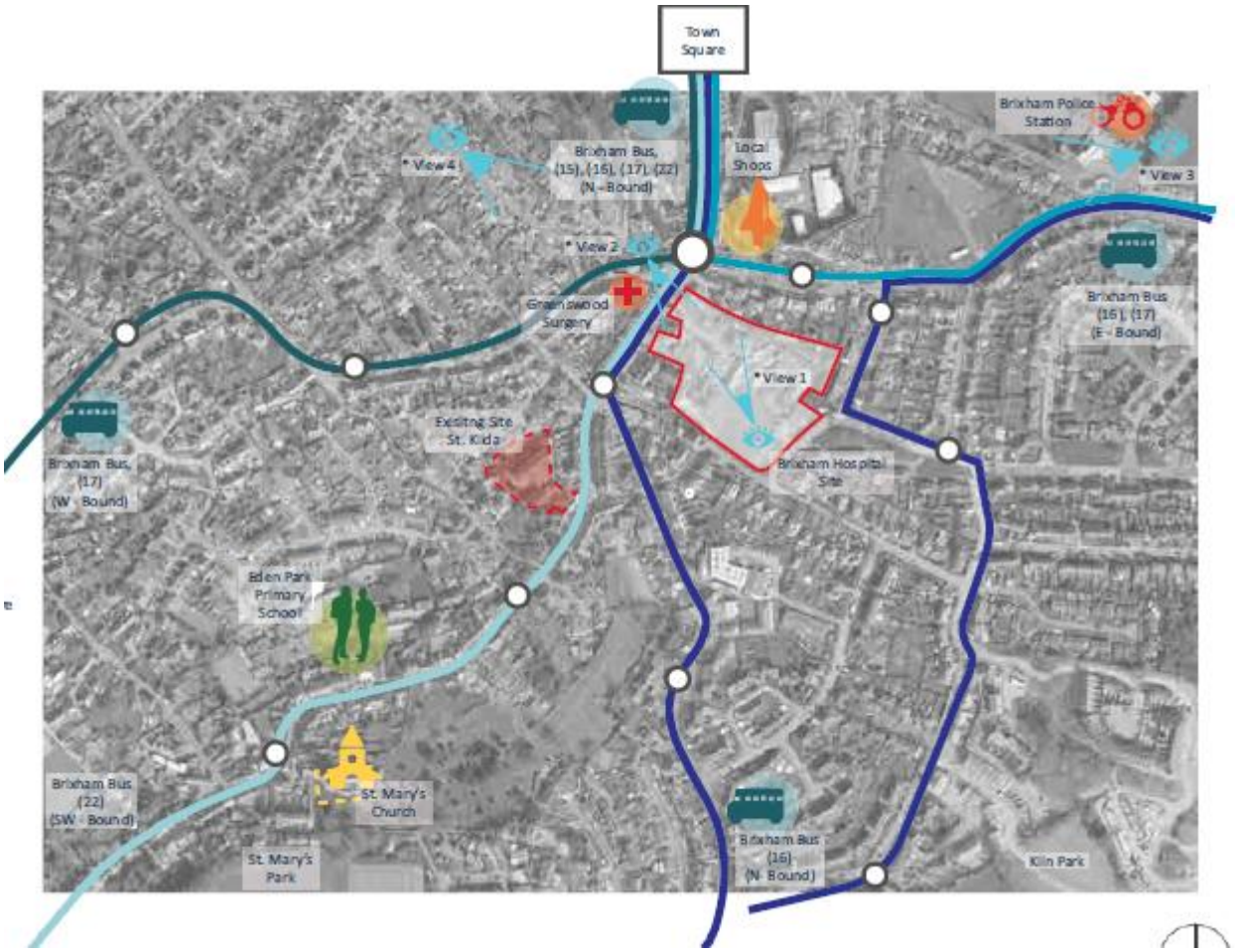
The Health and Care Trust's catchment area covers 350 plus square miles – from the South Hams (Plymouth boundary) and South Dartmoor to the length of coastline which stretches from the mouth of the River Exe (Dawlish), past the Teign and Dart estuaries (to Kingsbridge). Services in Torbay and South Devon are commissioned by Torbay and South Devon Clinical Commissioning Group. The 'bay' is a collective grouping for the towns of Torbay, Paignton and Brixham under the control of the Unitary Local Authority of Torbay Council.

The Town of Brixham has a population of approximately 21,000. The town has a strong sense of community and a vibrant third sector. Brixham Community Hospital, owned and run by TSDHC, is well located, close to the heart of Brixham and key local amenities including shops and a GP surgery. The area is well populated with many residential properties close by. The Hospital is seen as a community asset by the local population, and is well regarded and supported by the Brixham Hospital League of Friends and Brixham Town Council who take an active interest in the site and its future. The Hospital houses a 20 bedded in patient ward and other facilities such as an MIU, Outpatients, Diagnostics, Minor operations facilities as well as a small ambulance station. The Brixham Health and Social Care team are housed on the Brixham Hospital site; their co-location is fundamental to the delivery of 'joined up' care. The team are accommodated in a Portakabin on site, which the Trust purchased two years ago. This temporary solution is suitable in the medium term, however this is not a long term solution. Currently, residents to the east walk through the site to gain access to the town centre, the local primary school and the local shops etc. The hospital is well connected via a number of frequent bus services into Brixham. The site has opportunities for development.

The St Kilda Care facility is a 36 bedded purpose built care home on three levels. (only 28 are currently used) that provides residential, intermediate and respite care services for the population of Brixham and surrounding area. Built in the 1960's it is owned and maintained by Torbay Council, and leased to TSDHC, who in turn sub-contract the running of the service to Sandwell Community Caring Trust (SCCT). The 28 beds are paid for on a block contract with an annual value of £860k. The service contract is in place until 2018 but includes a nine month break clause at any time. The standard of the service is excellent; however, the current building is in very poor condition, has significant maintenance issues and site constraints e.g. parking, such that is likely to be unfit for purpose much beyond 2015. St Kilda's has seven permanent residents who have publically been promised a new home by the Chief Executive of the Primary Care Trust (PCT) at the time and the Mayor of Torbay. As with the Hospital, St Kilda is well respected and supported by the residents, Brixham Town Council and the Brixham Hospital League of Friends.

St Kilda is located a short walk to the west of Brixham Hospital site as shown in diagram 1. overleaf.

Diagram 1. Brixham Hospital, St Kilda's and surrounding area



St Luke's GP practice is located in the centre of Brixham, accommodation is poor, and the GP's have been looking for some time for a viable solution to relocate their premises to the Hospital site. Greenswood Road GP practice is situated close to the Hospital and has similar if not more pressing accommodation concerns that are driving the search for more suitable and better quality premises. Both practices together serve a population of 11,000.

SDHCT working in partnership with other health and care providers and commissioners are rightly proud of its reputation for innovation and leading edge integrated services. The Trust and community are constantly developing new ways to make services more accessible for the local population, and introducing new opportunities for individuals to take more control over the care and support they receive to help them live their life the way they want to.

Making improvements to the quality and the safety of the environment for the residents and social care clients of St Kilda's, enhancing GP services, delivering services in the heart of the community and developing the Brixham Hospital site to deliver joined up services whilst making more effective use of budgets is a priority for: the Mayor, Torbay Council, the CCG, Brixham Council and the Torbay and Southern Devon Health and Care NHS Trust Board (TSDHC).

1.2 National Context

The Kingsfund define three key benefits to the successful integration of health and social care namely:

- Better outcomes for people, e.g. living independently at home with maximum choice

and control

- More efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time
- Improved access to, experience of, and satisfaction with, health and social care services. [1]

The Government has made clear its commitment to the integration of health and social care, beginning with a pledge to break down the barriers between health and social care, and culminating in proposals for the reform of the NHS and adult social care.[2]

The financial and demographic changes facing both services, and in particular the higher than average numbers of the elderly, alongside unprecedented levels of local authority budget reductions are a significant challenge. Local health communities need to think radically about a new model of integrated care to join up care and make best use of the reducing budget for health and care services.

"To improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs." 2013 Government spending review.[3]

The integrated care proposals and new and innovative service model presented in this business case entirely reflects the national direction of policy, pioneer aspirations and the challenge of delivering new models of care.

1.3 Local Context

- *Locality Plans*

  Under the direction of the CCG and with clinical engagement, the Brixham locality have undertaken a comprehensive public engagement exercise to determine the communities high-level commissioning priorities for the next five years. These are:

  - Develop joined up services including patient centred community hub(s) to link services together, improve access to primary and community services and shared IT systems
  - Develop co-ordinated services to support people to stay at home, reduce social isolation and improve well being
  - Promote and develop self-care support, education, health prevention and lifestyle advice
  - Review and optimise the provision of primary and community health & social care services within the locality

  Their plans are to optimise the provision of primary and community health and social care services in each town and the number of sites needed to be effective. It also plans to consider using each site as a hub to provide services common to all GP practices, joint

[1] http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-where-next-kings-fund-march-2011_0.pdf
[2] https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together 2014
[3] http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-itf-sup-pck.pdf

working with community services health & social care teams as well as meeting urgent care needs for the local population. The aspirations of the Locality plans underpin this business case and the development of the Brixham site which is fully supported by the community and CCG. The full locality plan 2014 to 2019 is enclosed in Annex 1.

- *Improving the patient experience*

Ensuring patients have a good experience of health and care services is a key priority for the Board of Torbay and Southern Devon Health and Care Trust. The Trust's aim is to:

"Provide the right care, in the right place, at the right time".

This business case, service model and development of the Brixham site is underpinned by a set of core principles as detailed below:

- **People;** Provide people with the support they need to maintain good health, recover from illness, remain in control of their lives, and live as independently as possible.

- **Quality;** Ensure that all our services are of the highest quality because they are designed to keep people safe, prevent ill health, treat illness and promote independence.

- **Impact;** Deliver services that are innovative, personalised and focussed on promoting healthy communities, restoring people who have been ill to good health, reducing delays and keeping people safe at home.

- **Partners;** Work in a way which generates success for all our partners, in the provision of health and social services, and achieves best value for tax payers and those who fund us.

- **Affordability;** Make the best use of public money by ensuring that our services are efficient, effective, sustainable and that we are regarded as being the best at what we do.

- **Our staff;** Our staff are the foundation of all that we do, we want to make sure they are involved in setting our priorities, know what is expected of them and received the respect, trust and support they need to do their jobs.

- **Our community;** We will ask people about our services, listen to what they say and then design services so that the care we provide matches the needs of the individuals and communities which we are here to serve

- *Integrating Hospital and Community Care*

The new Integrated Care organisation (ICO) provides an opportunity for both organisations (Secondary Care and Community Services) to work more closely in the development of integration plans from both patient-facing and back-office perspectives. It also allows the organisations to jointly work with other partners in the local community (through membership of the "Pioneer" collaboration) to ensure that the vision for the Integrated Care Organisation's (ICO) future is aligned with the wider community. It has

become clear that this acquisition will put TSDHC, SDHCT and the local community in the best position to face the unavoidable challenges arising from the populations' increasing health and social care needs in the context of austere financial settlements. It will bring new opportunities to improve the quality of care with a set of initiatives. The Integrated St Kilda facility fits into this context.

In terms of non-financial benefits it should be noted that the Torbay area has been at the cutting edge of an integrated care model that merged the NHS community functions and Adult Social Care in Torbay since 2006 placing the client at the centre of our model of care ("Mrs Smith"). The town of Brixham was the pilot for this approach so the methodology is embedded and has been tested and has been evaluated externally. The approach has been to have a co-ordinated approach to client assessed and service provision across both health and adult social care provision.

Fundamental to this way forward has been an investment in preventative community services, the ethos being that patients and clients should have services in their own home or closer to home. Overtime we have looked to reduce our reliance on bed based care and meet the challenges of aging population and to address issues such as an increase of Dementia in the population and consumer choice in wishing to receive services closer to home.

At the centre of the ICO approach and ethos is the new model of care. In Torbay and Southern Devon, there is a commitment to an ambitious and all-inclusive vision for improvement in health and well-being for the population from all local stakeholders in health and social care, and that vision has been awarded Pioneer status by NHS England. The development of an (ICO) through the acquisition process will be one of the major enablers in the transformation of services, and developing a new approach to health and social care.

The proposed St Kilda facility is part of a redesign of services that meet the needs of our local population and that are co-ordinated and integrated in ways that benefit service users. The ICO has committed to develop services that are responsive and flexible and which link, without break, with services of our partner organisations such as primary care. A major feature of the services developed will be that they are seamless and provide continuity. Applying this to the St Kilda facility, the beds in the building will not be constrained by the traditional physical and professional barriers of health and social care. Staff involved in the care of individuals within a community setting, will continue to be involved in the care of that person if they need to be admitted to hospital. Staff who have traditionally worked in the hospital will support or deliver care in the community when needed.

- *Brixham Site Master Plan and Estates Strategy*
  The Trust is committed to developing its estate to support the delivery of high quality clinical services and meeting the Trust's core aim of achieving excellent patient outcomes.
  The shared community estates vision is to transform and develop the estate to deliver 'a quality patient environment and patient experience delivered through an energy and low cost estate which is fit for purpose, functionally suitable, well maintained, flexible and responsive to the changing needs of the services'.

1.4 Strategic Outline Case

The Trust has been seeking to replace the aged St Kilda's care home and working on the development of a solution for a number of years. In November 2012 the TSDHC Board received and approved an outline business case that consolidated a number of years' work with regard to proposed developments on the Brixham site including modernisation of NHS facilities, the

aspiration of bringing GP services onto the site and the decision to re-provide the St Kilda building/service at the Hospital to create a community health and social care campus or "hub".

This business case detailed and endorsed the case of need detailed in this case and acknowledged that the current St Kilda building has a limited lifespan and more could be achieved at the Brixham Hospital site with regard to using the land and assets in a more joined up fashion.

It re-iterated the overall vision for the Brixham site and the development of Brixham Hospital as a focal point for local changes and services. Three key elements were envisaged detailed in table 1. Below.

Table 1. 2012 Three key development objectives

		Components
1	Re-location of inpatient facilities to be based on a nurse / therapist led model	• Step down care following acute hospitalisation • Intermediate care • End of life care • Day care (e.g. transfusion)
2	Modernisation of MIU and Outpatient services	• Nurse led Minor Injury Care • Local access to diagnostics • Local access to a wide range of consultant led, specialist, Outpatient care
3	Development of wider health and social care services	• Primary Care 'One Stop Shop' (Integrated GP practice on the Brixham site) • Office and clinical space for the Brixham Integrated Team • Education space for service users and health and social care professionals • Services to promote health and well being • Like for like re-provision of St Kilda's residential/intermediate care centre on the Brixham Hospital site

Since the 2012 case, a number of key strategic drivers have changed influencing both the scope and the nature of the solution for the development of the Brixham Site. These are detailed below:

- Reduced demand for social care residential provision and a significant reduction in funding rendering a like for like Reprovision of St Kilda not the preferred model. The 20% reduction in social care funding alongside the intention to spot purchase rather than block fund social care beds significantly impacts on the viability of a like for like solution.

- Pioneer status, Joined-up, and innovative service models and models of care driving better outcomes for people through the true integration of services and the requirement for fully flexible buildings.

- Challenging Health finances driving the integration of services to make better use of public money by reducing inefficiencies, duplication and hand off's.

- The CCG and local commissioning plans and the local population shaping the nature of services required on the Brixham site. The previous model of care fit no longer fits with the shared aspirations of reduced bed based care and increased investment in community services, to care for people at home.

- GP's are collaborating and coming together to share services and costs.

- Brixham Community Hospital beds will require upgrade or re-provision in the future to meet CQC standards of privacy and dignity, and the changing building needs for an increasingly elderly population with a high incidence of dementia.

It is clear that these recent changes in the health and social care sector have required the Trust to review and change the scope and the solution to that previously anticipated. This business case addresses all the new developments needs of the site and the services as detailed in section 2. It details a solution whereby a new social care provision can be built to replace St Kilda therefore honouring the long term commitment to the residents, and at the same time being financially viable and future proofed being funded from both health and social care as part of an integrated solution.

2. Economic case and case of Need

The case of need underpinning this business case, the 'new' St Kilda and the development of the Brixham Hospital site are detailed in the following section.

2.1 The care environment of the existing St Kilda's

St Kilda was built in the 1960's and although fit for purpose at the time is not suitable for the delivery of 21st Century care and residential services. Space is cramped and inadequate to deal with the currently aging client group that are St Kilda's core service users. The beds are often occupied by patients who have "stepped down" from the secondary care setting or are undergoing Rehabilitation or Intermediate Care programmes, a completely different customer that conceived when St Kilda opened as a traditional Care Home 50 years ago. The environment is some way off meeting current Privacy and Dignity and Infection Control standards.

The space to nurse and care in is compromised both in terms of the undersized bed rooms and ancillary and support services, for example management of waste is a significant issue. In summary the environment is no longer acceptable and the care has become impacted as a consequence of its limitations. The full 36 beds in St Kilda have not been used for some time and effectively it has been operating as a 28 bedded unit.

The care provided by Sandwell is excellent but the building increasingly is a hindrance in this regard as they face a range of day to day safety and compliance issues. The build design, layout and infrastructure does not lend itself to the level of improvement that would be acceptable even if significant capital investment was available.

Although residents are stoical in the face of adversity they deserve better.

2.2 Building condition and logistics at St Kilda's

The building itself faces significant estates challenges. The buildings infrastructure is aged and breaking down on a consistent basis. The Local Authority has limited funds to address these shortfalls and the care environment itself cannot be adapted to expand within the building foot print. There have been material problems with the roof, windows and operating plant on site. The site is also cosmetically poor and lacking in public amenities. The building does not comply with the Disability Discrimination Act, a significant issue bearing in mind the age group of the clients.

As well as a poor ergonomic environment and limited space for patients, maintaining the building to retain the confidence of CQC (who have visited a number of times and expressed concerns) has become particularly challenging. This past winter has seen a series of roof leaks and building infrastructure and system failings, all requiring urgent maintenance or replacement.

Access is difficult to the back of St Kilda, consequently making kitchen deliveries and waste pick up a significant issue and parking provision is extremely poor. This very much impacts on the residents who have a permanent home at St Kilda as there is little or no space for their relatives or visitors to park.

2.3 Care environment of the Brixham Hospital inpatient beds.

Inpatient facilities on the Brixham site were re-located into the Briseham unit in 2008. (The Briseham unit was purpose built as an adult mental health unit in 1987). Facilities at the time were constrained by the footprint of the existing building. Space requirements have increased since the unit was developed and consequently the inpatient facility no longer complies with current infection control and privacy and dignity requirements. In Brixham the critical issue for the delivery of inpatient care in community Hospitals are that they are not designed inside or out for the care of the increasingly elderly patients and for those with dementia. Despite local improvements to make facilities more dementia friendly there remains a fundamental issue with the infrastructure impeding the delivery of care for this group. Space is needed to enable the active rehabilitation of inpatients to get them home quicker. In summary the issues can be identified as: not enough single rooms, insufficient space around beds and for ancillary and rehabilitation services and facilities not designed for the care of frail elderly and those suffering with dementia.

2.4 Brixham Hospital site layout

The Brixham site is somewhat fragmented with the wards located in a separate building to facilities such diagnostic and ancillary services. Some of the facilities on site are in need of modernisation. Whilst space has been refurbished to deliver improvements the main buildings on site are approximately 80 years old, not adequate for sustainable 21st century health care. Services on the site have been extended over the years without any supporting infrastructure. There are very few services and amenities on site for visitors or people attending during the day including café or retail facilities.

There is a public footpath through the centre of the site used by the local residents to access the Town centre and bus routes. Rather than see this as an opportunity to cement the Hospital at the heart of the community it is seen rather as a nuisance. Future plans need to build on the unique position of the Hospital in the community and consider it as an opportunity for health promotion and prevention and to influence the local population.

Land is available on site to be used for reducing the building liabilities of the Trust and the Council and allowing for development potential and for improvement to parking on the site.

2.5 Facilities to meet the needs of the local population

This plan needs to respond to the needs of the local population and the Local commissioning strategy as detailed in Section 1 local context and as shown in Annex 1. Local Dementia Statistics 2007 (Alzheimer's Society national figures) highlights that the proportion of both males and females aged 65 and over with dementia in Torbay is the highest in England, at 6.57% and 11.0% respectively. The Trust's Dementia Strategy highlights Brixham as having an older

average population age than the remainder of Torbay. It is therefore fair to assume that the prevalence of dementia within Brixham is higher than that within the remainder of Torbay. As a consequence of this current and developing demand, care of those with Dementia need to be at the forefront of planning across all elements including residential, intermediate and nursing beds, outside space and day services and requires services that are fundamentally different in design. In Brixham with its increasingly aged population, people suffering with dementia are likely to be the majority of the very elderly in the Future.

2.6 Provision for carers

Brixham has a large number of carers, looking after people with a wide range of conditions and disabilities. Accordingly, local services are being developed to support carers in addition to the Bay wide services available to them. The Zone Team undertakes Carers' Assessments as part of care management services and holds a quarterly Carers' Forum. This is well attended and is used to consult on local strategy and to engage carers in service development, as well as providing information about other available services. Brixham Carers' Centre was established in June 2010 as part of the strategic development of improved access to support through local carers centres in each town in Torbay. The centre also provides an information service for carers at Brixham Hospital with an advisor visiting wards weekly to identify new carers and give information. An increasing number of carers supporting people with dementia are being recognised within the community. Putting carers and the centre at the heart of the Hospital site is a fundamental part of this case.

2.7 Re-designing care services to reduced bed based care and invest in the community to care for people at home.

Analysis has been undertaken by the Trust's Operations Directorate to examine the care market in Brixham and Torbay to future proof of requirements. The evaluation covered Nursing, Residential and Dementia Care provision in Brixham. With the new model of care it has been substantiated that an investment in community services and re-ablement teams could substantially reduce the requirements for bed based care. The recommendations in this case of a reduction of 12 beds (20+28 = 48 versus the new St Kilda with 36) is considered reasonable when considered alongside the flexible model i.e. both social and health care bed numbers can flex up and down. Building a new St Kilda's integrated unit of the Hospital site will future proof the provision of bed based care on the site into the future.

2.8 An integrated and flexible health and social care service model.

As detailed in section 1.2, the national context, there is a need for local health communities to think radically about a new model of integrated care. This is to promote improvements to care and make best use of the reducing budget for health and care services. The delivery and management structures for healthcare and social care in Brixham and specifically St Kilda and Brixham inpatient unit are currently entirely separate. This means that there are duplicated service and management costs. This business case proposes a fully integrated and flexible model; that of one fully integrated staffing structure for health and social care within a flexible building. The 36 beds are all single rooms en-suite and are of unified design all built and designed to the same dementia friendly template and of nursing care standard if required. This means, that with the corresponding flexible budgetary arrangements the beds can be used for any purpose across the spectrum of health and social care at any time, flexing up and down according to the community need. The distinguishing feature and cost driver becomes the staffing required to meet the needs of the individual rather than 'the bed'. This model is supported by commissioners and will be the first of its type.

2.9 GP Services integrated into a 'health hub'.

There has been a long standing desire for more integration of GP, community Hospital and social care services. This is linked to the health communities and ICO vision to move services out of the acute Trust and closer to people's homes. A wide range of services are already delivered on the Brixham site. This business case seeks to enhance and develop these services, with the realisation of the Locality clinical commissioning strategy and local GP aspirations to have an active presence and to be undertaking more activities using the facilities on site. For example, minor operations could move out of the Hospital to be delivered by GP's on the Brixham site. All three GP practices – Compass, St Luke's and Greenswood surgeries will have a base on the site under this plan, and are all an active part of the development of the CCG led clinical strategy. St Luke's and Greenswood have acute accommodation issues that Compass does not, with poor quality practice accommodation that is clearly not beneficial for patients. As part of this development both practices will move into some shared accommodation in the space vacated by the inpatient beds moving into the new St Kilda to promote a better patient experience. Importantly all three practices will retain an element of their own accommodation and retain their individual practice identities.

2.10 Promise to the local population and current residents of St Kilda's

Both the Council and the Trust have made a series of public promises over time that a new St Kilda will be delivered and a new home provided for the current residents. According to previous discussions and approvals the expectation is that a new facility will be built on the Brixham hospital site as soon as possible. The Trust has actively worked in partnership with the Brixham League of Friends, Town Council and the residents and their families over quite a long period in planning the development, and everybody would now wish it to move forward at the earliest opportunity. There is likely to be a substantial negative stakeholder reaction should the development not proceed as promised. The League of Friends particularly has invested a significant amount both financially and emotionally in the scheme over a number of years.

2.11 Health and Social Care Team accommodation

The Brixham Health and Social Care team are housed on the Brixham Hospital site, their co-location is fundamental to the delivery of 'joined up' care. The team, in the short term are accommodated in a Portakabin on site. It is proposed that the zone team move permanently into the underutilised area of the existing hospital (existing kitchen and offices). This will be fitted out for office accommodation which will be in addition to that provided for some staff in the GP area (e.g. district nurses). The Zone team Manager is happy with this proposal.

2.12 Summary of Need

There are multiple needs that come together to form the drivers behind this business case. Whilst it is first and foremost about the re-provision of social care and residential beds currently provided in the aged St Kilda's; it is also about the development of joined up health and care services for the future, meeting the specific needs and expectations of the local population and developing a hub of health services with GP's central to the new model of care and local community.

2.13 Investment Objectives and Objective outcomes.

Arising from the need detailed in the previous section the investment objectives and objective outcome of this business case are:

A solution that

- Replaces the social care provision delivered in the current St Kilda by 2016.

- Is compatible with the new ICO and Pioneer model of care and its approach to integrated care.
- Both delivers savings from the ASC (Adult Social Care) and NHS revenue budgets (from integration) as well as increased investment in the community to support care at home (from shift in bed based care)
- Improves the patient experience and environment and delivers joined up care.
- Creates a vibrant health and social care hub for Brixham at the heart of the local community.

The strategic drivers and objective outcomes for this case are detailed in table 2. below.

Table 2. Objectives and outcomes

Objective		**Outcomes**
1	Modern fit for purpose and dementia friendly Community nursing beds in Brixham Hospital.	• 100% en-suite single rooms • Dementia friendly design • Purposed designed outside space
2	A commissioned integrated local 'health' services model focussed on a wide range of services being delivered on the Brixham site	• Nurse led Minor Injury Care • Local access to diagnostics • Local access to a wide range of consultant led, specialist, Outpatient care • Minor ops/procedures re-located from the acute Hospital to be carried out by any GP's across the bay.
3	An integrated and flexible health and social care service model.	• Staffing model that is fully integrated • Single management structure • Dual registration • Building that can flex bed numbers up and down according to need • Base for the third sector and carers • Day centre services
4	Reducing bed based care and investment in Community Services to care for people in their own home.	• New St Kilda's providing a mixed provision of 36 beds, with a base of 18 nursing and 18 social care • Enhanced skill mix with more Physio, OT and social workers that will follow and care for people in their own homes
5	Integrated GP services	• Primary Care 'One Stop Shop' • St Lukes and Greenswood GP services located on site sharing some accommodation, and a base for Compass, all retaining individual identity.
6	Permanent facilities for the Brixham integrated team	• New accommodation on the same site as health, social and GP services
7	Provision of 'community' services and creation of a heart for the Brixham site and improved logistics	• Creation of a 'square' at the heart of the Hospital • Retail pharmacy • Café and Shop in the centre of the site • New parking plan • Integrated public walkway
8	Local stakeholder and Commissioner support	• CCG and Torbay Council • Brixham GP's • Brixham Town Council and League of friends

2.14 Development of the preferred solution: Summary of Options

Following the change in the strategic drivers since the previous case was considered, the Trust has sought to re-examine a range of options to deliver the prime objective of replacement of the social care delivered in the existing St Kilda. The options and subsequent evaluation are shown overleaf and in table 3 on page 17.

Option A: Do nothing and close St Kilda

The do nothing option would result in the closure of the existing St Kilda facility, a move of the permanent residents into alternative residential accommodation and the spot purchasing of intermediate and nursing beds from the existing provision in the independent sector. This model would put additional pressure on the existing bed provision and will mean a shortfall in social care bed capacity. It is likely to have the reverse affect to that intended in that the lack of social beds would drive an increase in the use of Hospital beds, the exact opposite of the health community's vision. This option would only partially deliver the totality of savings required as spot purchasing is a variable and uncontrolled cost. Spot purchasing of beds in the independent sector to this extent, is likely to increase the instances of patients being placed in a care facility outside of their local community due to the unevenness of market provision. Our promise to the local community and residents would also not be met. This option provides no secondary opportunity for improvements in ward facilities and the development of the site other than a separate business case, which would be weakened by the loss of the integrated care driver and loss of the immediate driver to replace St Kilda's.

Option B: "Like for like" re-provision of the current St Kilda, new build 36 social care beds

Rebuilding St Kilda on a like for like basis (either at Brixham hospital or an alternative site in the town of Brixham) would not meet the objectives with respect to the integrated model and flexible bed use. It is not affordable within the social care funding, and would result in an overprovision of social care need in the new service model. Nor would it allow the delivery of savings through an integrated model and investment into the community through a reduced bed base. This option is not supported by the commissioners nor does it fit with the objectives of the ICO and national policy. This option provides no secondary opportunity for improvements in ward facilities and co-locations of GP services.

Option C: Smaller scale new build based on the same service model on the Brixham Hospital site

Whilst a small scale scheme at the hospital may deliver some of the requirements related to integrated care and flexibility, a smaller building of less than 36 beds would not provide sufficient economies of scale, staffing reliance and capacity to make it viable. It would be much more challenging to staff a smaller building and to recruit the staff needed, and the costs per individual would increase because the smaller scale. With spot purchasing rather than block purchasing i.e. no secured income it is unlikely that it would be viable cost wise for any stand-alone provider to deliver the service. Commissioners are unlikely to support this option as it does nothing to move towards integrated care. It is likely that we would also loose the support from the community. As with Option A, the reduced fixed number of beds means funding the additional cost of spot purchasing beds in the independent sector. Similarly this option provides no secondary opportunity for improvements in ward facilities and co-locations of GP services.

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Option D: New build 36 beds for health and social care with a changed service model and flexible and fully integrated solution.

A fully integrated building of 36 beds accommodating both health and adult social care beds and a flexible and combined service model with the appropriate staffing will deliver many of the objectives expected from the scheme. If health inpatient services move into the new building alongside social care beds, it frees up space on the site to accommodate the GP's, deliver the integrated health hub public facilities and permanent accommodation for the health and social

care team for Brixham. Investment in the community can be delivered through a reduction in the total bed base (20 + 28=48 to 36) and savings through the economies of scale and integrated structure. Local stakeholders, staff, GP's and commissioners are all supportive of this option.

2.15 Options Appraisal

An appraisal of the options against the objectives has been undertaken using a basic scoring matrix to determine the preferred option. The scoring is shown in table 3. below

The scoring is simply: 0 does not meet the objective; 1 partly meets our objective and 2 fully meets the objective.

Table 3. Scoring matrix against objectives

		Option A	Option B	Option C	Option D
	Objective Criteria and score	**Do nothing and close St Kilda**	**Like for like replacement**	**Smaller scale build**	**New build health and social care**
Objective 1.	Modern fit for purpose and dementia friendly Community nursing beds in Brixham Hospital.	0	0	0	2
Objective 2.	A commissioned integrated local 'health' services model focussed on a wide range of services being delivered on the Brixham site	0	1	1	2
Objective 3.	An integrated and flexible health and social care service model.	0	0	0	2
Objective 4.	Reducing bed based care and investment in Community Services to care for people in their own home.	0	0	1	2
Objective 5	Integrated GP services	0	0	0	2
Objective 6	Permanent facilities for the Brixham integrated team	2	2	2	2
Objective 7	Provision of 'community' services and creation of a heart for the Brixham site and improved logistics	0	2	2	2
Objective 8	Local stakeholder and Commissioner support	0	0	1	2
	Totals	**2**	**5**	**7**	**16**

The preferred option is clearly Option D: a new build 36 bedded integrated health and social care facility that houses social care beds moved from St Kilda's and health beds moved from the inpatient unit on site. This in turn frees up space to develop the health hub to house GP services and provide the missing public amenities needed to support the site. Option D is described in detail in the next section.

2.16 Preferred Option – Option D

Significant design development has been undertaken by the Trust with the support of a design team led by Kay Elliot architects. Kay Elliot were appointed as the outcome of a design competition where the Trust invited five local architect companies to participate to submit their

design concept for a 36 bedded new build on the Hospital. The brief was to accommodate residential, intermediate, nursing and hospital care within the one building as well as a site development plan. The stage D designs were signed off by the Trust in February culminating in successful Planning approval in March 2014.

The detail of the £6.123m building and site development plans are shown in the diagrams below and in more detail in the design and access statement for planning shown in Annex 2.

2.17 Build form: New build St Kilda's, mixed economy 36 beds.

Diagram 1 shows the built form of the new St Kilda's and its close location to the existing Outpatients and Minor injuries unit, together with the existing inpatient unit to be freed up to accommodate the GP practices.

Diagram 1 Built for on the Brixham Hospital Site

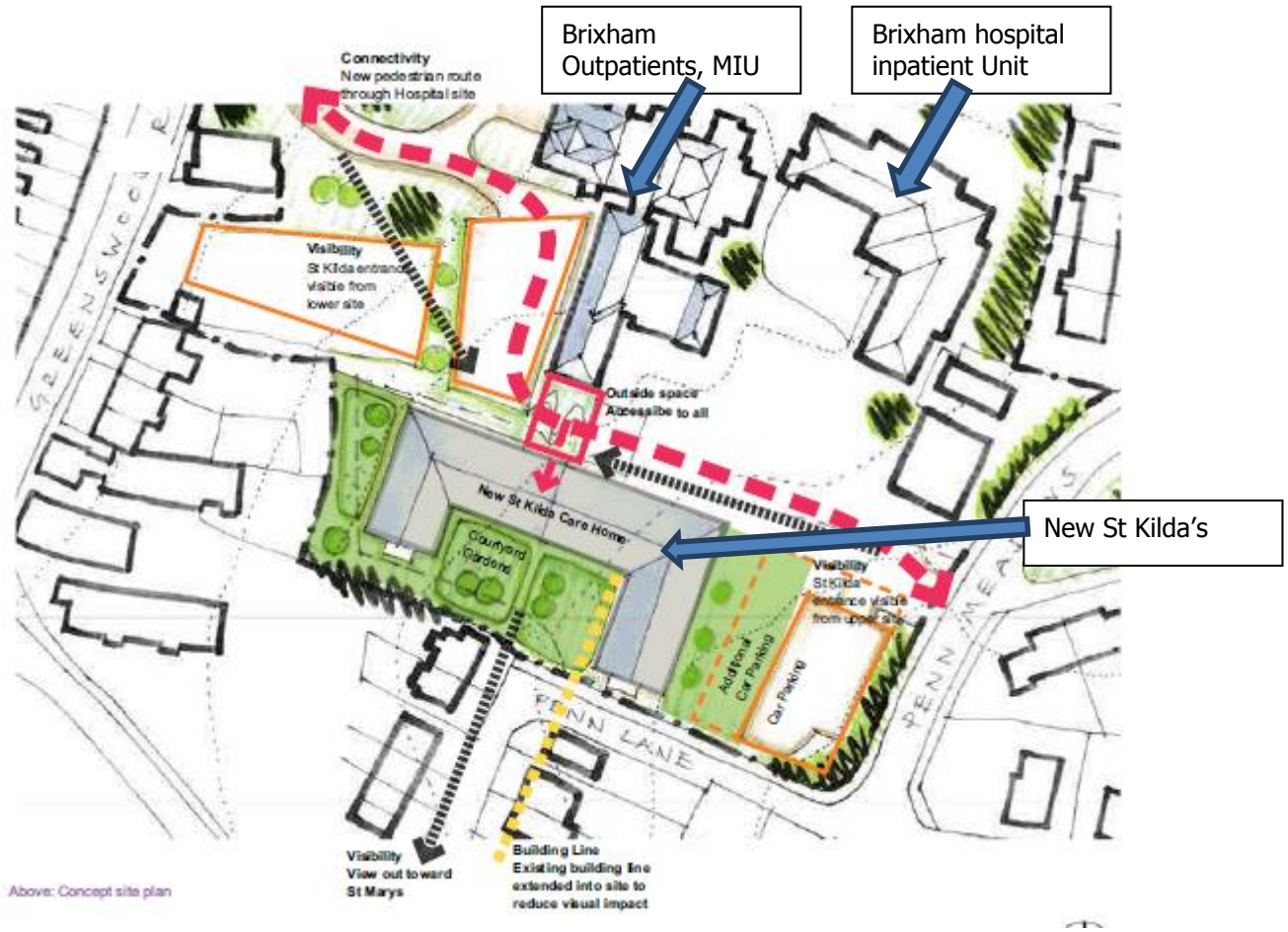

Diagram 2 overleaf shows the rear elevation of the new St Kilda's build, garden access and relationship with the neighbouring residents.

Diagram 2 Rear Elevation new St Kilda's

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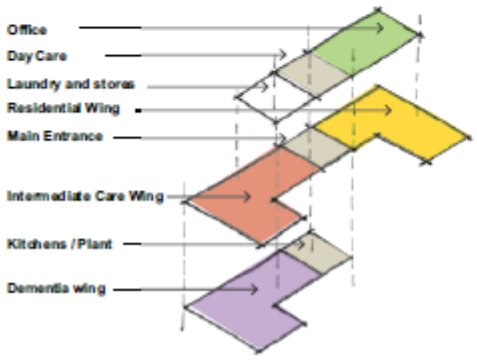
Diagram 3 Ground floor Plan

Above: Ground floor plan

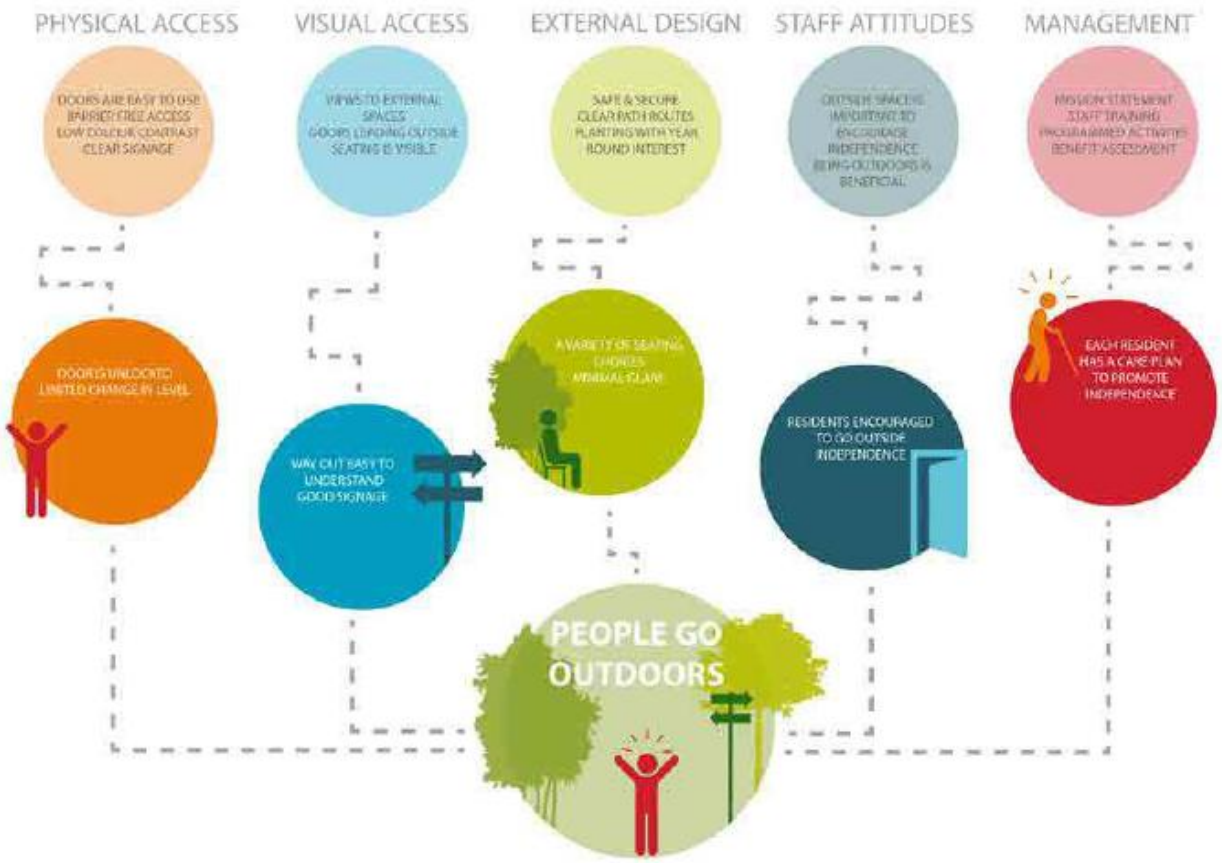


Above: Concept plan

2.18 Design Principles: Designing for the elderly and care of dementia

Design is about more than shaping the physical environment to counter the impairments which come with dementia. It involves addressing standards, practices and behaviours of professional staff and changing the way people with dementia are engaged with in the environments in which they live. Getting design right can make a fundamental difference to the lives of people with dementia. It improves their life experiences and can increase their life expectancy.[4] The Trust and the design team have worked with Sterling University who are nationally recognised as experts on designing for dementia, to come up with a building that is purpose designed with dementia in mind from top to bottom, to support the delivery of care for the elderly population of Brixham for the future. The design model is shown in diagram 4 below with the full critique of the design of the building and outdoor spaces by Sterling University shown in Annex 3.

Diagram 4 Sterling University dementia out door model.



Source - *'Designing outdoor spaces for people with dementia' - University of Stirling*

Outdoor spaces are really important, this building will be home for some people. There is significant evidence that outdoor spaces not only enhance the recovery of health but also have a key part to play in the care of people with dementia. All the ground floor rooms have access to gardens that are designed such to enhance the quality of care.

It is important that people are able to access gardens and outdoor areas adjacent to their homes. Going outdoors has been shown to have multiple benefits including; providing physical exercise; helping to maintain normal sleeping patterns and daily rhythms; improving mood and helping people to cope with stress. A well-designed outdoor space can be enjoyed by people with sight loss and dementia, as well as their families.

[4] http://dementia.stir.ac.uk/design/good-practice-guidelines/outdoor-spaces

The design of the gardens is shown in diagram 5 below.

Diagram 5 Designed for Dementia garden design.

2. Developed proposal allowing rationalisation of private garden space and allowance for vehicle turning area in front of main entrance

2.19 GP services on the Brixham hospital site

Moving the inpatient beds from the old Briseham unit in to the new 'St Kilda' frees up c800m^2 of existing space at the top of the site which can feasibly be developed to house both the St Lukes and Greenswood GP practices and provide a base for Compass. The GPs, in partnership with the CCG, are currently developing the commission model that would support this primary and integrated care development. The 800m^2 of space fits exactly with the GP premises funding model for the accommodation needed for these two GP practices. This model and proposal is fully supported by NHS England (Local Area Team) who are responsible for, and supply, GP premises funding. Both GP practices have met and shared their thoughts and aspirations and both are excited about the possibilities this model delivers. The proposal will see the two GP practices co-located, sharing some accommodation e.g. reception, waiting, meeting, generic consulting rooms whilst retaining their individual identity and any bespoke non common areas.

2.20 Zone Team

The zone team will move permanently into the underutilised area of the existing hospital (existing kitchen and offices). This will be fitted out for office accommodation which will be in addition to that provided for some staff in the GP area (e.g. district nurses). The Zone team Manager is happy with this proposal.

2.21 Public amenities and development of the 'heart' of the Brixham Site

Freeing up the Portakabin in the centre of the site will allow for the development of a 'social hub' something the council asked the Trust to consider as part of the planning permission conditions. This space will be used for the provision of a shop, retail pharmacy and café which will both support the local neighbourhood, the services and staff on the site and also provide income to the Trust as part of the business case and revenue model. There is currently no café or retail activity on the site. The scheme will also include a public realm improvement in the form of a community public right of way walkway through the site from top to bottom. Currently this occurs informally

so the scheme will normalise this arrangement with a marked walkway and appropriate lighting. With the GP's locating on the site and the enhanced pedestrian access through the site as dictated by planning the footfall on the site will increase, thereby creating an income opportunity for the Trust.

The planning approval for the St Kilda building also included the required number of parking spaces as required by the Local Planning Authority (LPA). The Trust has acknowledged that further parking needs to be including on site if the GP scheme and the relocation of the health and social care team is to take place. A parcel of unused land has been allocated at the bottom of the site near the Greenswood Road entrance to increase parking. A scheme from the Trust capital programme will be progressed in the next two years to reconfigure the parking and provide appropriate capacity working closely with the LPA.

The proposed site development and parking configuration plans are shown in the diagrams below and overleaf.

Diagram 6. St Kilda and heart of the site

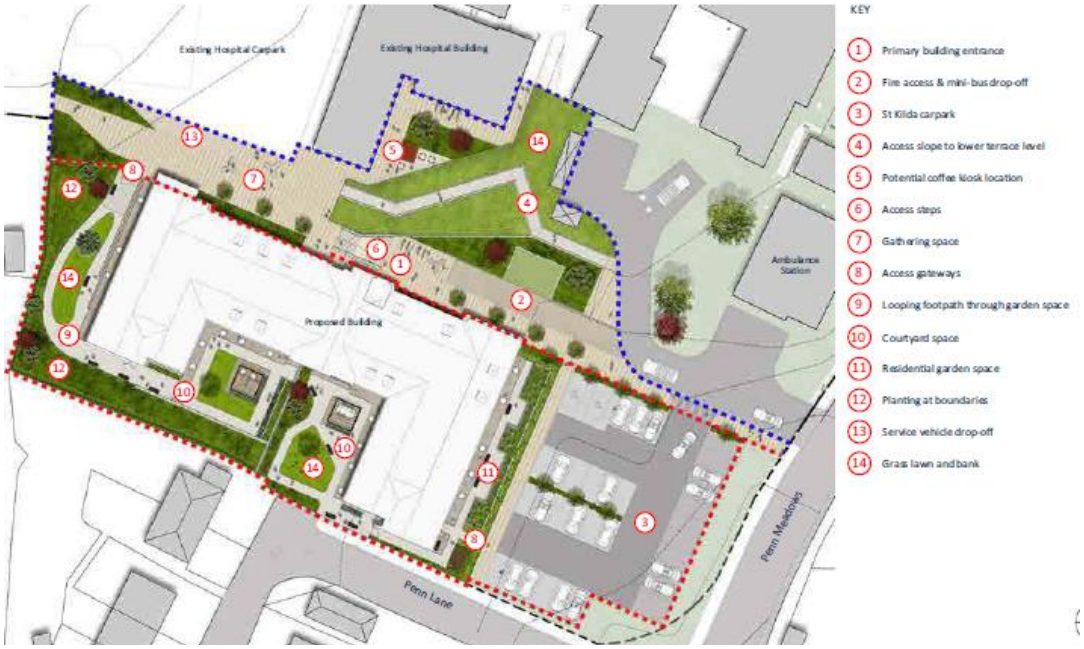
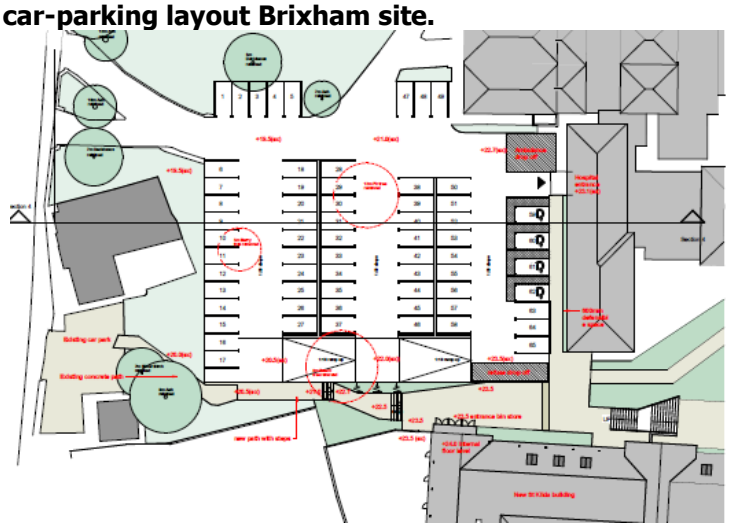


Diagram 7. Revised car-parking layout Brixham site.



2.22 Service Delivery Model

There are a number of service models that the Trust has considered for the operation of the new 36 bedded integrated facility.

1. Contract the entire service delivery to the independent/private sector

The Trust has considered the option of contracting out the entire provision of local inpatient care delivered in the new facility to the private nursing/ independent Sector. There are a number of key issues that render this not the preferred option.

- **Stakeholder support.** This option is not supported by any of the local stakeholders who are very proud of their local public sector NHS and social care services.
- **Likelihood of delivery.** Because of the different funding routes, different regulators, uncertainty of financial flows relating to spot purchasing and the dramatically changing health and social care landscape it is unlikely that any private/independent provider would take the risk on the service delivery without a block contact in place.
- **Risk to the Trust.** Contracts would be required to be sophisticated and actively managed, the community would lose a significant amount of flexibility and control over local services, loss of local support would significantly affect the Trust's reputation. No precedent for provider contracts for mixed health and social care.
- **Future flexibility and benefits to the community**. Because of the nature of the service model, flexibility is the overriding requirement. There is unlikely to be a contracting mechanism and model with the private sector that would allow the degree of flexing up and down and changes to staffing mix required to manage the needs without having to constantly re-negotiate contracts. There are few discernable benefits to the community and this does nothing to integrate services across the wider community and external to the building.

2. Retain a mixed economy of delivery.

The Trust has considered the option of asking the independent sector to provide social care services whilst the NHS retains the responsibility for the health delivery. The Trust would be unlikely to find a service provider willing to take a risk on a small bed base with no surety of income due to spot purchasing. This option is even less favourable than Option 1 in that it has all of the risks of Option 1 and in addition generates none of the savings arising from fully integrated services and would result in no additional investment in the community. This option has been excluded on the grounds that it delivers none of the objectives.

3. The NHS to manage the integrated service delivery

This option means the Trust and the health and care community retain control over the delivery of services and more importantly the ability to flex beds numbers and staffing numbers up and down appropriately according to need with no changes to contract mechanisms. Savings and investment in the community are delivered and realised by the integrated staffing model. This model is the preferred delivery option for the new St Kilda's development.

Integrated Staffing Model

Work has been undertaken on the optimum integrated staffing model with the Brixham Community Hospital Matron and the Zone team Manager. The finances are modelled on a base

of 18 community hospital beds and 18 social care beds. Increases in nursing beds over and above this level will increase the trained nurse staffing requirements and therefore costs. Increases in social care beds will increase the requirement for AHP's whilst reducing the need for trained nurses and overall costs. The costed integrated staffing model for 36 beds is shown in table 4. below.

Table 4. Integrated staffing model

Health Beds	18		
Social Care/Int Care Beds	18		
Total Beds	**36**		
Health Beds			
Number of Beds	18	Number	Ratio
Skill Mix based on 1.2 per bed	21.6	Q12.6	58%
S/C 0.5 HCA per bed	9	UQ9	42%
Total wte	**30.6**	**21.6**	

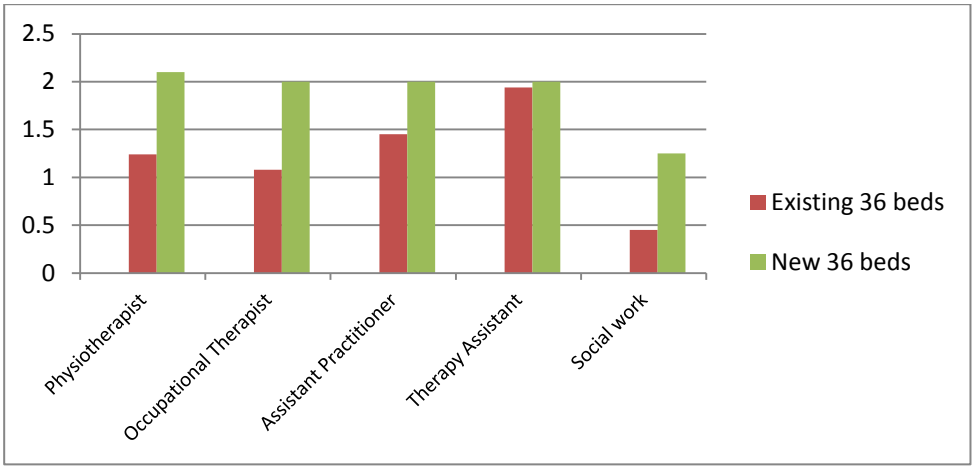
Care Posts	**Grade**	**WTE**	**Amount**
Matron	8a	0.84	**£**
Ward Manager	7	1	
Qualified Nurse	6	2	
Qualified Nurse	5	9.6	
HCA	4	2	
HCA	2	7	
Qualified Nurse	5	1.5	
HCA 18 beds	2	9	
Total		**32.94**	**1,051,803**

Other Post and Pay inc GP costs	**Grade**	**WTE**	**Amount**
Locality Business Manager	5	1.00	**£**
Admin	2	1.50	
Anciliary	3	1.20	
Anciliary	1	7.00	
Total		**10.70**	**352,458**

Other Community Staff	**Role/Grade**	**WTE**	**Amount**
Physio	7	0.6	**£**
Physio	6	1.5	
PAMS	3	2.0	
OT	6	2.0	
Care assistant	4	2.0	
Social work	7	0.4	
Social work	6	0.8	
Total		**9.3**	**306,381**
Grand Total		**52.9**	**1,710,641**

To compensate for the reduction in beds an increase in the establishment of professions allied to medicine has been included to enhance rehabilitation and get people home quicker. The difference in AHP numb ers is shown in Graph 1 overleaf.

Chart 1. Wte therapies as costed in the new service model compared to existing



The staffing model is compliant with the 1:8 registered nurse per hospital bed National Quality Board safe staffing standards. Brixham Community Hospital Matron and the Zone team Manager are both fully supportive and very excited about this proposed new model of care. The team are confident that the model meets the needs of the clients and is an innovative solution that will improve patient experience and outcomes. Work streams will be put in place to work through how exactly the 36 beds will operate across the two floors of the building.

2.23 CQC Registration

The new building will be required to have dual registration for NHS and ASC. We have consulted CQC and secured legal advice such that the Trust is confident that it can legally dual register the proposed model of care. As with any registration the Trust would be required to safeguard the health, safety and welfare of service users, by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. There is no requirement in ASC for a specific ratio of care staff to residents or for specific shift patterns. This is because each home differs and so do the needs of the people using the service. Ultimately, it is the providers' responsibility to ensure staffing levels are appropriate in order to meet the needs of people using the service at all times. The staffing model proposed has considered, and on-going staffing levels will need to ensure, continued consideration of:

- The dependency needs of people using the service.
- Skills of the staff
- Layout of the home
- Ratio of carers to support staff. For example, domestic staff, evening catering staff, activities organizer.
- Changing needs of residents. Staffing levels are not necessarily static but are variable dependent upon changing needs. For example, if there are residents who are ill and require a lot of support or someone just to sit with them in their rooms. What may have been a satisfactory staffing level at one point may not be at another.
- Variations during the day. For example, peak periods or periods when less staff are needed, maybe when people are out during the day.
- Whether commissioning arrangements stipulate specific staffing for an individual. For example, one to one staffing for particular individuals for a particular activity.

- Whether or not staffing levels are maintained at an adequate level, for example whilst staff are undergoing training.

We will have an on-going dialogue with QCQ on operating the specific arrangements for the facility in due course and as the full business case and building develops.

2.24 Delivery

The development of the site will be phased according to the build phases. The programme for the new build St Kilda is shown in Section 4. Phase 1, the first quick win will be the new configuration of parking at the entrance of the site to mitigate any loss of car-parking spaces during construction. Reconfiguration of the existing inpatient area for the GP services will follow the commissioning of the new build.

3 Financial Case

The financial case for the investment sets out the capital costs and financing options, revenue costs and overall affordability of the St. Kilda development, affordability, impact on the balance sheet and sensitivity analysis.

This business case is funded by health revenue (income from community hospital beds) and adult social care revenue (income from residential and intermediate care beds). The model also ensures that proportionately some of the savings from a reduction in beds will be re-invested in community services to support people at home.

3.1 Capital Costs

The budget cost for the total scheme is set at a maximum of £7m. The St Kilda's element is c£6.2m. A contribution of £800k from Brixham Hospital league of Friends will contribute to the funding of this development.

3.2 Capital Cash flows

The outline project plan the new St Kilda development is detailed in Section 4 of this business case. Table 5 details the capital cash flow requirements for the whole site developments including parking, GP services and Zone team accommodation.

Table 5. capital cash flow £6.123m new St Kilda's and site development together with GP surgery, zone team accommodation and parking re-configuration.

	St Kilda's & site devt	Parking	GP	Zone team	Totals
	Spend (£m)	Spend (£m)	Spend (£m)	Spend (£m)	Spend (£m)
2014/15	391	250			**641**
2015/16	4,079			200	**4,279**
2016/17	1,522				**1,522**
2017/18	131		350		**481**
Total	**6,123**	**250**	**350**	**200**	**6,923**

Further design and detailed costings will be developed for the detail on the Zone team and GP accommodation and a value engineering exercise will be undertaken during the detailed design with a view to maximising value for money.

3.2 Source of Capital Funding

The primary source of cash for capital investment, in addition to that financed from internal resources, is through interest bearing capital loans accessed through the NHS TDA with final approval being provided by the DH. However, in exceptional circumstances, where loans are deemed unaffordable, the NHS TDA may approach the DH to provide funding in the form of PDC.

The Trust will apply for exceptional PDC (Public Dividend Capital) to fund this investment. The case for exceptional PDC is summarised below:-

- As the Trust is going through a divestment process, there is an element of financial risk to the repayment of a loan
- The development is a novel service reconfiguration which will make a step change in integrating community health services with primary care and social care
- The scheme delivers real and deliverable savings in health and social care costs in the future

However, should the Trust's application for PDC funding be unsuccessful, the Trust will apply for an interest bearing loan. Both sources of funding have been tested in this OBC to demonstrate the overall affordability of the investments. For the purpose of this OBC it is assumed that the loan will be for a period of 20 years at an interest rate of 2.87% (this is the current NLF rate at the time of writing).

The primary source of capital will be a loan sourced for £6m. Other capital costs will be funded through the Trusts operational capital.

3.3 Revenue Costs: Income assumptions

The revenue costs of the development and the service model that will be delivered from the new facility will need to be affordable within the income streams from two sources: health revenue (income from community hospital beds) and ASC revenue (income from residential and intermediate care beds). The income assumptions incorporate the Torbay Council required savings of £320k in 2016/17 from the existing St. Kilda block contract and the NHS 4% efficiency expectation.

The financial model includes the cost of running the new configuration of services plus cost of capital for the new build, GP premises and Zone team accommodation plus investment in the community; minus rental income from the GP practices and retail, and any direct system benefits/savings of this model of care. The costs of the new service have assumed an even distribution of beds for people receiving health care and those receiving social care. The new facility is designed to operate flexibly between health and social care. Staffing for health beds requires a higher proportion of registered staff. This is considered a prudent financial model as in practice, the need is likely to be for fewer "community hospital" type beds and more intermediate/social care beds. The costing model is based on the National Quality Board's recommendations of 1 registered nurse per 8 hospital ward beds.

The financial summary of the revenue costs and income for the preferred option in the first full year of steady state operation is set out in Table 6 overleaf for both potential funding options;

Table 6 Revenue costs and income for preferred option

	Option 4 18 Health beds/18 Res/Nurs/IC Beds	
Bed Numbers	**PDC Funded**	**Loan Funded**
Health	18	18
Intermediate/Social care	18	18
	36	**36**
Income	**£000**	**£000**
Opening Contract Income	2,784	2,784
Less: ASC savings	(320)	(320)
Less: NHS CIP	(42)	(42)
GP Service charge income	214	214
Practice rent	120	120
Retail income	76	76
Total income	**2,832**	**2,832**
Operating Costs		
Pay	1,711	1,711
Non Pay	369	369
Depreciation on new assets	123	123
Depreciation on existing assets	164	164
Total Operating costs	**2,367**	**2,367**
Operating Surplus/(Deficit)	**465**	**465**
Financing Costs		
Interest on loan	-	166
PDC dividend	210	53
Total costs	**210**	**219**
Overall Surplus/(Deficit)	**255**	**246**

The overall loan interest payable at the current rate would be £1.751m. The financial model in table uses the interest payable in the year 2015/16, however the interest payable will reduce as the outstanding loan principle is paid off each year, thereby increasing the level of surplus in the preferred model.

For the purposes of this business case, we have simplified the calculation of the PDC dividend payable and made the assumption that there will be a net overall increase in assets of £6m and therefore additional PDC dividend will be payable on this value. Depending on construction timelines, PDC dividend will become payable from 2015/16 but will be based on the value of the asset under construction at that point (c£4.5M) and would produce a divided requirement of c£0.158m. The full dividend of £0.210m will be payable from 2016/17 when the asset is fully constructed and in use.

The annual fixed principle repayment of £300k for 20 years is a purely cash transaction and not charged to operating costs. This would be financed through the Trust's capital programme and movements in working capital to generate the cash required to fund the repayments. The overall impact on the Trust's balance sheet and cash flow is set out below

Under the loan financed option, the initial PDC dividend payable would be reduced as the loan (liability) will in fact reduce the value of average net assets. Once the asset is fully valued and bought into use on the balance sheet there will be an outstanding loan to offset the increased fixed asset value and therefore overall PDC dividend payable. The costs in Table 7 have used

the asset value of £6m less the loan outstanding at year 5 (£4.5m) and assumed PDC dividends are payable on the net £1.5m. Over time as the loan is repaid, the offset is reduced and PDC dividends will increase.

A full income and expenditure model for the life of the project will be produced for the final business case. Depreciation on the new build and equipment is estimated at £123k per annum and is based on a building life of 50 years and fixtures, fittings and equipment lives of 15 years. The GP practice and rental income are based on estimates provided by the District Valuer and are considered prudent. Any additional income achievable through this route would form an upside in the final business case (FBC).

The financial model demonstrated that the scheme is affordable and delivers recurring cash savings in health and social care. There is a net surplus which can be used to further invest in community health services or to deliver further CIP savings in future years.

3.4 Impact on balance sheet and Liquidity

Table 9. sets out the Statement of Financial Position: -

i) Before the capital scheme
ii) After the capital scheme is completed based on PDC funding
iii) After the capital scheme is completed based on loan funding

Table 7. Statement of Financial position

Statement of Financial Position	Option 4 18 Health beds/18 Res/Nurs/IC Beds		
	Current £m	PDC Funded £m	Loan Funded £m
Non-current Assets	64.8	71.7	71.7
Current Assets			
- Receivables etc	4.4	4.4	4.4
- Cash	2.9	2.0	1.7
Total Assets	**72.1**	**78.1**	**77.8**
Current Liabilities	10.8	10.8	10.8
Non-current Liabilities			
- Loan (St K)	0	0	6.0
- PFI loan	20.3	20.3	20.3
Total Liabilities	**31.1**	**31.1**	**37.1**
Total Assets Employed	**41.0**	**47.0**	**40.7**
Taxpayers Equity			
Public Dividend Capital	(2.4)	3.6	(2.4)
Retained Earnings	29.2	29.2	28.9
Revaluation Reserve	14.2	14.2	14.2
Total Taxpayers Equity	**41.0**	**47.0**	**40.7**

Table 8. overleaf shows the impact on the Trust's cash position based on both funding options:-

Table 8. Cash position

Cash Flow	Option 4 18 Health beds/18 Res/Nurs/IC Beds		
	Current £m	PDC Funded £m	Loan Funded £m
Surplus/(Deficit) from operations	4.2	4.7	4.7
Movement in working capital	0.3	0.3	0.3
Net cash inflow/(outflow) from operations	**4.5**	**5.0**	**5.0**
Cash flow from investing activities	**(2.1)**	**(9.0)**	**(9.0)**
Cash flow before financing	**2.4**	**(4.0)**	**(4.0)**
Cash flow from financing activities			
- PDC received	-	6.0	-
- Dividends paid	(1.1)	(1.3)	(1.1)
- Interest paid on loans	(1.8)	(1.8)	(2.0)
- Drawdown of loans	-	-	6.0
- Repayment of loans	(0.6)	(0.6)	(0.9)
Net cash inflow/(outflow) from financing	**(3.5)**	**2.3**	**2.0**
Net cash inflow/(outflow)	**(1.1)**	**(1.7)**	**(2.0)**

3.5 Impact on CIP/Future capacity

The Adult Social Care (ASC) and NHS CIP (recurrent savings) requirement is delivered in the current preferred option. Any ongoing organisational CIP requirements will be achieved through continued service redesign and operational efficiency. It is envisaged that the preferred option will provide enough flexible bed capacity to cope with future demand. However, should demand increase, there is sufficient headroom within the business case model to spot purchase additional independent sector beds should the need arise in future.

3.6 Impact on Continuity of Service ratings

The impact of either financing option would not adversely impact on the Trust's Continuity of Service rating.

3.7 Finance Summary

The Trust is confident that the scheme is both deliverable and affordable in the short and longer term. The new service model delivers savings from integration such that it is viable within the reduced ASC and Health budgets. The model includes nursing at the required 1:8 ratio and encompasses a significant increase of AHP and support services for the bed base. In addition it delivers a surplus, a proportion of which could be used for further investment in community services and for funding the on-going year on year 4% CIP requirement.

4. Commercial case

4.1 Construction Procurement Methodology

The Trust has already successfully secured planning permission and has a scheme designed to RIBA stage D. Together with Sweets, cost advisors the Trust has been working on the best value for money procurement option for delivering this scheme.

The options are:

Private Sector Procurement: In the absence of successfully securing public sector capital the Trust could source a private sector partner for the development. It is a small scheme and therefore not attractive to the market nor would a private sector build be particularly beneficial for the Trust at this time, unless capital was needed. The prohibitive costs of a PFI on a small building would not be best value for the Trust.

Procure 21: Procure 21 is a method by which pre-selected partners can be selected for an NHS build on a pre-agreed schedule of rates, which is usually above the competitive market rates but provides costs certainty particularly important with large schemes. P21 partners are national construction partners who do not normally have a local presence or supply chain. P21 is of most benefit with large scale developments £50 to100m+ where specific expertise is needed and where they are able to get involved early in the design stage, none of which is relevant in this case.

Conventional design and build: The Trust will be looking for a reputable construction partner with a local supply chain, procured from a local framework who has the capacity to deliver this relatively small development in a relatively difficult to access area. The Trusts preferred option therefore is to commission Kay Elliot as the architect following a market testing exercise and to undertake a two stage design and build process culminating in a NEC from of contract which will allow the Trust to secure value for money and deliver a guaranteed maximum price (GMP) and cost surety but secured though the competitive market place rather than through fixed rates.

4.2 Project Plan

The indicative delivery timetable for the St Kilda's element of the project is shown below in table 9. with the full programme shown in Annex 3. This is an indicative programme pending tender return and the team with and contractors will be working together with the aim of pulling the programme forward wherever possible.

Table 9. High Level Project Timetable

Phase Component	Target Date
Trust Board OBC approval	30/07/2014
Invite expressions of interest from contractors	04 /08/2014
Issue first stage tender	15/08/2014
First stage tender return	18/09/2014
Award preferred contractor	06/10/2014

Phase Component	Target Date
Start 2nd stage negotiations	6/10/2014
Design development from D to F and to GMP	06/02/2015
Secured funding and Trust Board FBC Approval	25/02/2015
Start on site	30/03/2015
Completion	24/06/16 (65 week contract)
Trust Commissioning/fit out	27/06 to 19/08 2016

As the size of the scheme exceeds the Trust's delegated limits of authority for approving capital investment (currently 3% of turnover, i.e. c£4.5m), this OBC and subsequently FBC and source of funding will need to be approved by the Trust Development Authority (TDA), which may impact on this timetable.

4.3 Service model and TUPE transfer

TUPE (Transfer of Undertakings, Protection of Employment) will be applicable as a consequence of this proposal for staff currently delivering social care services in St Kilda's and employed by Sandwell. The Trust has already received the TUPE list and will be working closely with Human resources and the staff through the transitional period into the new scheme with a project plan to manage the process of the SCCT staff at St Kilda transferring back to the NHS. Sandwell staff have been part of the consultation process to date. During the year before the envisaged new building opens this work will occur in earnest. We will also involve workforce planning in establishing a new staff model built on flexibility outlined above to ensure we have a workforce fit for purpose in delivering our objectives. The Trust is confident that it can accommodate staff transferring into the Trust either in the new St Kilda or deployed into other vacancies across the Trust. By the time the TUPE transfer is applicable the ICO will be in existence and consequently there will be a larger pool of potential vacancies and opportunities.

5 Management Case

5.1 Communications Plan

Stakeholder engagement and communication will be absolutely essential in the successful delivery of the St Kilda's project and Brixham site development. The public and the Trust's and Sandwell's staff will need to be kept continuously informed of progress and developments and the consultation precedent already established will need to continue.

The communications team will be actively involved and with the support of the sub-groups, Head of Operational Change and the Director of EFM will lead the communications process. A comprehensive communications plan is currently in development.

The Objectives of the communications plan can be summarised as:

- To communicate the proposed changes to the configuration of services on the Brixham Hospital site to our staff and key stakeholders, including patients and members of the public, in a clear, open and timely way

- To highlight improvements.
- To maintain the confidence of staff, patients, and the public that public money is being spent appropriately
- To ensure that stakeholders understand the need for the change and the principles and benefits of the new service model.

Our communication will:

- Be targeted to, and respectful of, the needs of our different stakeholder groups
- Be clear, timely, professional and honest
- Allow opportunity for feedback.

During our communications process we will lean the following lessons from research into implementing new integrated care models.

- Ensuring that new partnerships and integrated services are developed in such a way that the different professions and agencies involved understand their aims and objectives, and appreciate the relevance of the initiative to the local context.
- Involve operational staff in initial discussions about such ventures is one way to overcome misconceptions about new services, while regular meetings provide an opportunity to develop policies and procedures as well as offering a setting to resolve problems and review practice.
- Transparent and appropriate management arrangements are vital to the success of any joint working venture. Clearly articulated and effective managerial structures, that incorporate both professional as well as organisational managerial support, appear to be associated with staff feeling more secure and confident in their new roles and working contexts.
- Successful joint working requires practitioners to reconcile their professional values and roles with the aims and objectives of the joint initiative. One way to achieve this is to ensure that the outcomes for service users and carers are made explicit from the start, so that practitioners appreciate the benefits of the joint activity to those they support, and progress can be monitored routinely.

Communications to date

Torbay CCG, NHS England (LAT), Torbay Council, the Zone team Manager and Community Matron and all the GP practices in Brixham have been fully involved in the development of the concept and are currently working on the details. They are all fully supportive and excited about the proposals, and are confident that others will also see the benefits.

Stakeholder support CCG: Commissioning colleagues have been briefed with respect to the development of the scheme and are very supportive of the new model of care and integration which reflects the ethos of Pioneer approach. The CCG and NHS England support the primary care elements of the scheme from both the integration perspective and that the move to the site would resolve estates issues for the two practices concerned who are both significantly under size and trading in sub- standard accommodation for some years.

Stakeholder support Torbay Council: The Council are equally supportive and the Adult Social Care Programme Board has been kept informed of the general progress of the project. Updates have been given to various council committees. The Health and Wellbeing Board will be kept fully aware during the FBC and the build.

SDHFT approval and ICO: This scheme will be a legacy transaction for the ICO, thus we will also wish for the Board's approval of the business case to be endorsed by the SDHCFT Board. All stages of the approval process will need to go via this route from this stage onwards.

Staff consultation: The Trust has kept staff informed throughout the development of this scheme over its duration at regular intervals. In recent weeks staff briefing have taken place with the St Kilda staff group, the nursing staff at Brixham hospital and the Brixham health and social care team. Staff have been fully briefed with regard to the scheme and have been assured that regular updates will occur over the next two years of project implementation.

5.2 Governance

Project management arrangements for the delivery of this project is headed by the Director of Estates as Project Director supported by the established staff and public sub-groups who will continue to be instrumental in the development, delivery and communication of the final solution. The Team will continue to be supported by Finance. Additionally, the Trust intends to appoint External Consultants such as Cost Advisors and Consultant Services to advise on specialist areas where a resource does not exist within the Trust.

In addition to the Head of Operational Change, who will retain an interest on this project, a full time dedicated and experienced capital Project Manager will be appointed to lead the project, to deliver the preferred option on time and within budget, and in accordance with all necessary Trust and industry requirements using PRINCE 2 methodology. The principal element of this role will be to coordinate and communicate the users' and stakeholders' requirements and oversee the detailed design and phasing of the delivery. A formal Project Board will be established, reporting to the Finance and Operations committee. Workstream 5 and the Capital and Infrastructure Steering Groups CISIG will also receive regular updates on progress against plan.

Project development and governance are overseen by the Project Board (which will meet monthly). The Board will oversee all the project governance requirements and all key project documentation, including risk registers, project programme and financial records etc.

5.3 Risk management arrangements

The scheme will be implemented under robust project management arrangements which will include active risk management using recognised guidelines. The project will maintain a risk register and issues log in which recorded risks will be assigned a severity and appropriate remedial or mitigating action identified. The Risk Register and Issues Log will form part of the Project Director's regular report to the Steering Group and the Trust as appropriate.

To ensure linkage with the Trust's wider corporate risk arrangements, the Trusts project lead will ensure that any risks that are pertinent to the corporate risk register are notified to the Company Secretary.

The following Risk Management framework has been established by the Trust for the identification, evaluation and mitigation of project risk.

Table 12. Risk Register template

HEADING	ACTION
Risk Identification	Initial listing of risks applicable to the scheme and preparation of Risk Register
Risk Evaluation	Allocation of cost and/or time estimates to identify risks.
Risk Analysis	Analysis of the cumulative effect of the cost and/or time consequences of the evaluated risks.
Risk Mitigation	Provision within the procurement strategy and project management procedures for methods of responding to or accommodating cumulative risks.
Risk Management	Management if individual risks as they occur through established project management/risk management procedures.
Risk Reporting	Regular review and updating of Risk Register throughout the project and incorporation of adjustments to risk mitigation procedures and risk management activities.

An extensive Risk Register will be drafted in conjunction with the Project Team which will form the basis of a continued risk reduction process from OBC stage through to completion setting out key decision dates.

The Risk Register will be reviewed on a regular basis by way of individual input and by joint input at designated risk workshops. Each risk will have a "risk owner" who will be tasked to mitigate the identified risk at or before pre-arranged dates such that that risk does not present an unacceptable risk moving forward.

5.4 Benefits Realisation Programme

The benefits realisation of the changes for the proposed new St Kilda included in this Business Case will be fully assessed and incorporated into the FBC.

5.5 Benefits Realisation Programme

Following the completion of the project, as assessment will be made of the effectiveness of the scheme by carrying out a post project evaluation (PPE). The main objective of the PPE will be to assess the benefits that are being or have been derived from the project, compared with those that were envisaged in the business case. Post project evaluation (PPE) will be consistent with relevant good practice such as the requirements of the Capital Investment Manual and the Department of Health's Good Practice Guide 'Learning Lessons from Post Project Evaluation' (January 2002).

5.6 Conclusion

This OBC brings together all the components of an integrated care facility that is both economic and innovative in its care model and delivery. The scheme, as now configured, allows the Trust to honour its long-term promise to the Brixham community to rebuild St Kilda but with a care approach that is future proofed and aligned to national policy and the ICO's objective and raison d'etre; to deliver integrated solutions to meet the needs and future demographic challenges of the local population.

This case fits with the Trust's objectives of improving the patient experience and quality of care, working in partnership and the strategic vision for the Trust and integrated care organisation. It is affordable and within the financial model and constraints of the capital programme presented as part of the LTFM and business case for the Integrated Care Organisation.

5.7 Recommendations

The Torbay and Southern Devon Health and Care NHS Trust Board are asked to approve this OBC, and specifically:

- Approve the preferred Option D, service delivery model set out in section 2.22, and the funding route (interest bearing loan or PDC).
- Subject to the receipt of letters of support from the Trust's commissioners and endorsement by the Board of SDHCT at its August meeting, approve the submission of the OBC to the NHS TDA Director for formal approval to proceed to FBC.
- Approve the commencement of the procurement process and commitment of £319,000 of 2014/15 operational capital at risk to develop the detailed design.
- Note the intention to provide a Full Business case, construction contract and loan/PDC application for final approval by the Trust Board in February 2015.