NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
27th August 2020

Subject:	**Arran Integrated Island Services – changes to Initial Agreement**
Purpose:	The Integration Joint Board are asked to approve the changes to the Initial Agreement.
Recommendation:	Members are asked to note the changes on Arran over the last four months and support re-submission of the initial agreement to Scottish Government.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IA	Initial Agreement
CIG	Capital Investment Group
SCIM	Scottish Capital Investment Manual

1.	**EXECUTIVE SUMMARY**
1.1	This report provides an update on the re-formatting and updates carried out on the Arran Integrated Island Services Initial Agreement after comments received from the Scottish Government Capital Investment Group in February and March 2020.
2.	**BACKGROUND**
2.1	Following submission of the Initial Agreement for "Arran Integrated Island Services" to Scottish Government Capital Investment Group (CIG) in November 2019, it was noted that the format deviated slightly from the standard guidance contained in the Scottish Capital Investment Manual (SCIM) and NHS AA were requested to address this.
3.	**PROPOSALS**
3.1	The current version of the IA (Version 2.7 Reformatted) now aligns specifically to the SCIM guidance. This has been done by changing the order in the document of the various sections. There have been a couple of smaller changes within the document itself to link sections appropriately. One section has been added to address the possible disposal in the future of any existing buildings.
3.2	As the document is to be re-submitted to CIG, after the peak of Coronavirus and all of its resultant change requirements, it was considered that an opening section to the IA should be created to reflect the changes/accelerated service change and models of delivery and accelerated facility closures that have taken place since the original IA was submitted.

3.3	A summary of the changes are noted below :- • IA content retains 99.9% of the original content but in a slightly different order. Some linking sentences/paragraphs have been inserted to improve flow of information • All costs remain as per the original document previously submitted through NHS A&A internal governance. • Construction Cost indices have been updated but this has had no impact of the original cost projections • One new section reflecting on the changes required by Covid 19 confirms the new model of care described in the Initial Agreement. In addition the necessary temporary facility closures due to Covid 19 have also supported and tested the new model and proven how some of the efficiencies with new ways of working can be delivered. • One new section, not in the original IA, notes that some facilities will be available for disposal following successful completion of the project.
3.4	**Anticipated Outcomes**
	It is anticipated that the Arran IA will be approved by the Scottish Government to move to the next stage of the SCIM process i.e. to develop an Outline Business Case.
3.5	**Measuring Impact**
	This Initial Agreement precedes the Caring for Ayrshire Programme Initial Agreement and is seen as being closely aligned to this initiative and is potentially an early example of what will be agreed for the mainland.
4.	**IMPLICATIONS**

Financial:	Costs remain same as in initial agreement considered by the Integrated Joint Board on 20th June 2019
Human Resources:	No staffing implications.
Legal:	No legal implications.
Equality:	Not applicable
Children and Young People	Not applicable
Environmental & Sustainability:	Not applicable
Key Priorities:	Not applicable
Risk Implications:	Delivery of integrated plans for Arran locality will be impacted without support for the Arran IA.
Community Benefits:	Not applicable

Direction Required to Council, Health Board or Both *(where Directions are required please complete Directions Template)*	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	x

5.	**CONSULTATION**
5.1	The Board has carried out its duties to involve and engage external stakeholders where appropriate through the project group.
6.	**CONCLUSION**
6.1	Members are asked to note the changes that have occurred on Arran over the last four months and support re-submission of the initial agreement.

For more information please contact Ruth Betley on 01770 600777 or ruth.betley@aapct.scot.nhs.uk

North Ayrshire Health and Social Care Partnership

Arran Integrated Island Services

Initial Agreement

Version 2.7 (20th July 2020)

Version Control Table

Version	Date Issued	To	Content
1.4	11th Feb 2019	Steering Group	Initial Draft for Comment
1.5	5th Mar 2019	Hub South West	Revised draft incorporating comments and changes from SG members
1.6	18th Apr 2019	Hub South West	Insertion:- Model diagram; Paragraph relating to the Plaque in the AWMH; Inclusion of all Costings
1.7	17th May 2019	Steering Group	Final SG changes
1.8	11th Jun 2019	Steering Group	Final Version
1.9	12th July 2019	Infrastructure Programme Board	Revised to include updated Finance section relating to revenue costs and Governance programming
1.10	22nd Aug 2019	Caring For Ayrshire Board	Revised to include reference to Caring For Ayrshire Strategy
1.11	5th Nov 2019	Performance Governance Committee	Revised to include comments relating to workforce numbers.
2.1	27th Apr 2020	Steering Group	Reformatted version
2.2	2nd Jun 2020	Steering Group	Reformat with Covid 19 Learning
2.3	11th Jun 2020	Steering Group	Retitle and Indices updated p86 as per Currie & Brown update
2.4	14th Jun 2020	Steering Group	Remove Covid Action Plan as an appendix as per RB 12/6 email
2.5	18th Jun 2020	Steering Group	Retitle and changes from CfA team
2.6	17th Jul 2020	Steering Group	Timetable amendments
2.7	20th Jul 2020	Performance Governance Committee	Timetable updated for governance and business case production.

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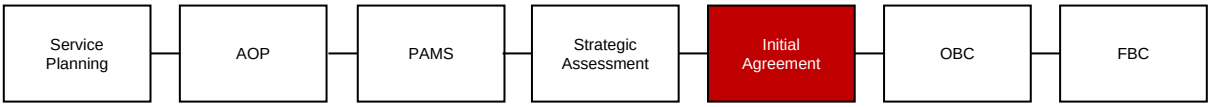


1 Executive Summary

1.1 COVID 19

During the process of submission and comment on this Initial Agreement (IA), the COVID 19 pandemic occurred requiring all health and care services to immediately develop and implement new and innovative ways of working. It is important that, with the resubmission of this IA, it now reflects changes in existing services and highlights the differences in the model of care that have been developed to cope with these extraordinary circumstances. Key service model changes include: -

- Staffing – accelerated integration of nursing teams with all aspects working together during crisis – practice nurses, community nurses and hospital
- Coordination Centre – acting as a single point for coordination of all island health and social care services to assess capacity and meet pressures due to operational challenges of COVID e.g. staff self-isolating, PPE, redeployment of staff from e.g. physio to assist in hospital
- NHS Near me – move to all appointments by phone or NHS Near me – reduction in requirement for sites for GP and nurse consultations
- Three GP practice sites closed
- Care at home and community nurses integrating to provide e.g. palliative care at home and facilitate early discharge
- Zero delayed discharges facilitated by care at home, community nurses and Multi-disciplinary hospital at home
- Vulnerable and frailty lists assessed, and Anticipatory Care Plans developed and put in place at pace
- Adoption of virtual team meetings meaning a reduction or removal of some proposed meeting rooms that are now considered no longer necessary
- New nursing rota tried and tested to accommodate COVID and non COVID ward areas and sustain essential services eg Urgent Unscheduled Care Services
- Care homes supported with enhanced clinical input and advice regarding COVID
- Voluntary/Community Hub established to support most vulnerable and isolated with medication delivery and food packages
- Arran CVS established Keep Arran Talking Service for all island residents

Some of the above relate to specific learning and changes implemented by the Health & Social Care team on Arran itself but many of these changes resonate on a wider scale across Ayrshire & Arran and all Scottish Boards. They also reflect more global changes in care across the world, and some of these are noted in a new publication in May 2020 from the International Foundation for Integrated Care, "Realising the True Value of Integrated Care: Beyond COVID-19. Key challenges and ideas on future delivery of care noted in the document include:-

- The current innovative and risk enabled inter-professional ethos augurs well for workforce reform. We have a unique opportunity to test integrated workforce solutions that will strengthen our systems and lead to better health, better care and better value.
- The evidence of how digital solutions can help deliver care with greater scale, flexibility and sustainability is there for everyone to see and we have a responsibility to act now to ensure we all continue to benefit.
- Network governance models can be used to rethink the way cross-organisational services and joint actions are contracted and funded, coordinated, inspected and regulated, and on how outcomes and benefits are assessed for the care recipient, care teams and the system.

- Just as there is no 'one size fits all' model of integrated care that suits all ambitions, situations and contexts, there is no one single tool or approach that can be used to measure the progress, results and impact of an integrated care initiative which consists of a number of interrelated interventions, rather than a single one.
- Our goal as a society must be to strengthen and accelerate efforts towards universal access, and crucially to address the determinants of health on a global scale.
- Harnessing the power of multi-sectoral, interdisciplinary, collective action, begins through co-creating shared values, societal goals and vision amongst all partners.
- We need to take advantage of the current appetite for more radical options to transform public services. We need to ensure that they are adequately supported by public funds and institutions and that they are shaped by the people who need them.
- The current pandemic has heightened our sense of solidarity and illustrated that we cannot overcome a crisis of this scale on our own.
- Health and care workers are our greatest asset, working alongside family carers, community partners and local networks of support. However, without reforms, sustaining the workforce is also one of our greatest challenges.

The changes implemented to services on Arran are broadly in line with many of these and has provided a confidence in the model going forward. The document has also been attached to this IA at **Appendix T.**

While these changes, have accelerated originally proposed service changes by necessity, there remains a vital challenge on the island in relation to inpatient beds and urgent unscheduled care services being delivered in a separate location from the long term care beds and the pressures that this continues to place on GP's and hospital staff providing cover for both the hospital beds, long term care beds and the urgent unscheduled care service. In that respect the proposed model of care and requirement for a single site for all beds on the island remains the same.

1.2 What is the proposal about?

The integration of Health, Social Care, Third and Independent Services within North Ayrshire provided an opportunity to review how services are provided on the Isle of Arran by local Health and Social Care Teams, as well as by Third and Independent Sector providers. This approach aligns with the Caring for Ayrshire programme of work which is the strategic direction of health and care services over the next ten years in Ayrshire and Arran. This whole system health and care redesign programme will be a collaboration with North, East and South Health and Social Care Partnerships and will align with their individual Strategic Plans. The opportunity to co-produce and collaborate services at a locality planning level will ensure that the local planning of services is informed by staff, public and key stakeholders who deliver and access these services. The Arran Integrated Island Services approach reflects the key elements of the Caring for Ayrshire health and care model and is an integral component of our approach to whole system redesign of services.

To support this review a multiagency, multidisciplinary group was formed to engage members of the public and staff through a review and assessment process.

Using a wide range of consultative techniques, the Arran Review of Services 2015-16 led to a clear consensus on a future model of care. The review provided an overview of current services, need, challenges and opportunities. Detailed recommendations on delivering integration on the island were endorsed by the Integrated Joint Board in May 2016.

Health and Social Care on Arran reflects the structures, staffing and need seen across Scotland. It is a

small-scale example of the complexities and challenges of integration and supply vs demand in a demographically challenging environment. It includes all of the core areas of provision seen elsewhere in the country including hospital services; inpatient beds; urgent unscheduled care services; residential care; day care; home care; social work; community nursing; primary care; dental services; teams, etc and faces the same challenges – frequently to an even greater degree due to specific local circumstances. It is, in effect - and in-line with the island's popular strap line: "Scotland's Health and Social Care challenges in miniature". This means that an effective solution developed for Arran, is likely to have more widespread applications.

Public sector teams on Arran have historically worked separately, under different lines of management and with different budgets. They have used different records systems and have organised care around the capacity and diary of each individual team. They are often geographically isolated from each other, based in several sites across the island, in buildings of variable standard. The teams are small, often a fragment of a larger mainland-based service, and services are highly vulnerable to difficulties with recruitment, retention and sickness absence.

Reflecting national issues and an elderly population with high multi-morbidity, there is already significant difficulty in meeting the need for Health and Social Care on Arran. The dependency ratio, shrinking workforce and additional challenges associated with demographic changes in coming years will have a profound impact on the demand for health, social and long-term care. The current model of care is ill adapted to cope with this.

Over a number of years, the partners on the island have strived to improve health and social care services within existing budgets and ever-increasing demands on services. Primary Care has remodelled itself from multiple practices into one practice to support stresses on the provision of 24-hour rotas and to provide peer-to-peer interaction. This change is already acting as a major enabler, however the on-going use of dispersed and multiple delivery locations across the island limits the impact that could be achieved by situating more services in a single primary delivery point supporting satellite services through other community sites and more innovative ways of accessing services. Bringing services, staff and teams together into a single Hub will support and facilitate the success of the new Model of Care.

This document sets out the proposed development of a new "Hub" concept that would provide this central primary delivery point and include all health and social care beds on the island as well as a service delivery and administration point to enable all partners to work together in one place. By providing flexible and multi-functional space all partners would have the ability to work together, including staff and consultants from the mainland who visit the island regularly. Making maximum use of the estate resource and protecting future service model requirements will allow models of care to evolve and develop in a facility that will serve the population and visitors to the island for many years to come.

It is envisaged that Scottish Ambulance Service will also be part of this hub, with the potential for staff to become integrated into the proposed Model of Care, to enhance the robustness and the sustainability of 24-hour care on the island. By providing flexibility and innovation in health care delivery through integrated and multi-disciplinary teams, significant improvement in the delivery of Health and Social Care could be achieved.

The historical separation of Hospital and Care Home places has placed especially severe pressure on the island's ability to provide appropriate numbers of the required staff in both settings – particularly as these areas represent the balance of 24 hour care services on the island. This is particularly challenging in the face of unpredictable urgent unscheduled care presentations and daunting in the

face of a shrinking island workforce and growing demand. The development of integrated and flexible teams using innovative and forward-thinking care models would support longer-term sustainability of all services across Health and Social Care.

Some physical reconfiguration work has and is being undertaken at the existing Arran War Memorial Hospital (AWMH) to improve unscheduled care access and assessment. This will increase capacity and supports new ways of working including developing advanced nurse practitioner roles. An innovative pilot study, of integrated care, including a new Health and Social care worker role, is on-going and provides a dedicated team member looking after Complex Care cases. Work has begun on the local integration plan and changes are taking place in how teams deliver the services required. However, although these initiatives are improving service delivery today, there still exist major challenges that cannot be addressed within the existing estate configuration which leaves Primary, Social and Hospital care in a fragile state that could easily be disrupted through any loss of staff, staff illness, increased needs within the community, recruitment and retention challenges, a lack of affordable housing or a myriad of other reasons.

The Arran Review confirmed that "the time is right" and change is required now – the services, communities, and the Arran Economic Group, are all committed to change and an extensive consultation supports this view. The key estate facilities are ageing and not fit for the delivery of modern health care and the opportunities to build on recent investment are very real. The challenge has never been greater, and the way forward must lie through integration of the delivery partners on and off the island to support the new Model of Care.

In order to deliver this change, and fully implement the new Model of Care, the on-going creation of a virtual central Hub is essential to embedding the new care delivery services. Although some of the on-going work is making a significant difference, the full opportunities and benefits associated with this virtual hub cannot be realised until it developed into an actual physical entity that supports the physical co-location of all 24 hour services on the island, along with re-developed, integrated multi-disciplinary teams that are also physically co-located.

The defined geographical area, advanced local integration plan and engagement of frontline teams presents an opportunity to rapidly advance HSCP integration and new ways of working on the Isle of Arran. Transforming services is the key driver for the development of a Hub designed around the future model of care and will allow a sustainable vision of health and care to be delivered on Arran. With additional capital investment a new Hub will provide the infrastructure that will support true integration and flexible service delivery to provide patients with seamless Health and Social Care through multi-disciplinary working and sustainable care provision that consolidates all resources – but especially those delivering services outwith normal hours and 24 hours/day – into the same physical locale and under the management of the same single 24 hour team.

1.3 Summary of the Strategic Case

With ever increasing pressures on resource and the need to maintain Primary and Secondary Care services on the island and a fully supported Urgent Unscheduled Care Service, the Board believe that to provide sustainable services on the island, major service redesign and reconfiguration of existing estate has to take place to deliver the proposed model of care.

The key objectives for health and social care services on Arran that must be considered include:

- Flexible, equable, integrated and sustainable hospital, primary care and community services supported by the Integrated Joint Board

- An Arran population that is able to live healthier lives, at home or in a homely setting on the islands for as long as possible.
- The need to plan for all services – but especially acute, hospital-based services – in a local, regional and national context to ensure safety, optimum local delivery, minimal travel (especially off island) and sustainability.
- Urgent Unscheduled Care Service, assessment, diagnosis and a range of sub-specialist care being delivered through a sustainable local Rural General Hospital (RGH) or equivalent on Arran.
- A consolidation of the physical locations delivering beds and 24 hour services.

Along with all other Boards, it is recognised that NHS Ayrshire & Arran is working in a challenging context in which there is a need to balance delivery of quality services with ambitious improvement targets and standards, while also living within the financial realities facing public sector. The need for transformational change is recognised, alongside continuing to delivery safe and effective services of the best quality possible.

In addition, Arran faces particular challenges associated with the sustainability of services and the recruitment and retention of staff, who often work in small teams or single-handed and often in rural areas. Care at Home services are a key area where services cannot meet the demand, particularly in the outlying rural communities.

Staff recruitment and retention is further exacerbated by a chronic shortage of affordable housing. Many homes on the island are used as second homes or for tourist rentals and turnover of homes in this area is very low. The Arran Economic Group had previously undertaken a survey that identified a need for an additional 200 affordable homes on the island. The Group has work ongoing around developing Arran as a place to Work, Live and Visit. This includes discussions with Scottish Government, and North Ayrshire Council. The NAC now has plans to build an additional 32 “housing units” to replace public/community homes.. The newly formed Arran Development Trust charity will apply for SG funding from the Regional Island Housing Fund and if successful this could support the addition of 30 new homes per year over the next 6 to 7 years. This work is critically supported by the integrated relationships that have been developed across the island.

Notwithstanding these challenges, which are being addressed through a range of on-going projects, it is important to recognise that all recent business strategies (including those developed locally, regionally and nationally) underline the requirement for hospital service delivery on Arran and the consequential requirement for a hospital facility to support this.

The proposals contained in this IA can therefore be seen as the natural continuation of a structured, whole-system planning process that has been continuous but that can trace its specific ancestry to the 2020 vision of 2005 or earlier. Specifically, its intention is to present a strategy for delivering care through multidisciplinary integrated and co-located teams that are supported by a new Hub facility which will maintain the delivery of acute services in Arran through the effective use of otherwise essential investment wherever possible, recognising the finite lifespan of the existing buildings.

In summary, it is possible to conclude that:

- Arran, like other areas across the country, is facing a growing range of challenges relating to the delivery of safe, sustainable and affordable health and social care delivery.
- The challenge in Arran is escalated by the issues relating to island geography including issues around recruitment and retention.

- There are too many disparate service delivery locations and facilities for an island/population of this size.
- The new model must have the ability to increase Out of Hours cover – which can only be achieved through a single 24-hour service and new flexible and innovative "mixed" rota from staff who are truly integrated and co-located in a single site including the development of new roles such as ANP.
- The new model can only be fully implemented by a solution that brings both inpatient and residential care beds together on one site.
- The impact and cost of transfer to the mainland is a major consideration on a patient by patient basis and at a strategic level.
- Regional planning is playing an increasing role in determining the future of acute services across Scotland, with NAHSCP and its planning partners actively engaged in the West of Scotland Regional planning discussions.
- Local, regional and national planning has done nothing to negate or change the requirement for an acute hospital facility in Arran.
- The push for more local service delivery, especially out-patient services and ambulatory care, facilitated by enhanced technology and techniques, will only add to the requirement for these services to be delivered on Arran.
- The existing hospital facility on Arran, the Arran War Memorial Hospital, has long since exceeded its lifespan and – based on national estates planning tools & guidance – requires complete replacement as soon as possible.
- The existing Arran War Memorial facility, whilst reasonably maintained for its age, has very poor clinical functionality – particularly in relation to the in-patient accommodation, outpatient functionality and urgent unscheduled care facilities. This will continue to be a huge burden to effective and sustainable service delivery if it is not addressed.
- While an ongoing small reconfiguration project will address some of the clinical concerns for Unscheduled Care and Radiography the planning exercise has concluded that there is no way to address these clinical functionality issues within the existing Hospital that fall short of its complete replacement. Also, given that the in-patient facilities are effectively spread across seven areas and there is restricted access to key hospital services, that replacement of these facilities effectively means replacement of the entire facility.
- This represents the use of "otherwise essential investment" to address a long-standing clinical functionality and capacity issue within the Hospital as a whole, whilst addressing concerns regarding in-patient areas.

Overall, the purpose of this IA, in line with Scottish Govt. guidance, is to secure the required funding to address core clinical functionality issues within existing facilities, deliver appropriate accommodation to fully implement the on-going findings of the review process, support multi-disciplinary teams in the most effective way possible given the estimated lifespan of the existing buildings and the current pressures on providing robust 24-hour care.

1.4 Summary of the Economic Case

The Economic Case provides a robust assessment of the service solution set out in the Preferred Way Forward. The details of the project have been developed in a methodical and measured manner to provide all governance groups with the information required to support decision making with appropriate evidence to show that best value has been secured when compared against a 'Short List' of options.

The project team engaged in an extensive review and option appraisal process, involving consultation with key stakeholders. Extensive communication has also taken place with patient and

public groups, with more in depth engagement scheduled to take place following approval of this IA and in advance of developing the Outline Business Case (OBC).

An initial 'Long List' of options for the proposed model of care, and any associated physical infrastructure required to support this service model, was then developed.

The Preferred Strategic Service solution for the proposed model of care requires all island services, including inpatient and care beds, to be co-located and integrated. Various options to deliver this were looked at along with options which would only partially support this. It was agreed by all that to deliver a sustainable service with hospital and unscheduled care maintained, that all staff across the Health and Social Care Partnership need to be co-located to drive maximum efficiency within existing resources.

In consideration of all of the issues, business needs, risks, opportunities, inter-dependencies and other relevant considerations, the options short-listed for consideration at IA stage are therefore:

Option 1. Do Nothing (The Status Quo): Continue to deliver services in the same way from existing facilities without change.

Option 4. Descriptor Twin Hub - Maintain the current residential home (Montrose House) within the existing facility. Re-provide hospital, GP, community and social care services within a new, separate, primary & secondary care hub.

Option 5A - Single Combined Acute, Primary & Social Care Hub – Reconfigure/Extend Montrose House -Reconfigure and extend Montrose House to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility

Option 5B - Single Combined Acute, Primary & Social Care Hub – New Build/Site - Build a new facility to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility

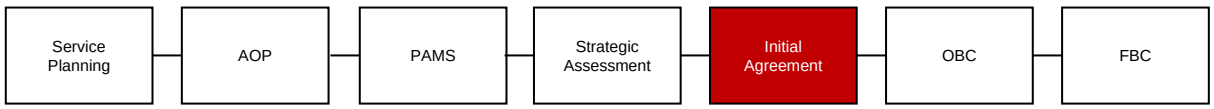
Options 5A and 5B are considered to be realistic options that will support the proposed model of care while Option 4 will only deliver a partial version of that, with inpatient beds and teams continuing to be provided on separate sites reducing the ability to deliver maximum efficiency.

1.5 Summary of the Commercial Case

The Commercial Case concludes that the proposed service and estate solutions will be attractive to developers and the Board believes that a commercially beneficial deal can be secured despite the geographical challenges the project has. While the procurement routes are set out within this document no firm decision has yet been taken on the most appropriate choice and this will be taken forward in line with Scottish Government guidance and support from Health Facilities Scotland and Scottish Futures Trust.

External advisors for Technical and Legal services will be procured by NHS A&A to scrutinise design stage submissions, and to assist the Project Team in the administration of the project.

The procurement timetable will be aligned with the business case process at Outline Business Case (OBC and Full Business Case (FBC) stages.



1.6 Summary of the Financial Case

The Financial Case sets out the solutions that could support the Preferred Strategic Service solution and provides the details of the projected costings.

Indicative Capital Costs

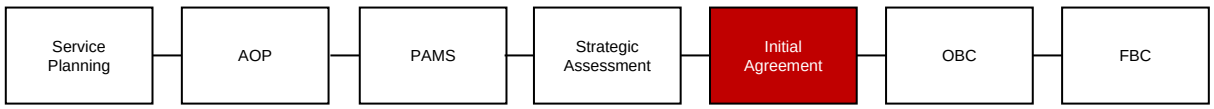
Costs in £millions	Option 1. Do Nothing	Option 4 Twin Hub	Option 5A Single/Montrose	Option 5B Single/New Build
Capital cost (or equivalent value)	**Circa £7.1m**	**Circa. £30.10m**	**Circa. £28m**	**Circa. £39.70m**
Whole of life capital costs	Low- £23,956,000 High - £27,018,000	Low - £15,785,000 High - £19,543,000	Low - £10,335,000 High - £12,796,000	Low - £14,137,000 High - £17,503,000
Whole of life operating costs	N/A	£0.87m	£0.72m	£1.27m
Estimated Net Present Value of Costs	N/A	£30.93m	£26.97m	£42.95m

Indicative Revenue Costs

NON CLINICAL REVENUE COSTS FOR RE-PROVISION OF SERVICES					
		Current/ Do Nothing	Proposed Solution 1 (Option 4)	Proposed Solution 2 (Option 5A)	Proposed Solution 3 (Option 5B)
New Build Square Metre		2,035	**3,360**	**2,752**	**4,488**
Refurbishment Square Metre				**529**	
		£	£	£	£
ANALYSIS OF NON-CLINICAL COSTS					
Catering	Presume Same patient numbers no additional cost	84,978	84,978	84,978	84,978
Rates	£36 per m² New	30,360	120,960	99,000	161,568
Energy	£30 per m² New (Assumed no Income)	43,761	100,800	82,560	134,640
Domestic	£45 per m²	119,781	151,200	123,840	201,960
Maintenance	£29 per m² New	25,930	97,440	79,810	130,152
Portering	£12 per m² New	38,462	40,320	33,027	53,856
Laundry		8,800	8,800	8,800	8,800
Capital Charges	Depreciation (based on 50 years new/10 years Equipment) 4/5A/5B	78,949	715,845	664,581	943,866
TOTAL RUNNING COSTS FOR NEW PROJECT		**431,021**	**1,320,343**	**1,176,596**	**1,719,820**
CURRENT COSTS FROM EXISTING COSTS SHEET		0	454,923	454,923	454,923
ADDITIONAL RECURRING COSTS		**0**	**865,420**	**721,673**	**1,264,897**

1.7 Summary of the Management Case

The Management Case highlights the key challenges to be managed and mitigated to effectively and efficiently implement the service solution through robust governance arrangements across all relevant partners including NHS A&A, NAHSCP and SAS.



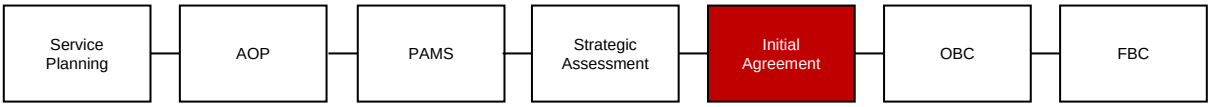
A project governance structure has been established for this project using a Programme and Project Management approach (PPM).

A high-level programme for the project has been compiled by the Board that considers all required planning activities/timescales, approvals/business case and construction elements. This includes estimated timescales for the further submission of Outline Business and Full Business Case's required to deliver the preferred way forward whilst ensuring service continuity and is presented as **Appendix O**.

This programme will be kept under continual review and modified/updated/enhanced as appropriate as the project moves forward.

Key dates in the overall Programme include:

Activity	**Completion / Target Dates**
NHS A&A, NAHSP & NAC Approvals Complete Integration Joint Board meeting Infrastructure Programme Board Caring for Ayrshire Programme Board Corporate Management Team Performance Governance Committee NHS Board meeting	30th August 2019 20th June, 2019 8th July 2019 21st August 2019 17th September 2019 10th October 2019 2nd December 2019
Initial Agreement submission to Scottish Government Capital Investment Group	11th December 2019
Initial Agreement considered at Scottish Government Capital investment Group	10th February 2020
Initial Agreement re-formatted and updated	May 2020
Infrastructure Programme Board	6th July 2020
Caring for Ayrshire Programme Board	8th July 2020
Performance Governance Committee	30th July 2020
NHS Ayrshire & Arran Board	17th August 2020
Scottish Government Capital Investment Group	September 2020
Taking account of the Covid-19 Pandemic and its impact on all services, the remaining timetable has been adjusted to incorporate not only the actual delays through the first half of 2020 but also acknowledges the likelihood that other activity and engagement going forward in developing the OBC will take longer to allow for ongoing social distancing etc. These dates will be reviewed on an ongoing basis and adjusted where required.	
OBC Commences	September 2020
OBC complete	June 2021
Governance	June – September 2021
FBC Commences	September 2021
FBC complete	May 2022
Construction commences	June 2022
Construction complete	June 2024/5



1.8 Conclusion

To support and facilitate all the above it was recognised that the current estate does not provide opportunities for bringing staff together from all partners to work in multi-disciplinary teams to deliver efficient and seamless care to patients and users of services. The sustainability of the current model of care and disseminated teams is challenging and places significant pressure on team members trying to maintain 24-hour care where and when this is required. The Review identified a need for a new "Hub" that would bring all partners together in a single location and provide true integration for teams to deliver flexible and sustainable services. It would allow the rapid establishment of the new service and model of care that focuses on the patient at the heart of all activity. This new service will include:

- A Single Management Structure
- Single Teams
- A new Model of Care
- Single Care Records
- Single Point of Contact - SPOC
- A new Hub facility

It is recognised that AWMH is an ageing facility that is not well suited to the delivery of modern-day healthcare" and would not support the establishment of integrated teams nor offer the opportunity for the model of care to be fully developed. Although recent service redesign projects have identified optimal patient pathways through hospital care, limitations of space and long-time establishment of some departments make it very difficult to configure the hospital in a way that is best suited to service delivery".

The development of a new integrated Hub will provide improved access to a wider range of services from a single location in a central facility and fully support the proposed collocated and integrated MDT's.

Importantly – and essentially – this new hub would also physically bring all existing beds on the island together to ensure sustainability, efficiency, and optimally safe service delivery for all.

2 Strategic Case

2.1 Current Arrangements

2.1.1 Service Details

The following facilities, which deliver both acute and primary care services on Arran, are relevant to this IA:

- Arran War Memorial Hospital (AWMH)
- Brodick Health Centre
- Lamlash Medical Centre
- Lochranza Surgery (Branch Surgery)

The above properties are all effectively owned and maintained by NHS Ayrshire and Arran and subject to contract arrangements with the Arran Medical Group.

In addition, the following properties are operated under a 3rd Party agreement with the Arran Medical

Group. Both leases were signed in 2007 and run for 25 years:

- Shiskine Surgery
- Whiting Bay Surgery (Branch Surgery)

These two buildings will be retained in the future model to continue to provide local service delivery on an outreach basis.

Other properties owned and operated by North Ayrshire Council which are used as part of the North Ayrshire Health and Social Care Partnership service provision that have also been reviewed are:

- Montrose House – A 30 bed care home in Brodick
- North Ayrshire Council North Ayrshire Health and Social Care Partnership – Lamlash (Within North Ayrshire Council offices)

In addition, discussions have taken place with Police Scotland, the Scottish Fire and Rescue Service and multiple third sector organisations on the island regarding existing facility availability and need.

2.1.2 Service Arrangements

2.1.2.1 Acute Hospital Provision on Arran: The Arran War Memorial Hospital, Lamlash

The AWMH, Lamlash is the only acute general hospital on Arran. It serves both the population of Arran of approximately 5,000 as well as a seasonal population of around 400,000 visitors, mainly in the summer months, along with a high number of temporary residents.

The hospital is a 2-storey building, opened officially in 1922. At that time it was a 10-bed hospital with 1 operating theatre and 1 consulting room. Over the years the building has been extended, remodelled and added to and now provides 12 inpatient beds (additional beds added in 1974) with urgent unscheduled care services, maternity (added in 1930), a surgical operating theatre (added in 1980 but no longer in use) and a range of outpatient services. It is staffed by local GPs supported by other professions, both visiting and inhouse. The hospital had up to 17 beds available until recently although this has been reduced to 12 due to changing activity patterns, staffing, extension of the urgent unscheduled care facility and on-going re-design activity. The 12 inpatient beds are spread over multiple areas throughout the whole hospital footprint. Two single rooms have been modernised and ensuite facilities added however the rest of the bedded areas do not lend themselves to the provision of quality clinical care, with limited manoeuvrability and lack of privacy. Apart from the two single rooms, there are no ensuite facilities. Storage provision is distributed in small areas throughout the hospital.

The hospital is NOT clinically fit for purpose and fails to meet many modern space and care standards. In addition it is:

- Functionally unsuitable
- Ageing badly (Condition “C”)
- Difficult to access (externally and internally)
- Difficult and costly to staff and supervise
- Dis-jointed and sprawling despite it’s diminutive size
- Without any meaningful pick up and drop off area
- Lacking in storage space
- Located at the top of a hill

- Constructed over multiple different levels and height changes
- Lacking in car parking
- Difficult to secure due to multiple entrances
- Spread across multiple separate buildings
- Nowhere near a suitable helicopter landing site
- Etc.

Services currently delivered at AWMH include:

- Urgent Unscheduled Care Services (full acute trauma PCEC 24/7 supported by existing Arran based staffing compliment and retrieval team if required e.g. EMRS / liaison with University Hospital Crosshouse)
- In-patient GP beds
- Day cases / ward attenders (including IV therapies and transfusions, cancer therapies, ECGs)
- Radiography service (Plain film X-ray only)
- Visiting out-patient services (Various specialties)
- Physiotherapy treatment and gym (outpatients, inpatients and community/domiciliary visits)
- Occupational therapy team input
- Midwifery service
- Nursing, Medical, Management, Hotel Services, Porter, Catering, Reception / Administrative / Medical Records
- Mortuary service (no local mortuary management, contract in place with local undertaker firm re usage, agreement in place with Police Scotland re usage)

A Modular (outpatients) building supports:

- District Nursing, Community Psychiatric Nursing, Reception (when required), local 'Alert' Social Care Team
- Approximately 25 outpatient clinics/week including AWMH nurse led, visiting specialists e.g. AHPs, visiting clinicians / consultants, some supported via video conference e.g. cardiac - Range of clinic frequency: weekly, monthly, quarterly, ad-hoc...
- Meeting / training / conference needs as its modest meeting space is the largest resource available to health and social care and also used by local groups

Unfortunately, the ageing design of the building and lack of smooth Patient pathways through the building means that the facility is not as flexible as it could/should be. Clinical areas are not functional or suitable for modern health care.

As a small Rural General Hospital (RGH), the AWMH faces the challenge of providing a broad range of medical and urgent unscheduled care services from a small, multi-functional footprint that includes all of the basic elements of a much larger hospital but in a more flexible way.

Care is provided for a widely diverse patient population in terms of age and morbidity with the hospital providing the only in-patient area for the island and also the main ‘place of safety’ required for mental health and other patients. Some general improvements have been initiated including:

- All areas now benefit from cardiac monitoring facilities via WiFi, centralised to the main ward nursing station.

- Reconfiguration of some areas to provide for new radiography equipment when it arrives in early 2019 and a more functional and dedicated space for Urgent Unscheduled Care Services.

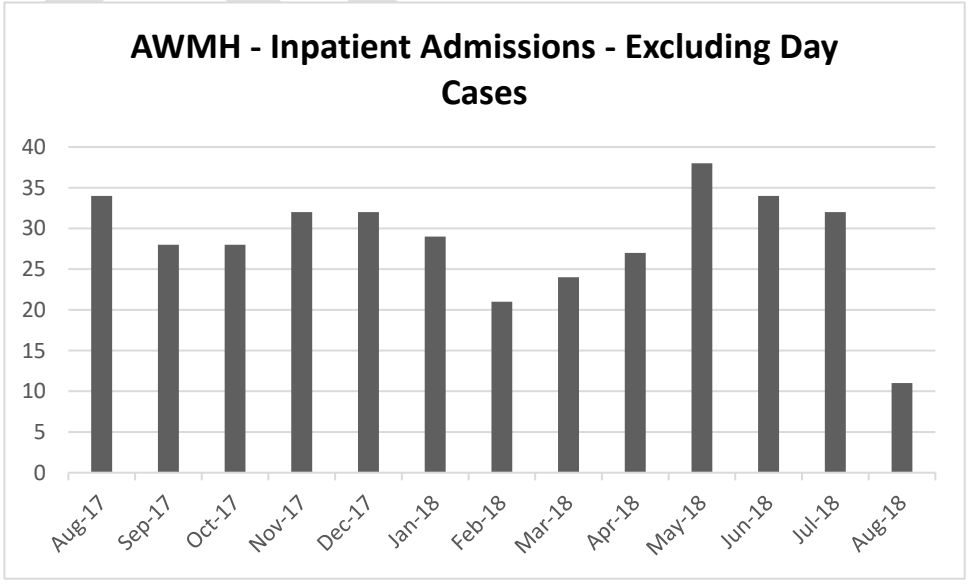
Staff rotas are fragile in both AWMH and Montrose House with key areas of concern around staff illness, work patterns and holidays. In Montrose House there is a legal requirement to have a senior team member on every rota and this is supported by Social Care staff. There is also a real sense that the current struggle to recruit appropriately qualified staff presents a "competitive" element between AWMH and Montrose House that helps neither facility or the population of the Island.

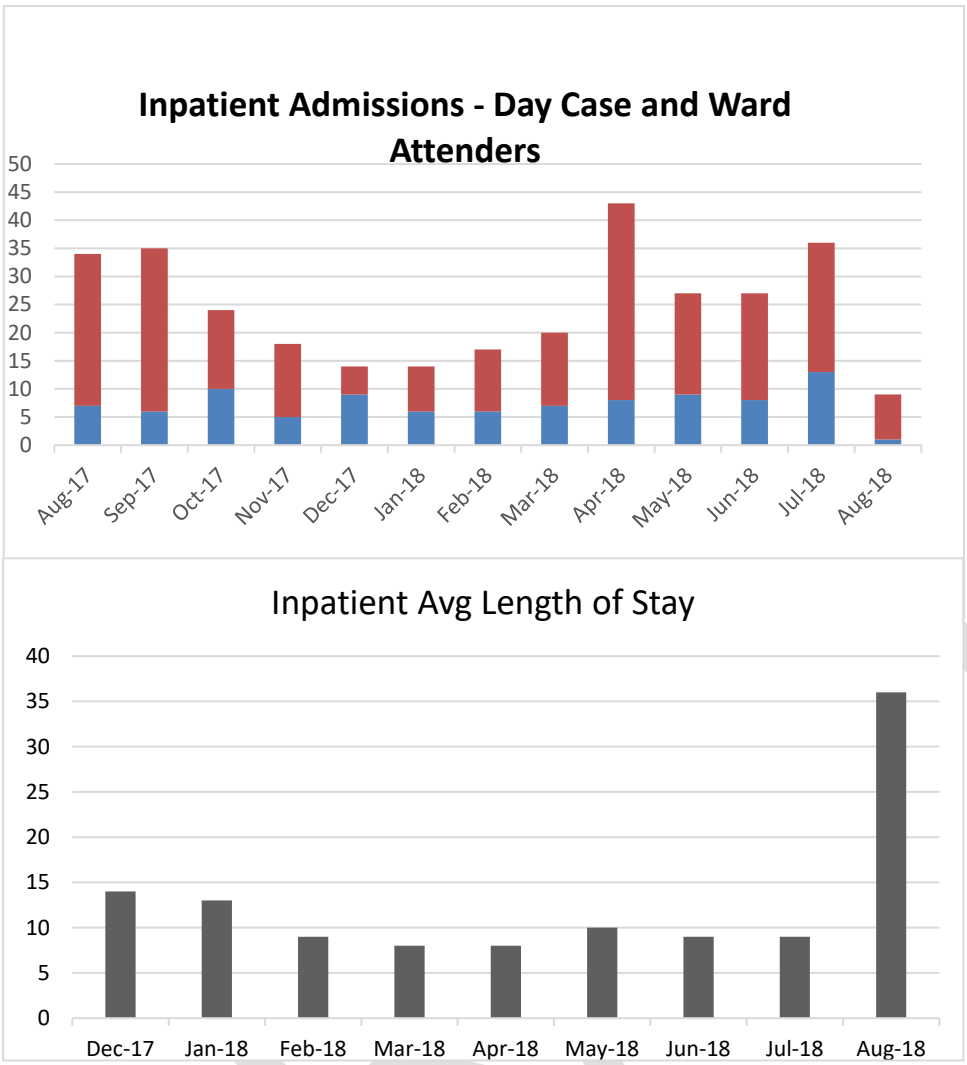
2.1.2.2 Inpatient Services - Arran War Memorial Hospital

Arran War Memorial Hospital is an active community hospital and delivers a wide range of essential and planned healthcare 24/7/365 to residents and visitors. This includes a non-bypass urgent unscheduled care service providing complete treatment to the majority of attendees. Care encompasses simple presentations such as minor illness and injury but extends to the full range of medical and surgical presentations including major trauma, sepsis and paediatric emergencies. High acuity cases are stabilised prior to emergency transfer to mainland units, and this often necessitates several hours of care before helicopter transfer can be affected. The hospital is also the Primary Care Urgent Unscheduled Care Service facility for out of hours care and this is integrated with urgent unscheduled care services. It is also the designated place of safety for psychiatric emergency care. There is a small midwife led, standalone birthing unit.

The 12 bedded inpatient unit allows the majority of those in need of an acute medical admission to be treated entirely on the island. Commonly treated conditions include pneumonia, urinary sepsis and delirium. In addition, a range of day case treatments are provided including drug infusions and blood transfusions. The inpatient unit delivers a significant proportion of the palliative and terminal care needs for Arran as well as step down care from larger mainland facilities.
Care is delivered by a team of Rural GPs and nurses who must have a broad skill set.

Inpatient data for 2017-2018 are shown below for Inpatients





Current Challenges in Inpatient Services

Key challenges facing in-patient services on the island include:

- OOH services are heavily doctor dependent with a GP as only healthcare member able to see, treat and discharge all presentations.
- With 1 duty GP to cover urgent unscheduled care, hospital care, care at home and in the community out of hours, periods of increased demand can lead to delays in care as GP will prioritise in-patients below A&E and urgent cases. The different physical locations also mean that OOH teams can spend unnecessary amounts of time travelling between facilities.
- Changing demand and working patterns are prompting changes to GP OOH rotas as prolonged shifts are no longer sustainable. This will reduce the availability of GPs in hours and increase the need for other healthcare staff to be first point of contact for presentations.
- The unpredictable workload of unscheduled care and lack of dedicated A&E staff means nursing staff must prioritise between urgent unscheduled care and in-patient activity.
- Minimal nursing staff out of hours when a high percentage of acute admissions and management of the deteriorating patient happens.

- Nursing staff must adapt rapidly to respond to major trauma patients in urgent unscheduled care and be expected to maintain skill levels to deal with this patient group.
- No dedicated Day-Case facilities
- Inpatient services have no dedicated administration staff, and this results in Admission Documentation being undertaken by nursing staff which is time consuming and removing registered nursing staff away from direct patient care
- No GP present 24 hours therefore nursing staff are on the frontline for urgent unscheduled care and in-patient deterioration.
- Mainland nurse bank cannot easily cover nursing shortfall on the island
- Limited to no specialist nursing input unless initiate phone contact.
- Out-patient and day case services have no staff allocation
- Pressure on hospital nursing staff to manage patients out with their speciality as no mental health cover out of hours.
- Difficulties organising and maintaining staff competencies due to the diversity of patients nursed.
- Although there is one nursing station and a 'duty office', available space for clinicians to work from is cramped.
- Access to IT facilities is good, however staff are required to work with a multitude of IT systems related to primary care, secondary, lab request & reporting and Out of Hours care.
- There is one very small waiting room for the hospital which is also used for urgent unscheduled care patients, x-ray patients, physiotherapy and day care patients, frequently over spilling into the narrow corridors accessing both the Accident Unit and Ward 1. No separate area for children (may see distressing situations) No Play area.
- Administrative services are provided on a Monday to Friday basis, this is related to reception for all hospital departments with minimal additional support provided to the inpatient and outpatient areas.
- Car parking for patients/relatives and staff is extremely limited and is provided in two small car parks each holding approximately 15 vehicles. The hospital is thereafter accessed by a steep road or stairway.
- Limited public transport is provided to the hospital.

- Environment
    - Small room for urgent unscheduled care services which can become very congested when patients require resus or acute care. No other area to see urgent unscheduled care presentations therefore having to utilise in-patient beds.
    - Separate buildings for in-patient areas and out-patients that the same staff will set up and work between.
    - The building is not fit for purpose with limited wheelchair access and dangerous grounds with steep slopes and constricted manoeuvrability for vehicles.
    - There is minimal security in the main hospital building. The layout of the building makes security a significant challenge. There are multiple entrances and minimal security measures in place. Outside Mon-Fri 0830-1800 there is no administration staff, and reception is unmanned.
    - Single carriage road access with no pavement or street lighting
- Human resources
    - Due to the sporadic nature of the activity, nurses are called in to work frequently out with their normal working hours. There is no formal process to manage this and it relies on the goodwill of staff to work on their days off or annual leave.
    - Recruitment issues- due to the shift pattern, nursing staff must live on the island therefore there is an expectation that staff will move to the island to work.
    - Lack of affordable housing

- Nursing staff who take charge have to problem solve all hospital issues and not just those relating to nursing
- Same group of nursing staff working in urgent unscheduled care, out-patients, wards, day cases, on a daily basis therefore staff management can be difficult.
- There is no community nursing or social care available for the majority of the out of hours period. This means that many cases, that could be dealt with in the community, default to AWMH, including on occasions resulting in admission. At periods of peak demand this will mean that medical cases are transferred off island as capacity has been exceeded.

- Discharge
  - Delays in discharge as local chemist who dispenses discharge prescriptions has limited stock. Often there are delays of 24 hours for them to receive a postal delivery of drugs.
  - Social care services on the Island do not have the capacity to meet current demand and delays to discharge are frequent as a result. As the social care team are based at a different site there are challenges to effecting efficient discharge.
  - The Scottish Ambulance Service has a single vehicle on Arran. This ambulance also covers the PTS Service. This presents several challenges as planned discharges and transfers can be cancelled or significantly delayed if urgent unscheduled care cases arise.
  - Extra nursing time therefore spent liaising with homecare/ social services and family.

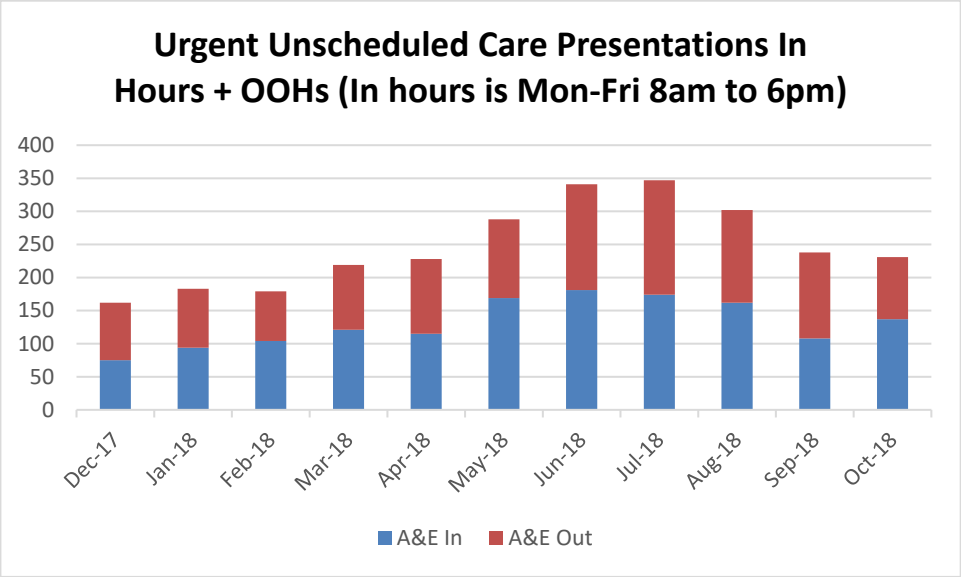
- Administrative
  - There are no dedicated administration services for nursing staff which results in nursing staff spending time away from direct patient care.
  - Nursing staff answer all calls to the hospital out of hours as there is no telephonist/ receptionist service out of hours.

2.1.2.3 Urgent Unscheduled Care Services

The AWMH Urgent Unscheduled Care Service is provided on a 24 hour a day, 7 days a week basis including public holidays. The service is GP led, supported by nursing staff. While many smaller hospitals provide minor injury services only with serious trauma and illness bypassing to larger units this is not possible on an Island. This means there must be capacity for the full range of presentations to be treated, from minor injuries to major trauma patients requiring resuscitation, stabilisation and emergency transfers to mainland facilities. Within AWMH, medical staff provide resource for this service plus inpatient and community patients at the same time, therefore prioritising both routine and emergency care across the island. Demand is highly seasonal in urgent unscheduled care as a result of visitors to the island and can be doubled in peak months compared to low season.

There are no ENP or ANPs at AWMH though some nursing staff have minor injury training.

Activity such as Major trauma, Resuscitation, Minor Injuries, limb immobilisation, medical, surgical and paediatric admissions are provided in a single urgent unscheduled care room. Major resuscitations may continue for several hours and can involve the participation of mainland services such as additional clinicians and from the Emergency Medical Retrieval Service. There are no facilities to assess more than one patient at a time. There are no facilities to provide triage for patients. The unit sees approximately 2500s patient annually



- There is roughly a 50:50 split between in hours and out of hours
- The unit accepts adults and children
- There are minimal patient testing facilities available
- X-ray is provided with a 9-1 service (weekdays) and on-call service thereafter

Helicopter evacuation of acutely unwell people from AWMH is a frequent occurrence. Several factors are contributing to a rise in these. In the six months Jan-Jun 2017 there were 62 emergency helicopter transfers, compared to 45 in the same period in 2016. The period during which care for these patients must be provided at AWMH can vary greatly depending on helicopter availability in an approximate 1.5 – 8-hour window. The only landing site currently available is in the next village Whiting Bay, requiring additional road transport and extra physical transfers between stretchers for critically ill patients. Any future reprovision of facilities must consider the use of MediVac Helicopters and the relative proximity to the site or on-site provision.

Ferry transport is available for more stable patients needing urgent transfer and a recent service development has introduced twice daily transfers accompanied by Scottish Ambulance Service staff.

Emergency transfer of unwell patients from Arran is a frequent occurrence. In Jan-Jun 2017 there were 62. This compares to 45 in the same period in 2016.

Unscheduled Care has specific issues relating to availability of staff and lack of appropriate space including:

- Only one doctor to provide urgent unscheduled care services, inpatient and domiciliary care
- No other staff are able to see, treat and discharge any presentation Hospital nursing staff have different levels of training and experience in urgent unscheduled care presentations so there is variation in care
- There is no administrative support to urgent unscheduled care or patient arrival outside of normal working hours, i.e. evenings, weekends, and public holidays. Requiring nursing staff to also undertake an administrative role.

- A single high acuity case can demand all available staff to attend and can occupy the team for several hours. This is highly problematic when there are no admin staff Out of Hours and inpatients and other urgent unscheduled care presentations to attend to.
- There is no covered access to the entrance of urgent unscheduled care protecting patients from weather and providing privacy
- Seriously unwell or distressed patients are brought in the main entrance used by all visitors, relatives and past the waiting area on the way into the urgent unscheduled care facility. This presents challenges in several areas: dignity, confidentiality, distress to family and infection control.
- Access to the entrance is narrow and there is a slope up to it. This is the drop off point for disabled and frail patients and urgent unscheduled care ambulance access can be blocked at time.
- Narrow hallways
- No manoeuvrability for patient trolleys/wheelchairs
- The unit it is situated immediately adjacent to the main kitchen
- Lack of privacy for patients as the urgent unscheduled care facility is adjacent to the kitchen resulting in patient exposure to noise, cooking smells, equipment movement etc
- X-ray immediately adjacent to A&E with patient privacy compromised because of x-ray outpatient clinics
- The Urgent Unscheduled Care accommodation is very cramped, compromising clinical care.
- There is only one clinical room which is used for
    - Resuscitation
    - Assessment and treatment of minor injury patients
    - Assessment and treatment of medical and surgical patients
    - Assessment and treatment of adults and children
    - Fracture clinic
    - Limb immobilisation (casting)
    - Portable x-ray facilities
- There is space to treat only one patient at a time, there is no other space to assess and treat other patients arriving at the hospital
- Chairs need to be removed from the area before adequate work space can be achieve for a trolley patient
- There is insufficient space for multiple clinicians to work together safely, especially during resuscitation situation
- Insufficient accommodation for required additional patient care equipment eg., portable x-ray, resuscitation equipment ECG etc
- Cramped working accommodation increases Health and Safety issues and compromises A&A guidelines relating to urgent unscheduled care waiting area is very small and combines with the hospital waiting areas, outpatient waiting areas and AHP waiting areas.
- Frequent overspills with patients waiting in corridors and inpatient ward areas, therefore compromising patient privacy and increasing chances of cross infection
- There is no separate waiting or treatment area for children therefore exposing them to distressing situations/scenes
- There are no public telephones
- There are no refreshment area/machines due to lack of space
- There is no area to accommodate distressed relatives

Overall there is inadequate space to provide optimal patient care for one or more patients. There is insufficient space for the clinical team to safely work in the area at the same time and the limitations prevent service development. The treatment of a patient with major illness/injury

prevents the assessment and treatment of any other patients attending the hospital for a number of hours.

2.1.2.4 Out Patient Service

Outpatient clinics are held with a modular building in the grounds of the AWMH. It is also used as a base by district nursing, community psychiatric nursing and the local 'Alert' social care team. There are currently 25 different outpatient clinics provided from AWMH ranging from Podiatry to paediatric to videoconferencing cardiology clinics. These include those led by AWMH nursing staff, AHP's, visiting specialists e.g. visiting clinicians / consultants and mental health staff. Some clinics are supported via video conference e.g. cardiac - Range of clinic frequency: weekly, monthly, quarterly, ad-hoc..

Further nurse led clinics are held within Arran Medical Group (GP surgeries) including Asthma & COPD, chronic Kidney disease, diabetes, hypertension, pre operative assessments, dressings and sexual health.

In 2014 over 2100 patients were seen locally. Facilities are generally good however require to be adaptive for the number of specialist clinics taking place.

Current pressures on the services include:

- Care delivery is divided between numerous sites.
- There are steep steps, or significant slope on the roadway, to access other parts of the site e.g. for an x-ray
- There is no dedicated staff either clinical or administrative.
- It is often not possible to staff the separate reception and patients would have to make their way to the main building to seek assistance.
- The transportation of medical documentation is required between the main building and the Outpatient building.
- Privacy can be compromised because of the quality of sound proofing, this is especially true when utilising videoconferencing in the main outpatient building.
- Storage within the main outpatient building is poor

2.1.2.5 Radiology

X-ray services are a vital tool for inpatient, outpatient and GP diagnostic services and are currently delivered from two small areas across from the kitchen and adjacent to urgent unscheduled care services. The rooms are accessed by a narrow corridor which greatly hampers the manoeuvrability of patient equipment. The corridor is also used for urgent unscheduled care access and access to the kitchen.

X-ray is staffed by two part time radiographers, one of whom is retiring.
The provision of service is limited to the type and calibre of equipment available, but this is being updated in 2019..

Existing pressures and challenges include:

- Recruitment of radiography staff
- There is limited space to manoeuvre patients safely
- Restrictions on the equipment that can be used

- X-ray services are compromised because of immediacy to kitchen

2.1.2.6 Physiotherapy Service

The Arran physiotherapy service is based in the physiotherapy dept within AWMH. Staffing consists of three permanent staff that are based on Arran:

Grade	Wte	Job roles
Band 7 Physiotherapist	1.0	Provides care to musculoskeletal (MSK) out patients, urgent unscheduled care and AWMH ward patients
Band 6 Physiotherapist	1.0	Provides community physiotherapy plus non-MSK physiotherapy via out-patient clinics, community-based classes or 1:1 treatment sessions.
Band 3 Physiotherapy Technical Instructor	0.8	Supports both qualified staff and is responsible for own mixed clinical caseload.

Diversity of non MSK physiotherapy out-patients include cardiac rehab, pulmonary rehab, women's health, early pregnancy, neurology and falls prevention. We offer community-based classes for falls prevention and the Healthy and Active Rehabilitation Programme (HARP).
Visiting specialist physiotherapy is currently available for: lymphoedema, paediatrics and MSK complex-cases. MSK referrals are received through the dedicated pan Ayrshire MSK hub with new patients being appointed directly by the hub. Patients attend for treatment at the physiotherapy department within AWMH. AWMH ward referrals are received through verbal routes within the hospital MDT via the daily morning handover.

The band 6 Physiotherapist is part of a multidisciplinary (MDT) re-ablement team who receive referrals through a dedicated clinical mailbox which ensures a prompt, MDT approach to care. The Scottish Ambulance Service is able to directly refer to the team enabling early input with the aim of avoiding the need for hospital admission. Referrals for other non-MSK patients are also received via re-ablement mailbox.

The current service pressures include:

- Having only 2 qualified staff, means there are occasions when unplanned absence may result in no qualified physiotherapist being available. This results in a reduced service to all patients including MSK, ward or community patients.
- Limited gym space results in lack of MSK and non-MSK classes and reduces scope for assessment and treatment options for patients. Storage space for equipment is also limited.
- Video conferencing is used where possible both for clinical and management support; however, staff may have difficulty attending professional development opportunities on the mainland, particularly through the winter months when regular ferry cancellations can occur due to bad weather.
- Lack of common IT systems results in difficulty sharing patient related information.
- Limited network access on the island causes difficulties around lone working.

2.1.2.7 Occupational Therapy

The service began with an integrated Health and Social Care Occupational Therapy post providing input to community by way of equipment and adaptation provision, support with

housing assessment and input to AWM hospital. The service has since developed its scope and provides assessment and intervention across community rehabilitation and mental health services (AMH, CMHTE and primary care). The reablement and falls pathway has been developed via change fund and subsequently mainstreamed.

The team currently comprises:

Band 7: Management/team leader duties	1:1 assessment and intervention in community – equipment and adaptations, community rehabilitation, palliative care, AMH (CMHT) and older adult mental health (CMHTE), Primary care mental health referrals. Group intervention – delivery of 8-week mindfulness courses and 1:1 intervention. Delivery of low intensity psychological interventions 1:1 Cover AWM/Reablement caseloads when colleague is on leave.
Band 6: Hospital	Supporting discharge planning and pre-operative assessments, reablement team. HARP group, community equipment and adaptations, community rehabilitation, palliative care. Links with physiotherapy for reablement team meeting.
Band 4: Hospital cover	Can undertake assessments as directed by senior staff, fall groups/ falls assessments, equipment provision, and community rehabilitation – supporting delivery of plans developed by senior staff. Delivery and uplift of equipment.

Other examples of integrated working/potential developments:

- Physiotherapy colleagues: HARP group and Falls group are facilitated jointly by OT
- CMHT – Monthly supervision undertaken with Adult Mental Health (AMH) team lead and OT team lead. Also link with CPN support worker who is supporting OT work with client.
- OT team lead currently involved in Arran dementia friendly communities steering group. OT team lead is a dementia champion and sits on the dementia champion's forum
- Sensory impairment team – Joint visits have been undertaken with regular input then offered to facilitate a plan on Island.
- Specialist nurses – MND Nurse – communication/joint visit/links with other key people to co-ordinate care.
- Speech and language/Podiatry – relevant cases discussed/referrals.
- Psychology – CAHMS and adult mental health –
- Social services/Homecare – regular discussions regards shared clients/joint visits/responsiveness to urgent assessments enhanced
- Education staff – OT team lead provides 8-week mindfulness course and invited staff from education.
- Primary care mental health referrals from GP's have increased – OT team lead provides mindfulness-based interventions
- GP staff – link around people referred or people who we feel require further assessment/review.
- NAC community OT staff – links around equipment and adaptations restructure and ongoing development of Arran system.
- District nursing team – Trusted assessor training – 2 of the team members are able to provide assessment and provision of basic equipment

Current Service pressures/considerations:

- Equipment and adaptations/Store of equipment – space inadequate/delivery and uplift of equipment/minor adaptations process development still in process. Care & Repair role not fully functional yet–
- Equipment new contractor is mainland based – Potential impact on provision/ ability to respond to critical requests/cost will be higher for fitting of grab rails/banisters/Handrails
- Delivery of large pieces of equipment – Currently only 1 technician when delivering equipment to the Island. Equipment delivery can be delayed due to lack of staff to facilitate moving of large equipment.
- Mainland store deliver stock – there is no pre-determined time. Call and request delivery to replenish stock or for specific equipment requests - in accordance with technician availability/leave/boat bookings. More problematic in summer.
- The mainland store technicians are time limited and arrive at 11am and return of 13.55 (Winter) 3.15 (Summer).
- Working towards the care & repair member of staff co-ordinating stock audit, store visits and monitoring of stock however at present ongoing support is required.

2.1.2.8 Maternity Service

The Maternity service on Arran is based in the AWMH at present, this is classed as a midwife led unit. There are 35-45 births to Arran mothers each year but few of these are on the island (2 in 2017) with the majority of patients giving birth in the Ayrshire Maternity Unit, which is attached to Crosshouse Hospital in Kilmarnock. A well-defined pathway system has been implemented for expectant mothers to clearly identify and highlight where deliveries should take place. The new facility in University Hospital Crosshouse provides significantly improved accommodation which also provides overnight facilities for partners to stay in. There is a single midwife based on the island supported by the larger Ayrshire maternity team. When a mother opts to give birth on the island then the local midwife is joined on the island by a mainland-based midwife and both are on call 24/7 from 38 weeks gestation until delivery. Mother and baby are usually discharged in under 24 hours.

The maternity service provides ante-natal and post-natal clinics in the hospital and at local health centres.

In future women may still choose to give birth on Arran, either at home or in the midwife unit. Ongoing work has identified that there is no need for a dedicated “only for use as a maternity suite” within any new/reconfigured/refurbished facility. However, any design for a new or re-provided facility must make provision for some births on the island and have space available (a flexible use room) for storage and use of any equipment to support birthing.

2.1.2.9 Support Services

A range of other clinical and non-clinical support services are also delivered from/based at the AWMH that are essential to its operation and wider health services across Arran. These include:

- Basic Laboratory services – near patient testing
- Portering
- Domestic services
- Catering (Patient and staff, including a production kitchen)

- Estates
- Supplies

Staff are currently managed in a range of mainland based managerial structures and this can result in some challenges – longer term it is believed that management of all support staff on island may provide more flexibility and efficiency.

Previous work undertaken by NHS Ayrshire & Arran and North Ayrshire Council identified some critical challenges in bringing FM staff together into integrated teams linked directly to Terms & Conditions, which vary greatly between the NHS and Local Authority. FM services were not specifically covered in the Public Bodies (Joint Working) (Scotland) Act 2014 which would result in TUPE transfers (which the NHS are limited in implementing) having to be undertaken with resultant concerns from stakeholders regarding this. Should the project be approved for development of an Outline Business Case it is essential that this issue must be looked at in more detail to identify an appropriate solution.

2.1.2.10 Primary Care Provision

Arran Medical Group, formed from the merger of three practices, is the single primary care provider on the Island. A team of 4 full time and 4part time GPs delivers traditional, dispensing primary health care at five sites. A wide range of enhanced services are offered, as well as a full spectrum of additional services including out-of-hours care, medical input to Arran War Memorial Hospital, Montrose House, Private Care Home, Urgent Unscheduled Care Services, BASICS prehospital care and police surgeon work. Several GPs have areas of expertise that allow secondary care services such as a community gynaecology clinic and fracture clinic to be provided.

There are three main surgeries which are open and staffed every day - in Lamlash, which is the busiest site, Brodick and Shishkine. The Shiskine Surgery is a modern facility but both other facilities very much limit the delivery of modern health care. Other clinics are held in health centres in Whiting Bay, another modern build, and Lochranza which was originally built as a house, occasionally suffers from flooding, and is used by GP's once a week, nursing once a week and as a dispensary once a week. Covering the five Primary Care sites puts a significant pressure on GP and staffing rotas.

Patients include Arran's residents as well as the many visitors to Arran. There is a defined aspiration to being a Centre of Excellence of rural island healthcare, and there is ongoing engagement with teaching and training at all levels of medical education.

Following the merger of the three island practices in 2012 the practice was streamlined and strengthened its appointment system and has good access with available appointments, triage by telephone and ability to book appointment on-line. There is good management of chronic disease and the practice was a high QOF achieving practice. Recent Patient and Care Experience survey showed the practice to be providing high satisfaction levels to patients on the island. The top 5 results here all indicate 100% satisfaction and include the ability to book a doctor's appointment 3 or more working days in advance, ease of getting through on the phone and Doctors listen to patients. Where results are less than this they still remain high at 96% for ability to speak to a doctor or nurse within 2 working days and time waiting to be seen at GP practice. The practice also provides a Pharmacy Dispensary service.

A Modern Apprenticeship has been created and implemented into our Dispensary and the practice continues to build local links with the Arran High School to attract and "grow our own" future workforce.
The management of the is integrated with local HSCP management and this provides advantages in planning services on the island. Arran comprises a locality in North Ayrshire HSCP and the fact that the whole locality is covered by a single practice is again a significant plus when planning health and social care and ensuring primary care engagement.

The new GP contract offers opportunity also, changes already in progress include bringing in a new Pharmacist, a Mental Health Nurse and two Advanced Nurse Practitioners are being trained.

GP Services pressures include:

- OOHs/Community Hospital Inpatients/ urgent unscheduled care servicesand "in hours" primary care cover lead to complex rotas system to ensure adequate cover – this is fragile, and sustainability is a constant pressure. The practice must always provide an experienced Doctor to be on duty at the Hospital.
- It is proving increasingly challenging to staff 5 primary care sites and have workable rotas for both overnight and weekend on calls as well as periods of daytime duty at AWMH.
- Recruitment and retention of GPs – the practice has faced periods of sustained difficulty in recruiting GPs. Three of the current GPs have announced plans to leave in 2019.
- Some premises are outdated and not fit for purpose – Brodick and Lamlash. Some premises are underutilised e.g. Whiting Bay and Lochranza
- Poor connectivity impacting on IT systems reliability.
- Unresourced secondary care work shifts increase workload.
- Lack of interaction with fellow GP's resulting in isolation due to the shift patterns and localities.
- Lack of resource to provide appropriate 24-hour rota support.
- Re-active service needs to be replaced by a pro-active service.

2.1.2.11 Community Based Services

Provision of community services is distributed across the island addressing local needs, but this can produce challenges in linking in with other disciplines and supporting complex rota requirements over a 24-hr period.

At the current time there are no NHS Bank staff on Arran. Bank Staff can be accessed from the mainland, but this rarely results in shifts being covered. An initiative is underway to recruit Bank Staff on Arran to support services in the longer term, but it is at an early development stage.
A number of Bank Staff from the mainland support and cover our North Ayrshire Council Care at Home and Montrose House shifts and this can be approximately 8-10% currently.

2.1.2.12 Community Nursing

The Community Nursing Team are based at Arran War Memorial Hospital and cover the whole of the island. They provide a wide range of care to patients in all parts of the island. Travel times to some locations can be up to one hour.

The Team provides daytime care 7 days per week. As there are no other agencies providing input all palliative nursing in the community is provided by the team. There is no overnight nursing service except on occasions, by goodwill, for terminal care at home. There is close working with other community teams and those in the GP practice, residential and nursing home.

The team comprises of:

- District Nurse Team Leader x 1 (Full time)
- Community Staff Nurses- x 6 (4 full time, 2 part time)
- Healthcare assistant x 1 (part time)

Of the current caseload (150 patients), the majority are over 75 years of age with multiple morbidities and complex nursing care needs.

Challenges faced:

- Recruitment and retention have been a significant issue for this small team. At the time of writing there are two vacancies which has a marked effect on capacity within the team.
- Palliative care demand is variable and unpredictable. Terminal care in particular is high intensity work and evening and overnight calls in these circumstances impact upon daytime rotas.
- There is an inability at present to call upon the resources of the other nursing teams on the island when faced with periods of staff shortage.

2.1.2.13 Palliative Care

- Is provided mainly in patients homes by community nursing and GP teams.
- Arran Medical Group currently has 18 patients on their palliative care register (in need of support for end of life care).
- There are currently 10 patients on the district nurse caseload are classified with a 'palliative' diagnosis receiving nursing care and support
- In 2018 14 people received terminal care in their own home

Key Issues for Community Nursing

Specific issues for Community Nursing overall include

- A community nursing on call service which is very difficult to support with current community nurse staffing levels and there are often uncovered shifts. This is a real issue for palliative care patients in the community and a key driver for developing and changing our nursing rotas and looking to combine with Care at Home, Alert team and hospital nurses.
- Diminution of day staffing and therefore service as a result of on call requirements
- No available Bank Staff on Arran other than mainland staff supporting Care at Home and Montrose House
- Provision of role undertaken by specialist nurses and palliative care staff on the mainland
- Cars that are unsuitable for local road conditions
- Minimal administrative support
- Multiple communication systems requiring direct input by clinical staff with limited and constrained access or opportunity for agile working
- Lone working (particularly in the out of hours period) and poor mobile coverage.

2.1.2.14 Mental Health

At present, both Adult and Elderly mental health services are managed locally by the Community Mental Health Nursing team, based at AWMH. The service also provides backup to Inpatient services, manages Crisis events and secures Places of Safety (only available within the inpatient service at AWMH) and arranges and supports escorts to the mainland, which are undertaken either by inpatient nursing staff or a CPN from the mainland.

Two Consultant Psychiatrists from the mainland run clinics on the island however all Psychology and CBT is only available on the mainland.

At present there are no island based Mental Health Officer or out of hours mental health crisis team available. In the event of crisis or intervention care being required this is managed by the Hospital and Ambulance service, in liaison with mainland on-call Psychiatric service, to bring patients into the hospital environment as the only Place of Safety until further assessment and treatment can be arranged which may require the patient being transferred to the mainland with an appropriate escort. In 2018 this occurred on 4 to 5 occasions.

2.1.2.15 Social Care

Social Services on the island is provided by 2.7 Social Workers with 2 Social Work Assistants, 1 Family Care support worker and two part-time Adult Outreach Workers.

The Social Work team provides a generic service, one of the few remaining. They provide Service Access, Children and Family, Adult and Older People's services. The majority of work involves adult and older people which amounts to 75% of the workload with the remaining 25% of activity focussed on Children and Families. Over the last year the Service Access service has responded to 460 initial enquiries, advice enquiries and new referrals. The service currently has around 170 open cases requiring on going work.

The team provide the safeguarding elements of Child Protection and Adult Support and Protection. With such a small team this can have a particular impact when such work generally requires two social workers. In addition the supervision of children subject to a Compulsory Supervision Orders via the Children's Hearing system can have a significant impact on capacity, for example if there is a need to provide very regular supervised family contact. This contact regularly has to be arranged on the mainland, which has a significant impact on time.

The service operates normal office hours Monday to Friday. An out of hours service is provided by the Ayrshire Out of Hours Service, a pan-Ayrshire service that operates from the mainland. There are no out of hours services on the Island and so when there is an emergency this normally falls to police or ambulance services.

Alcohol and Addiction services come from the Mainland to run clinics. There is one Alcohol and Drugs drop in clinic per month at Brodick Health Centre. An Addictions CPN generally visits the island for approximately one visit per month.

The challenges of delivering social services on a small island to a small population can be challenging with such a small team. During periods of Out of Hours service when no local

provision is available staff members can have service users turning up at their homes to try and access services.

2.1.2.16 Homecare

While unpaid carers provide the greatest amount of care almost all care at home provided by employed staff on Arran is provided by the NAHSCP Homecare team. There are a small number of individuals offering private care and occasional shortterm use of private full-time carers but no independent providers delivering regular care.

The Arran team is part of the wider North Ayrshire service and is managed as part of the wider service. There is a Care at Home Manager supported by two island based senior carers.

There is also an Alert team, who should mostly be responding to personal alarms and providing short term support. Demand is such at present however that this team is significantly deployed in supporting the main rotas.

There have been persistent rota gaps and difficulty recruiting to posts. The current care cannot be delivered without significant input from mainland-based staff filling expected/unexpected rota gaps. Management work hard on filling rotas and arranging for staff to come over to Arran to ensure safe care.

Location plays a significant part in whether care can be provided as travel time clearly increases the overall time required. Service users living out with the Brodick/Lamlash/Whiting Bay axis are more challenging to provide care packages to.

2.1.2.17 Long Term Care - Montrose House

Montrose House is a purpose built, local authority owned care home in Brodick. It is a modern single storey building that replaced the older unit on a nearby site. It combines a residential care unit for older people with the Stronach Day Care unit. The residential part of the unit has capacity for 18 residents and has 2 beds which are used for respite care. All rooms are single occupancy with en-suite wet floor showering facilities and each room has a small patio area leading to a secure enclosed garden. There are bright and spacious common areas. The unit was built to accommodate envisioned step up/down care which has not been realised, as a result there is a wing of the unit that is unused and a further 10 beds that are not registered with the care commission. The residential unit consistently operates at capacity with a waiting list and is supported by the GP practice and AHPs.

The Day Care unit can accommodate up to 12 users daily in spacious, flexible and well-equipped spaces. This capacity has rarely been reached due to a combination of factors, including difficulty recruiting staff and challenges in transporting users from distant parts of the island to Brodick and home again. There is a waiting list for Day Care. Ongoing work is looking at an alternative provision through Outreach to mitigate the travel issues, but this is in the early stages of analysis and service modelling.

Unfortunately the creation of Montrose House, which occurred before the formation of the local health partnerships, was not seen as an opportunity to review and consolidate health and social care services across Arran.

2.1.2.18 Private Care Home

Corriedoon Nursing Home is a private nursing and residential Care Home in the village of Whiting Bay. It has been operated by the same family since 1988, in a two-storey converted hotel, first built in 1900. There are 16 single rooms some of which have ensuite facilities and 6 shared rooms that do not have ensuites. Corriedoon is registered to provide up to a maximum of 28 residential places and is also supported by local GP's and AHP's. There is some uncertainty regards the future. It is currently on the market and, should it be sold, or the owners decide not to continue the business it would be very challenging to find residents alternate accommodation on Arran – further underlining how such challenges disproportionately affect smaller communities.

2.1.2.19 Visiting Staff Accommodation

At the present time visiting staff from the mainland and local on-call staff are accommodated within one on-call room at AWMH, a three-bedroom house that is rented by the Board and Bed & Breakfast accommodation when required. Several essential services on the island are dependent on mainland staffing for sustainable rotas and accommodation on Arran is limited and expensive. The certainty of increased future need, alongside a falling working age population will see increasing dependence on mainland-based staff who will need temporary accommodation. Staff using these facilities include GP's on-call and Locum GP's, Radiographers, Midwives, Catering Staff, Social Work staff and Students.

In addition to the above there are significant periods when Residential Care staff and Care at Home staff also require accommodation on the island when staff rotas cannot be filled due to illness, holiday leave etc.

Accommodation availability on Arran, particularly B&B facilities, can be extremely difficult to access over the summer months.

Proposals for in-house overnight accommodation have been included in the Schedule of Accommodation supporting this initial Agreement.

2.1.2.20 Dental Care

Dental Care is provided on the island by two services. The first is an NHS Independent Dentist working out of their own practice building and the second is an NHS Public Dental Service Dentist working within a dental surgery located in a standalone building next to AWMH in Lamlash.

The NHS independent practice has been for sale for over a year, as the dentist is looking to retire, and relocate back to the mainland. The dental practice forms part of their home and therefore any perspective buyer would have to purchase the home and business together.

The practice located next to AWMH contains two surgeries. This is supported by 2.6 WTE admin and dental assistant staff. This building was refurbished 6 years ago as there were issues re flow of dirty/clean utensils moving through the Local Decontamination Unit (LDU). With only one Dentist currently available there are gaps in service over holiday periods and sick leave. The current position took 7 years to recruit.

With both dentists being at the point where they will be making retirement plans, any future developments must ensure that we are in the position to offer the best support and facilities to any new dentists who wish to relocate to Arran. The Scottish Government expects that due to the investment in dentistry and with record numbers of dental graduates over the past ten years that in the future all General Dentistry would be provided by Independent General Dental Practitioners.

Current assessment indicates that two dentists are required in future and that the surgery should be integrated into the new Hub facility. This could then be leased back to independent practitioners. Further analysis of current activity and potential costs is required before a formal position can be agreed, however accommodation has been included in the Schedule of Accommodation supporting this Initial Agreement.

2.1.2.21 Optometrist Service

Optometrist services on the island are currently provided via and independent Optician which is well used and liked by the community and there is no intention to change this in the context of any future model of care.

2.1.3 Service Providers

Health and Social Care services are delivered by NHS A&A and North Ayrshire Council. Scottish Ambulance Service are based at Lamlash Memorial Hospital and deliver services across the island including liaison with Air Ambulance and Ferry services where transports to the mainland are required. Various self help and support services are delivered by third sector partners.

2.1.4 Associated Buildings and Assets

2.1.4.1 Arran War Memorial Hospital – Lamlash

The main hospital building dates from 1922 when it was purpose built as a cottage hospital. It sits on a relatively constrained and split-level site at the end of a difficult to navigate single track road (Margnaheglish Road).

There is currently a War Memorial Plaque in the Main Entrance commemorating the people of Arran who lost their lives in war. It is an important piece of history for the islanders and further community engagement will be undertaken to ensure that, if AWMH is disposed of that, the Plaque will be moved to an agreed location as part of the overall project.

The accommodation is on two floor levels but with poor vertical communication provision. An 8-bed in-patient ward extension was built in 1972 and following that a new operating theatre was added in 1980. There is also a temporary modular building on site which provides space for out-patients, the community nursing team and meeting / seminar room.

Dental facilities are also located on site and these were comprehensively redeveloped and extended and completed in 2013.

The Scottish Ambulance Service has an ambulance station on site which is fairly standard provision of garage facilities, external hard standing, staff welfare - kitchen, sitting and changing areas, office and storage for medical consumables.

The relatively constrained site also includes two areas of car parking, estates buildings, boiler plant along with the aforementioned separate buildings – modular unit, dental and ambulance station.

Pedestrian access is affected by the sloping site and area available for compliant ramps. The public bus services that come to site have lifting platforms for wheelchairs, but there is no fully compliant route to access the main building from the drop off point.

The layout within the main hospital block presents many challenges for delivery of clinical services. As highlighted, the upper floor level which also contains clinical services – principally a small maternity unit, is not easily accessible and this creates compromises. There is one single main waiting area adjacent to reception and both this and the reception point are shared for all services and including A+E. This lack of segregation of flows also includes paediatric attendances. Space standards are generally constrained throughout, particularly in the original part of the hospital which includes the main entrance, X-Ray and urgent unscheduled care and with poor adjacencies affecting ease of delivery of much of the clinical activity. As an example, there is no suitable rehab gym and patients are assessed for mobility on the main stair off reception as there is no space elsewhere to put in a small testing stair.

The theatre suite is currently mothballed with no plans to bring back into service, but this area offers little scope for supporting the scale of reconfiguration required. In-patient accommodation has been upgraded with the creation of two single bedrooms with ensuites, but further improvements will be difficult to achieve within the current footprint constraints.

Development options were reviewed at a very high level and relative to the potential to bring more services onto site. Given the sloping site in particular and the challenges that presents along with the lack of physical site space available for any sort of phased redevelopment it was determined that any significant redevelopment on the site for modern healthcare services was not feasible.

Backlog maintenance and life cycle data has been reviewed for the hospital (including the ambulance station and external areas). Currently recorded backlog is sitting at £467,785 (with no High-Risk items, but with a Significant Risk item of £20k noted in respect of existing Boiler Plant). The building appears to be generally well maintained and the backlog figure is more reflective with the age of the building and where investment has been prioritised in recent years.

Looking at the life cycle profile for the hospital site, this highlights a total investment requirement of just under £2m (including noted backlog) within the next ten years. This requiring to also be aligned with the poor current functional suitability of the facility which cannot be addressed within the current buildings.

2.1.4.2 Brodick Health Centre – Brodick

Brodick Health Centre is located centrally within Brodick and is housed in a large sandstone Victorian villa with a modest and relatively new rear extension for main entrance, waiting and reception and with all clinical spaces generally within the original building footprint. There is consulting / treatment space on the first floor which is accessed via a single narrow staircase off the original entrance hallway. The spaces are of varying size and quality though are reasonably suitable for their function with the exception of the first-floor patient areas which are only accessible by stair. The largest room has been given over to the practice nurse as a treatment room and this is the most functionally suitable.

In order to provide related staff support space, a single modular building unit has been located

adjacent to the entrance at the rear.

Main car parking is to the front of the facility.

Backlog maintenance and life cycle data has been reviewed for the facility. Currently recorded backlog is sitting at £30,917 (with no High Risk or Significant Risk items noted).

Looking at the life cycle profile for the facility this indicates an investment requirement of just under £540k within the next ten years. This is a significant figure in the context of this relatively small and limited value property.

2.1.4.3 Lamlash Medical Centre – Lamlash

This facility sits close to the edge of the settlement boundary to the west of Lamlash and is close to the secondary school / community campus on the main A841 road around the island. Car parking is good and located adjacent to the main entrance.

The facility is circa 30 years old and was purpose built for its current functions. There are three consulting rooms and a nurse's treatment room. Functional suitability and space utilisation are generally satisfactory though there were some space constraints noted in respect of staff facilities and office accommodation. There is no dedicated staff room (there is a kettle, etc in the main reception office) and overall administrative facilities are constrained. This in part due to the facility housing the main call centre for the medical practice – appointment booking, etc.

Backlog maintenance and life cycle data has been reviewed for the facility. Currently reported backlog is £43,000 and with no High-Risk items noted. Significant Risks of £5k relate to electrical works.

Looking at the life cycle profile for the facility this indicates a total investment requirement of just over £176k (including noted backlog) within the next ten years.

2.1.4.4 Lochranza Surgery (Branch Surgery)

This facility sits within Lochranza on Newton Road and is close to the secondary school / community campus. Car parking is good and located adjacent to the main entrance. The facility is circa 30 years old and was purpose built for its current functions. There is a single consulting room and associated functional suitability and space utilisation are generally good.

Backlog maintenance and life cycle data has been reviewed for the facility. Currently reported backlog is £50,398 and with no High-Risk items noted. Significant Risks of £10k relate to statutory compliance works.

This site suffers from periodic flooding due to its location and this requires reactive maintenance to rectify the effects and also creates longer term impacts on the condition of the facility.

Looking at the life cycle profile for the facility this indicates a total investment requirement of just over £124k (including noted backlog) within the next ten years.

2.1.4.5 Shiskine Surgery

This facility sits within the settlement of Shiskine and off the String Road (B880) running across the

island. The surgery also includes an onsite dispensary as the nearest commercial facility is in Brodick. Car parking is good and located adjacent to the main entrance. The then First Minister Alex Salmond formally opened the surgery on 23 March 2009.

The purpose-built facility includes four consulting rooms, treatment room for minor injuries and a health education room which is also used by the local community. Functional suitability and space utilisation are excellent. The facility is leased by Arran Medical Group under a third part contractual arrangement over a 25-year period and there is still 13 years of this concession remaining.

2.1.4.6 Whiting Bay Surgery (Branch Surgery)

This facility sits centrally within the village of Whiting Bay on Montrose Terrace. There is some dedicated car parking adjacent to the main entrance.

The purpose-built facility includes consulting room and treatment rooms. Functional suitability and space utilisation are excellent. The facility is leased by Arran Medical Group under a third part contractual arrangement over a 25-year period and there is still 13 years of this concession remaining.

2.1.4.7 Montrose House – Brodick

This new purpose-built facility was procured by North Ayrshire Council (NAC) through Hub South West and opened in 2013.

The purpose-built facility is all single storey with a mix of accommodation suitable for its function with wide corridors and good access to all areas – both internal and external. There are three clusters of 10 single bedrooms with ensuites, although only two of these clusters are currently staffed. There is also a dedicated suite of rooms and spaces for older peoples' day care.

The building is accessed off Glencloy Road which runs from the centre of Brodick through a predominantly residential area and which is also adjacent to the Auchrannie Resort.

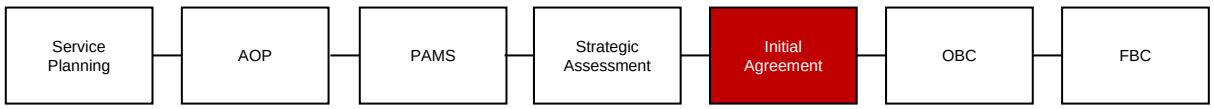
The building is functionally very good given its recent design and construction though it is significantly underutilised due to the 10-bed wing not being used for the relevant client group.

2.1.4.8 North Ayrshire Council NAHSCP – Lamlash

The Health and Social Care offices for social work and care staff are located in the first floor "attic" of the main North Ayrshire Council offices – a sandstone building of similar vintage to the hospital - within Lamlash and accessed off Kilbride Road and on the route to the Arran War Memorial Hospital. The facility is not functionally suitable for its purpose and is generally over utilised.

2.2 Why is the Proposal a Good Thing

NHS Ayrshire & Arran and the East, North and South Health and Social Care Partnerships have described a strategic intent to reform services and invest in infrastructure across health and care services – the Caring for Ayrshire programme. Caring for Ayrshire is a whole system collaborative approach to reform and delivery of health and care services across Ayrshire. It focuses on person centred approach looking to deliver health and care services in an integrated way as close to the service user as possible – a 'right care, right place' approach.



The Annual Operational Plan (AOP) 2019/2020 has been developed to support the long term ambition, whilst improving performance and addressing the national priorities.

NHS Ayrshire & Arran is promoting an integrated approach that will build on work already underway within our transformation programme and approach to service improvement and redesign. The Health and Care Delivery Plan reflects an integrated planning approach for health and care, this plan is appended to the AOP.

This strategic approach described in the NAHSCP Strategic Plan detailed below aligns to Caring for Ayrshire.

The North Ayrshire Health & Social Care Summary Strategic Plan

The North Ayrshire Health & Social Care Summary Strategic Plan for 2018 to 2021 sets out the challenges facing all partners with the increased demand on services year on year. The North Ayrshire Health and Social Care Partnership in an increasingly challenging financial environment will:

- work differently
- be more Innovative
- will provide safe and effective services

Residents of North Ayrshire or users of these services can assist this delivery by:

- taking care of their own health and wellbeing
- being more informed about how best to address their health concerns
- being mindful of the wellbeing of others in the community.

The stated vision is that all people who live in North Ayrshire are able to have a safe, healthy and active life. To reach this vision we will continue to focus on:

- tackling inequalities
- engaging communities
- prevention and early intervention
- improving mental health and wellbeing
- bringing service together

To facilitate the required changes, arrangements will be put in place to reconsider the level and type of service that we can sustain across the area including Arran. This reflects the funding available and recognises specific issues around the recruitment and retention of staff to various specialist posts and particularly on the island itself. A revised Model of Care will be required on Arran that will look specifically at:

- the hospital model, to determine what services need to be provided locally and which are best provided on the mainland, and the associated staffing levels required to maintain a safe, high quality and effective service.
- the primary care model, to determine an equitable distribution of primary care resources across Arran, recognising the particular recruitment challenges in this area set alongside the Government's commitment to secure investment at 11% of front-line services by 2020; and
- developing an affordable and sustainable social care model for Arran, which examines the network of care centres and Arran-wide services and responds to the need to promote self-care and multi-disciplinary teams working to support individuals and families to live well for

longer in their own home, or a homely setting. This is under-pinned by the Older People's Strategy and Shifting the Balance of Care from hospital to community settings.

The overall approach is to ensure that working collectively adds value and that it will be possible to demonstrate improved efficiency, quality and sustainability.

The collective vision for Arran is to create a health and care system which will:

- Prevent illness as far as possible and raise the profile of health and wellbeing as the major priorities
- Help people 'own' their own health and take responsibility for managing their own conditions
- Help people to make their own choices about their health, treatment and care
- Provide treatment and care as close to home as possible either through direct service delivery by staff, or by the innovative use of digital technology
- Where more specialist care is needed this will also be provided as locally as possible and in a way which minimises the need to visit hospital or stay in hospital
- Recognise the role that health and social care services play in the economic and social life of communities – this is especially important on Arran in relation to rural and island communities
- Develop staff to be as flexible as possible in the delivery of treatment and care for the people of the island
- Provide services within the resources that are made available by the Scottish Parliament and involve staff and the people on Arran in making decisions about what change is needed to achieve this.

By 2025 North Ayrshire Health and Social Care Partnership aims to be able to demonstrate that:

- The health and wellbeing of the population on Arran has improved and inequalities in health have reduced
- There has been a shift in our systems from a focus on treatment of ill health to prevention and meeting population health need
- People on the island have equitable access to safe and effective quality care and treatment
- Clinical services operate as a single system and the success of health and social care integration has reduced the need for hospital care and increase the resource available to provide care locally in communities
- The island of Arran is regarded as a model of integration, partnership working and public participation
- Access to services has been significantly improved through the use of technology – where we live is much less of an issue in relation to access to clinical advice and support
- The digital health infrastructure is significantly improved, and processes are in place that support people to live at home for longer, manage their own conditions, and access clinical advice and support from any community
- Successful and innovative approaches to workforce planning and development will play a critical role in the future model of care.
- Tertiary services are stable and sustainable on Arran and are accessible for the population.
- Transformation in the provision of outpatient services will have taken place on the island with enhanced technology and improved communication between primary, secondary and tertiary care.

The Model of Care for Arran aims to:

- Deliver the right level of health and wellbeing support, treatment and care for the people of

Arran and visitors based on the population.
- Help individuals and communities to stay happy and healthy and avoid the need for treatment and care
- Provide opportunities for treatment and care to be delivered at home or as locally as possible – this includes supporting people to manage their own health and conditions
- Minimise the need for people to attend, or be inpatients in hospital, but when this is needed, to ensure that this is efficient, high quality, and highly organised with primary and community care services

The high-level model of care will be similar in other regions of Scotland but the development of the model by NAHSCP needs to take account of the geography and population distribution.

It is also important to ensure that health and social care services are not seen in isolation but as part of the social and economic fabric of communities which contribute to overall sustainability. This is especially the case in rural and the island communities which, because of their distance from larger acute hospitals, need to retain a sustainable model of service which is very different to that found in more urban areas.

A specific service initiative, related to the above, outlines a review of Rural and Island General Hospitals.

- Ensuring the sustainability of hospital-based services across the island is essential in ensuring resilience and sustainability of local communities. Work will continue to establish the appropriate model of care to ensure that critical services can be retained where appropriate. This will be done by collaborating closely with the larger centres, in defining the new pathways and workforce models, including new roles such as Advanced Nurse Practitioner, that will assist in providing the essential services within these localities. The initial focus will be directed towards:

    - supporting sustainable trauma services;
    - ensuring sustainable and effective unscheduled care services for the local population;
    - minimising travel time by maximising the use of technology; and
    - creating an alternative workforce model and expanding opportunities for non-medical staff to develop additional skills and expertise working to the top of their licence.

The following integration planning principles (from Section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014) will underpin how we shape our services and find innovative solutions to meet our communities' needs and improve the wellbeing of service-users so that our services:

- are integrated from the point of view of service-users
- take account of the particular needs of different service-users
- take account of the particular needs of service-users in different parts of Arran
- take account of the particular characteristics and circumstances of different service-users
- respect the rights of service users, whilst ensuring they understand and respect their responsibilities
- take account of the dignity of service-users
- take account of the participation by service-users in the community in which service-users live
- protect and improve the safety of service-users
- improve the quality of the service
- are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the

provision of health or social care)
- best anticipate needs and prevent them arising
- make the best use of the available facilities, people and other resources.

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

Services in Arran will be designed so that:

- urgent unscheduled care is maintained in Arran
- care is only provided in a hospital setting if it cannot be provided safely and effectively in the community
- patients are only sent out with Arran for healthcare if it cannot be provided safely and effectively locally
- attendance at hospital for diagnostic tests and investigations, outpatient consultations and minor procedures is kept to a minimum
- healthcare is provided by multi-professional teams, with reliance on single handed practitioners kept to a minimum
- increased use of technology is helping us provide care for the most vulnerable and elderly in our community
- older people and people who are living with long-term conditions will be getting the services they need to help them live as independently as possible
- people will be supported to look after and improve their own health and well-being, helping them to live in good health for longer

West of Scotland Regional Planning

The launch of the Health and Social Care Delivery Plan in December 2016 set out an ambition to look across boundaries and to plan and deliver services that would meet the triple aim of:

- improving the patient experience of care;
- improving the health of populations; and
- reducing the cost of health care.

In the West of Scotland this has been added to by stating that the fourth aim should be about staff value. Since the publication of the plan, Regional Planning arrangements across Scotland have evolved. The West of Scotland group has been working across Health Boards and Integration Joint Boards to establish a common purpose to planning that respects the importance of local and locality planning:

- improving health and wellbeing;
- increasing care and quality;

- better workplace with a focus on staff; and
- delivering best value.

West of Scotland Region

The West of Scotland has a population of around 2.7 million people and covers approximately 8,777 square miles. There is a combination of urban, rural and island communities. A range of organisations have responsibilities for health and care services across the West of Scotland, including the five territorial Health Boards, 15 Integration Joint Boards and 16 local authorities. The vast majority of care in the West of Scotland is provided local to people's homes. For the period 2012/2013 to 2016/2017, activity within the hospital setting grew at an average rate of just under one per cent each year - with the growth much greater among those aged 65 years and over. Activity within the hospital setting in the West of Scotland is higher than would be expected (once age, sex and deprivation are accounted for) when compared to the rest of Scotland.

A draft regional position and discussion document has been developed that describes the collective ambition of the West of Scotland Boards to improve the health and care of the 2.7 million people who live within our communities. This will be done by providing care to and with individuals and their carers that fosters independence; is sustainable; and is safe, effective, equitable and proportionate to their needs. Working across and connecting beyond our traditional boundaries - across health and social care; across professions and disciplines; across settings; across specialties; and across organisations - will be critical to building a person-centred and sustainable service that is fit for the 21st century.

This is ongoing development will build on the engagement to date to create a more involving approach, to look to develop and successfully implement improvements for the West of Scotland. There is an understanding that this is a bold agenda going forward – whether at regional, health board, Integration Joint Board/Community Planning Partnership or locality level – there will need to be:

- celebrating of, learning from and scaling up of good practice within the region;
- co-production with individuals and communities; and across staff, services and organisations;
- fostering of support for improvement from within local communities;
- leadership for improvement at national, regional and local levels; and
- action at a "once for Scotland" level - across the three regions, and with the National Boards."

This has resulted in a Vision that states: -

"We will ensure that wherever you live in the West of Scotland that you are in control of your wellbeing and care, by respecting your wishes and empowering you to live independently.
Our priority is that you will get the care you need in the right place, at the right time, every time".

Patients and Service Users will:

be at the heart of decisions that affect you.

We will tailor our approach so that we provide integrated care organised around your needs and the needs of your carer.

be empowered.

We will provide support that enables you to take greater responsibility for your own health and wellbeing. This will include innovative ways of working to help you live a healthy life in your own home.

receive safe and high-quality care.
Wherever you receive your care and whoever is providing it, we will ensure services are safe and effective.

receive care in the most appropriate place for you.
We will provide care that is both convenient and of a high quality. We will do this by reducing unnecessary trips to health centres and hospitals and ensuring you get the most out of the visits you make.

experience compassionate care no matter where you live.
Wherever possible, care will be provided as close to your home as possible and reflect your care needs and personal circumstances.

All aspects and core of the Vision will be incorporated into the developments being put forward in this document

The Islands (Scotland) Bill

The Islands (Scotland) Bill states that "island communities face challenges around geographic remoteness, declining populations, transport and digital connections..." It is referenced and drawn upon heavily in all local, regional and national planning but also referenced here specifically for completeness.

The Scottish Government has confirmed the commitment to supporting the island communities and improving outcomes by creating the right conditions for growth. "Island-proofing" means considering the particular needs and circumstances of island communities when planning and designing public services.

While services in Arran are part of NHS Ayrshire and Arran and North Ayrshire Council and not specifically an Island Board, they still face significant challenges in being able to continue to provide safe and effective health and care services. It is further recognised that support to islands from the mainland is well established but also that there is an opportunity to strengthen these support arrangements to help both sustain services at a local level and also ensure access to more specialist services that are not available locally. Importantly, it also acknowledges that:

"The island hospitals need a level of activity to maintain an adequate level of provision for emergencies. The staff need a broad range of skills and are often required to undertake both generalist and specialist tasks. The Regional Plan provides a commitment to treatment as close to patient's home as it is possible and safe to do and this, alongside effective use of technology, will help to minimise the time which island patients spend travelling to/from treatment".

The evidence strongly suggests a reconfiguration of existing services, structures and leadership is required to improve access to services, reduce inefficiencies, improve service user experience and help to meet the increased demand for health and social care. It is therefore proposed that an Integrated Island Services Model for Arran, in line with Scottish Government policy, is implemented. New models of care for health and wellbeing developed for this project will inform the Caring for Ayrshire programme and whole system direction of travel throughout Ayrshire & Arran.

This approach will provide a continuum of integrated primary and community-based services for the assessment, treatment, rehabilitation and support for adults with long term conditions and older

people at times of transition in their health and support needs [Scottish Government, 2012].

The components of Intermediate Care across Arran are best delivered as a continuum of integrated local services with pathways that enable continuity of care and maximise independence for service users, blurring and expanding of roles for practitioners, develop trusting relationships between staff across different settings and provide opportunities for staff to rotate across teams and care settings.

The model is centred on the introduction of an Arran Hub facility (the Hub) to provide a single point of contact for all health and social care services co-ordinated through a single, island-based management team, to maximise resources, improve care co-ordination and reduce duplication. The Hub will provide multi-disciplinary triage to ensure assessment, treatment, rehabilitation and care provide an alternative to hospital admission. This will enable local people to maximise health & well-being to and stay as independent as possible and where acute or step up services are required, provide support to be discharged as early as possible. The key objective is to deliver a new model of care that integrates services. The development of a Hub will facilitate this on Arran. In addition, the project will

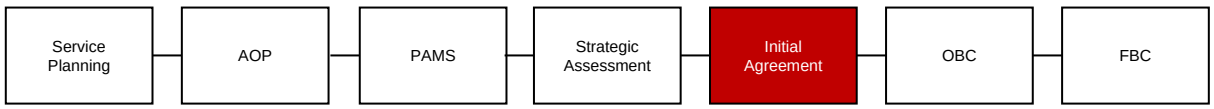
- Reduce the number of Public Sector buildings/sites on Arran
- Provide accommodation for integrated teams
- Provide up to date IT and telephony to support teams, reduce duplication, encourage communications and support a single point of contact for local patients and staff
- Allow the development of a single assessment and care record
- Identify other agencies/services that would be interested in joining eg; Scottish Ambulance Service/Police
- Incorporate overnight accommodation for staff as required
- Maximise utilisation of existing staff to provide a safe and supported 24-hour service to the island covering all aspects of health and social care.
- Work with partners to address accommodation needs across the island to support staff recruitment and retention.

From this work, the Board recognised that the Arran population wanted to build on the good quality services already provided and that they were broadly supportive of the present configuration of services. It also recognised that there were (and remain) challenges to sustaining this because of workforce and financial constraints.

The Arran Integrated Island Services model will provide a common framework wrapping services around the individual as outlined below.

The themes developed within the clinical strategy were:

- Reduce unnecessary patient journeys to the mainland;
- Integrate community and hospital services especially nursing;
- Develop a one stop shop approach to making appointments, starting with the hospital;
- Develop a more responsive mental health team;
- Proceed with a formal process to close NHS facilities where appropriate;
- Strengthen resilience and sustainability of healthcare on the island;
- Re-model clinical staffing to respond to the national shortage of junior doctors and challenges to the recruitment & retention of staff. An example of the clinical staffing model changes required would include the development of ANP roles, two of which are currently being developed, which do not currently exist on Arran, to create additional flexibility and innovation in the staffing of 24-hour rotas that must also cover urgent unscheduled care services in line with alternative models being used elsewhere.



The document also strengthened those principles previously agreed that were summarised as:

- Urgent Unscheduled Care Services must be maintained locally;
- Care should only be provided in a hospital setting if it cannot be provided safely and effectively in the community;
- Patients should only be sent out with Arran for healthcare if it cannot be provided safely and effectively in Arran;
- Attendance at hospital for diagnostic tests, outpatient consultations and minor procedures should be kept to a minimum;
- Healthcare should be provided in multi-professional flexible teams, with reliance on individuals kept to minimum.

The themes were then used as the basis for the development of a comprehensive action plan setting out the programme of work required in order to realise the clinical service goals described in this strategy.

Extensive engagement and consultation meetings have already taken place involving the wider community on Arran and will be progressed as the project develops further. The Arran Services Communication Plan is attached at Appendix

2.2.1 Need for Change

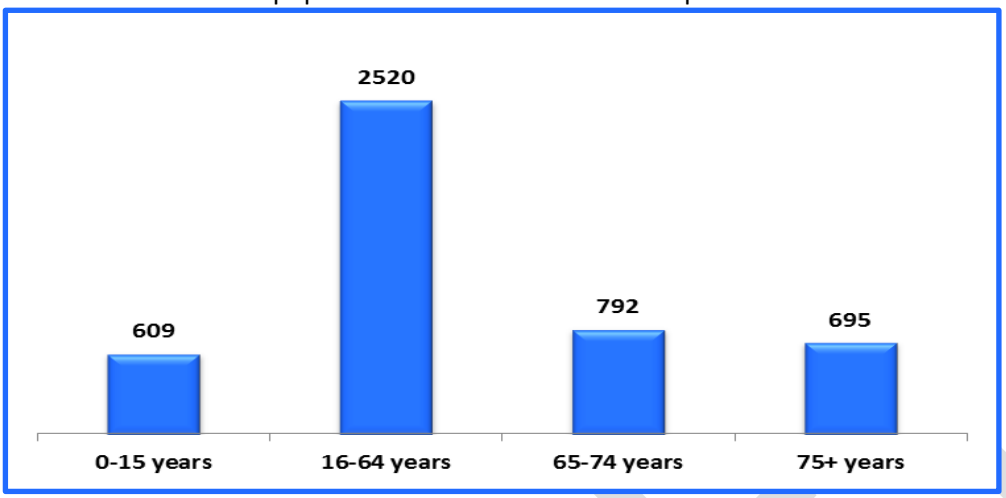
The Isle of Arran is located in the Firth of Clyde off the coast of Ayrshire. At 432km2, it is the seventh largest Island in Scotland.
The challenge of delivering health and social care to the population of Arran is escalated by being physically separate from the mainland and the geographically distributed population. The majority of the population resides in Lamlash, Brodick and Whiting Bay.

Population figures have been sourced from the Mid-year population estimates for 2016 from the National Register for Scotland. These figures identified that Arran has a population of approx 4500 with the majority of the population based in:

Lamlash	1120
Brodick	890
Whiting Bay	620

In addition to Brodick, Lamlash and Whiting Bay there are another 9 smaller settlements, with populations of between 40 and 250, scattered around the 56 mile radius of the Island, with the rest of the population living in single or small groups of houses in between these settlements.

A marked increase in the population is identified between April and October with visitors and temporary residents to the island. Figures for 2017 show circa 430,000 visitors, up from 2016 figures of 414,000, consistent with the overall trend of increased numbers over the last few years. Visitor numbers supplied from Visit Arran and the Arran Trust's STEAM (Scottish Tourism Economic Activity Monitor) Trend Report 2009 – 2017.



The proportion of Arran's total population aged 65 years and over has increased dramatically in recent years, rising from 23% in 2001 to 35 % in 2013. In comparison there has been a 32.0% fall in the child population (under 16s), and a 16.0% fall in the adult population (16-64).

The Gross mean house income in North Ayrshire in 2015 was £30,537. This was 12% lower than the Scottish Average of £34,625.

When referring to the graph above, it is evident that of the 2,106 households in Arran 1,353 (64%) had an income of less than the North Ayrshire Average. The highest proportion of households in Arran had an income of between £10k - £20k (29%).

There are no figures to estimate the population projections for Arran in the future. A simple analysis of current demographics would predict an overall fall in future population. However, this does not account for the fact that Arran sees significant inward migration, often around retirement age, and this will likely maintain the population and further skew demographics toward older age groups. Analysis of registrations with the GP practice reveal 30% of those aged over 65 have moved to Arran in last 10 years. Figures from NHS Ayrshire and Arrans Public Health report predict an increase for the coming decade of 50% in people aged over 80 and 25% in those over 75. population At the same time the proportion of adult (working age) population decreases from 51.8% to 47.4%.

(Data provided by GROS – small area population estimate by SIMD localities.)

Key strengths for the Arran population include:

- Higher life expectancy
- Low levels of deprivation
- Low unemployment

- High educational attainment
- Low crime rates

However, the island's needs in contrast to the strengths include:

- Falling population
- Geographic Access
- Older age profile
- High Dependency Ratio – a small shrinking working age population
- Housing Availability and Affordability

Arran has an older age profile than the mainland which will put increasing demand on health & social care services. The proportion of residents aged 65yrs and over is approximately 30% (based on GP registrations) compared with a North Ayrshire rate of 19%. There is also a higher life expectancy on Arran for both men and women in comparison to North Ayrshire and Scotland.

Local data indicates there is greater disease prevalence on Arran for people with Atrial Fibrillation, COPD, Depression, Epilepsy and Heart Failure. The prevalence for Cancer, CKD, Diabetes, Hypertension, Obesity, Palliative Care, Rheumatoid Arthritis, Stroke and Thyroid disease is the same as the rest of Ayrshire.

This means that there are significant numbers of frail elderly people with multi-morbidity. The exacerbation of any of these illnesses, common in the older person puts additional pressure on current health and social care services. Audit Scotland figures (http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_160310_changing_models_care.pdf) help understand the likely impact of an increasingly elderly population. As we head toward 2030 these predict a 33% increase in homecare clients, a 12% increase in GP consultations, 26% more acute urgent unscheduled care bed days and 14% more acute day cases. This is likely to be a conservative estimate given the greater elderly population on Arran.

Current service provision is complex and likely to appear confusing to service users and those who deliver treatment, care and support. There are many links and strong interdependencies necessary to ensure service delivery, some of which are tenuous and unclear. Services are being provided by multiple providers, from a variety of locations by a large number of professionals, but often, to the same client and in an uncoordinated way.

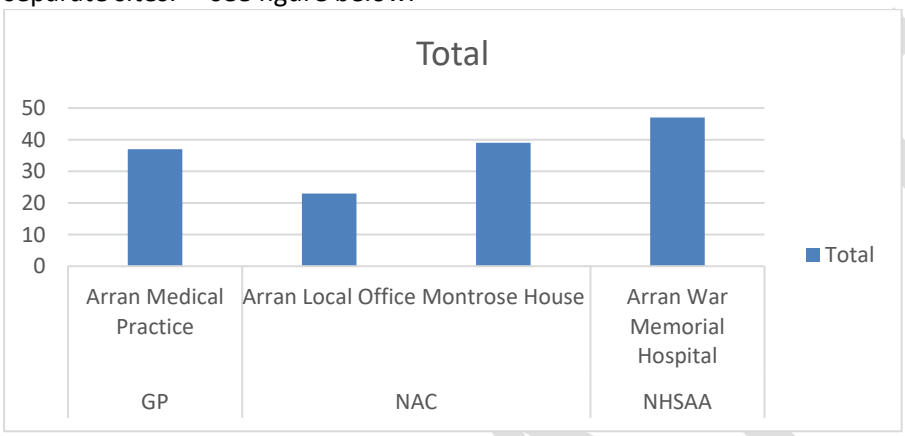
NHS Ayrshire & Arran corporately delivers its objectives through an established structure that includes a number of standing committees that cover key areas such as the Audit; Clinical Care and Professional Governance; Staff Governance; Remuneration; and Endowments. The Board has also established an Integration Joint Board, in conjunction with North Ayrshire Council to oversee the planning and delivery of Community Health and Social Care services. This is in line with the responsibilities under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. The functioning of the Integration Joint Board is described within the Integration scheme, agreed by the Cabinet Secretary for Health, Wellbeing & Sport and approved by order.

Health and Social Care services across Arran and North Ayrshire are delivered by a range of key stakeholders that include:

- NHS Ayrshire & Arran
- North Ayrshire Council
- 3rd sector and voluntary organisations

Direct health and care services are delivered from a number of defined locations across the island, although all hospital-based services are delivered from the Arran War Memorial Hospital, Lamlash which is the primary focus of this IA.

On Arran the North Ayrshire Health and Social Care Partnership, NHS Ayrshire and Arran Board, and Arran Medical Group, currently employs between them, 146 members of staff with an average age of 48. Over 49% of current FTE staff are in the 50+ age range and going forward specific recruitment drives must address the future planning to replace those staff nearing retirement. Staff are currently spread across multiple locations which effectively splits the existing bed base and staff across two separate sites. – see figure below.



GP's in the Arran Medical Practice deliver services 5 surgeries spread across the island with the resultant admin staff similarly spread across sites.

The option costs listed later in this document are based on a Schedule of Accommodation which has been reviewed against the analysis of the current workforce across the North Ayrshire Health and Social Care Partnership which is contained in **Appendix A**

2.2.1.1 Opportunities for Improvement

The "Vision of Arran's Healthcare", agreed in May 2016 following the Arran Review of Services 2015-2016, set out to determine the optimum shape of sustainable health and care services in Arran over the next 15 to 20 years. A key aim of this piece of work was to present longer-term choices for future service requirements in Arran, and those recommendations that would help to achieve this. The vision statement that emerged following extensive and inclusive engagement with multiple stakeholders was a requirement for:

"a *new model that increases support for an ageing population with increasing multi-morbidity, delivered by an enhanced and extended multi-disciplinary team that are truly integrated and co-located. This will result in a more responsive service resulting in fewer admissions and reducing delays in discharge with re-establishment of independent living in a person's own home, wherever possible."*

Key elements of this vision presented a situation where, by 2022 onwards:

- Arran will continue to deliver high quality, local health and care services, which have developed to ensure they are suited to the needs of the population moving forward. Services will make best use of community strength, community spirit and involvement, which has helped to shape services as well as the way of life. People feel responsible towards each other

within their own community. Self-help includes making healthy lifestyle choices, and people using their knowledge and own capacity to look after themselves and each other.

- Services will have fought hard against, and continue to tackle, the major threats to health –the whole community has been encouraged into more exercise and healthier eating. Teaching and support for children and families in emotional and mental well-being from an early age has changed the impact of early death and illness from the major preventable diseases.
- People will be in control of not just their own health, but how they use services and make decisions about their own care – working in partnership with professionals. Development of technologies has brought coherence and single platform access to electronic patient records. Communication technologies, such as the internet and videophones, are routine public facilities that have been integrated into service delivery. This has helped to improve professional and patient access to diagnostic tests, information and advice, and to enable remote consultations for patients, helping to counter some of the isolation of island living that can affect access to services.
- Community and primary care services (first access services) will be provided in localities from flexible shared facilities for the range of services that can be provided close to people's homes (for instance, schools and community education sharing facilities with leisure and social activities as well as health and social care staff). Close relationships amongst teams in local areas will maintain continuity of care and 'family health and care' services. The high-quality infrastructure of Arran care services will be been maintained and are used flexibly to support people and enable them to be cared for in their local communities, whether they live with disabilities or are frail and elderly. Integrated local community transport ensures equitable access to all health and care services, made as easy as possible for those living most remotely.
- People with disabilities will live their lives to their full potential within their local communities, supported as necessary either within their own families or living independently. In addition to employment and/or social support as necessary, communities will have taken on the skills and knowledge to include people with disabilities in all aspects of life.
- Arran's population will receive improved and ongoing urgent unscheduled care, assessment, diagnosis, treatment and a range of sub-specialist care through a local modern and functional "Hub" with multi-disciplinary teams providing these services consisting of consultants, nurses, allied health professionals and clinical support staff who work within flexible, patient-friendly facilities to deliver care in a way that cuts across traditional and professional boundaries to provide a patient-centred hospital service. The local workforce will deliver care in all available facilities across Arran, using locality facilities where possible and the hospital only where necessary. Staff will be skilled in roles relevant to the local service to deliver the range of care needed locally. For additional specialist and tertiary care, patients may require to travel to mainland centres, but only where care cannot be delivered safely and efficiently in Arran. Transition through these external services is improved and smooth thanks to efficient transport links, the use of a single patient record system and appropriate local support.

To support and facilitate all the above it was recognised that the current estate configuration does not provide opportunities for bringing staff together from all partners to work in multi-disciplinary teams to deliver efficient and seamless care to patients and users of services. The sustainability of the current model of care and disseminated teams is challenging and places significant pressure on team members trying to maintain 24-hour care where and when this is required. The Review identified a need for a new "Hub" that would bring all partners together in a single location and provide true integration for teams to deliver flexible and sustainable services. It would allow the rapid establishment of the new service and model of care that focuses on the patient at the heart of all activity. This new service will include:

- A Single Management Structure

- Single Teams
- A new Model of Care
- Single Care Records
- Single Point of Contact - SPOC
- A new Hub facility

The Vision also recognised that AWMH is an ageing facility that is not well suited to the delivery of modern-day healthcare" and would not support the establishment of integrated teams nor offer the opportunity for the model of care to be fully developed. Although recent service redesign projects have identified optimal patient pathways through hospital care, limitations of space and long-time establishment of some departments make it very difficult to configure the hospital in a way that is best suited to service delivery".

In addition, The Health and Social Care Locality Forum for Arran was established in March 2016.

Membership of the Forum includes Patient, Carer, Third and Independent Sector representatives, in addition to a GP from the Arran Medical Group, and a range of Health and Social Care Managers and Professional Staff.

It was agreed at the first formal meeting of the Forum that the following priorities (identified as part the Arran Service Review) would form the initial focus:

- Reducing Social Isolation on Arran (including extending provision of Befriending, potential use of Montrose House facilities for social activities etc)
- Transport (including conducting a mapping exercise of on and off Island arrangements in relation to Crosshouse and Ayr Hospitals, and exploring opportunities to improve future transport arrangements.)
- Generic roles

The development of a new Hub addresses several identified challenges and offers significant opportunity. The most important element is the development and implementation of a new model of care and sustainability of island services.

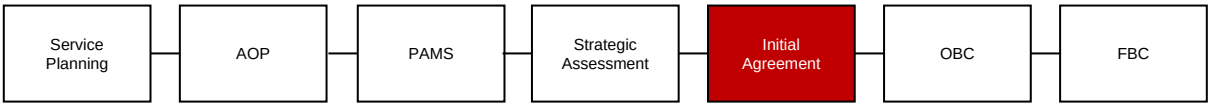
Meeting the needs of the local community and providing care by a range of staff with generic skills in their own homes or in homely settings is another key aim of the new model. This will require transformational change across services and will tackle issues of silo working, break down old interfaces and empower self-managed teams to deliver a joined-up service.

To underpin this approach, a single IT and telephone system will be developed which will support a single care record and therefore enable multi-disciplinary assessment to be made through a Single Point of Contact (SPOC). This will enable greater coordination of care and flexibility, which is crucial for maximising service delivery.

In addition, it is proposed that a reduction in the number of sites that services are currently delivered from is implemented, which will enable centralisation of services and at the same time address the inadequacy of some sites, and associated costs of running multiple sites.

There will be an opportunity for partners: Scottish Ambulance Service, Police Scotland, pharmacy and the third sector to engage in the new model of care and co-locate in the Hub.

The intention of this document, in line with Scottish Capital Investment Management Guidance is:

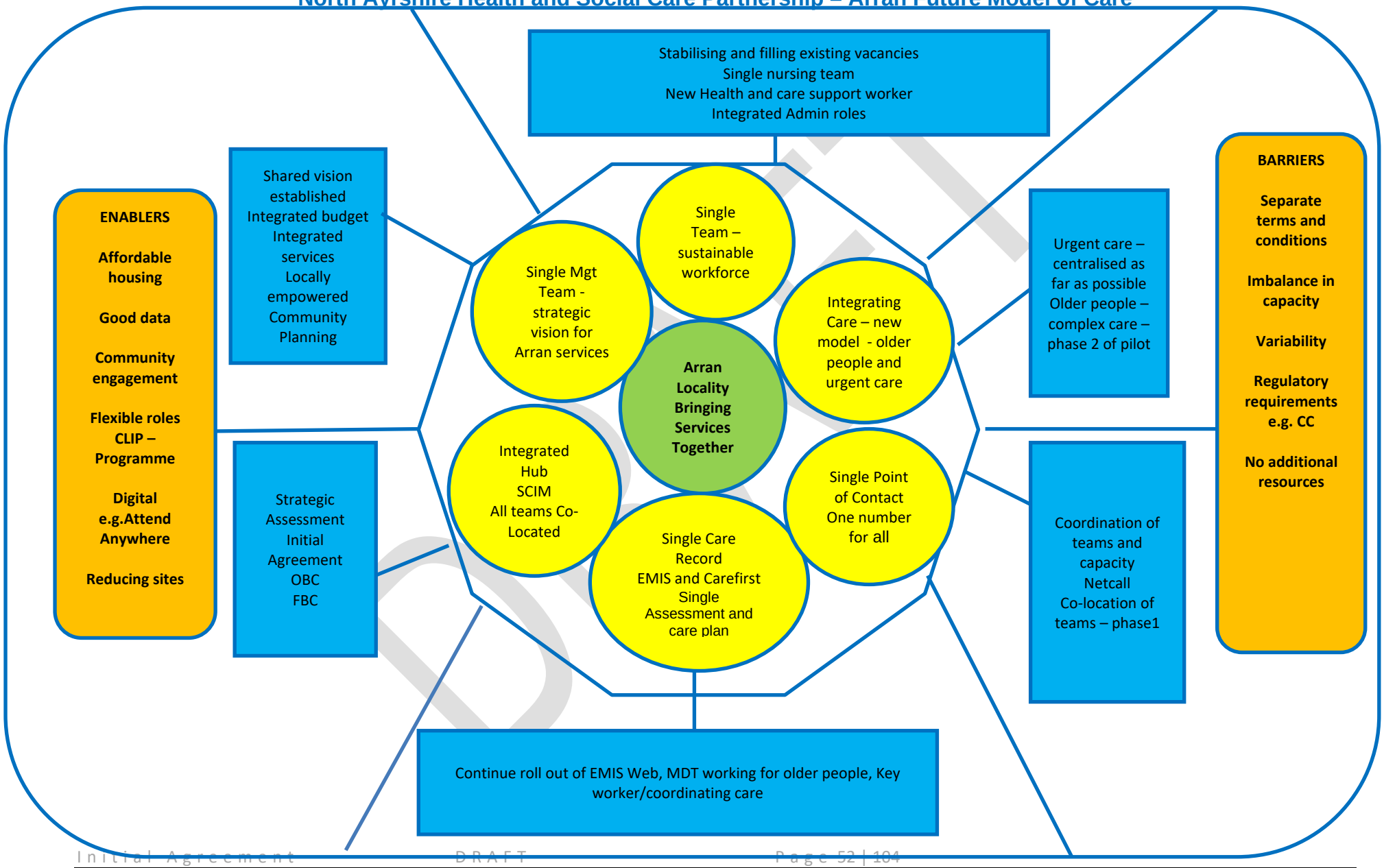


- To establish the case for change and the need for investment.
- To provide a suggested way forward for the scheme for the early approval of all stakeholders.
- To provide an early opportunity for NHS Ayrshire & Arran, North Ayrshire Health & Care Partnership, North Ayrshire Council, Scottish Ambulance Service and key external stakeholders including Police Scotland, the Locality Forum, Patient Groups, Elderly Forum, 3rd sector organisations and Arran Economic Group.to consider this proposal and influence its direction.
- To ensure 'initial agreement to proceed' with the scheme is provided by all stakeholders as appropriate.
- To ensure consistency and close alignment to all local, regional and national planning processes and frameworks.

There is an exciting opportunity through all of this for Arran to create a unique and forward thinking model for remote and rural healthcare that could be replicated across Scotland.

The figure shown overleaf represents the overall vision of services.

North Ayrshire Health and Social Care Partnership – Arran Future Model of Care



2.2.1.2 Problems with the Current Arrangements

This document sets out the current issues and challenges that affect the ability to deliver the future improved model of care. Key factors include:

On-going review has confirmed that there is little formal sharing of information between teams and a lack of understanding of each teams' roles, capacity, and limits. Leadership is team based and there is no joint scheduling or coordination of resources on the island across the whole system and no shared understanding of impact of decisions about limiting capacity in one part of the system and knock on effects of that to other parts of the system. In addition, different teams use different recording systems and therefore there is no single shared client record, making consistency and co-ordination of care difficult and time consuming. The existing IT infrastructure is not fully fit for purpose and is currently supported with Microwave technology.

Individual teams are often small and as a result the sustainability of many services is highly vulnerable to staff illness, recruitment and retention issues, organisational change and other resource limits. In addition, teams are often geographically separate and work along traditionally defined roles resulting in multiple visits and lack of consistency of care

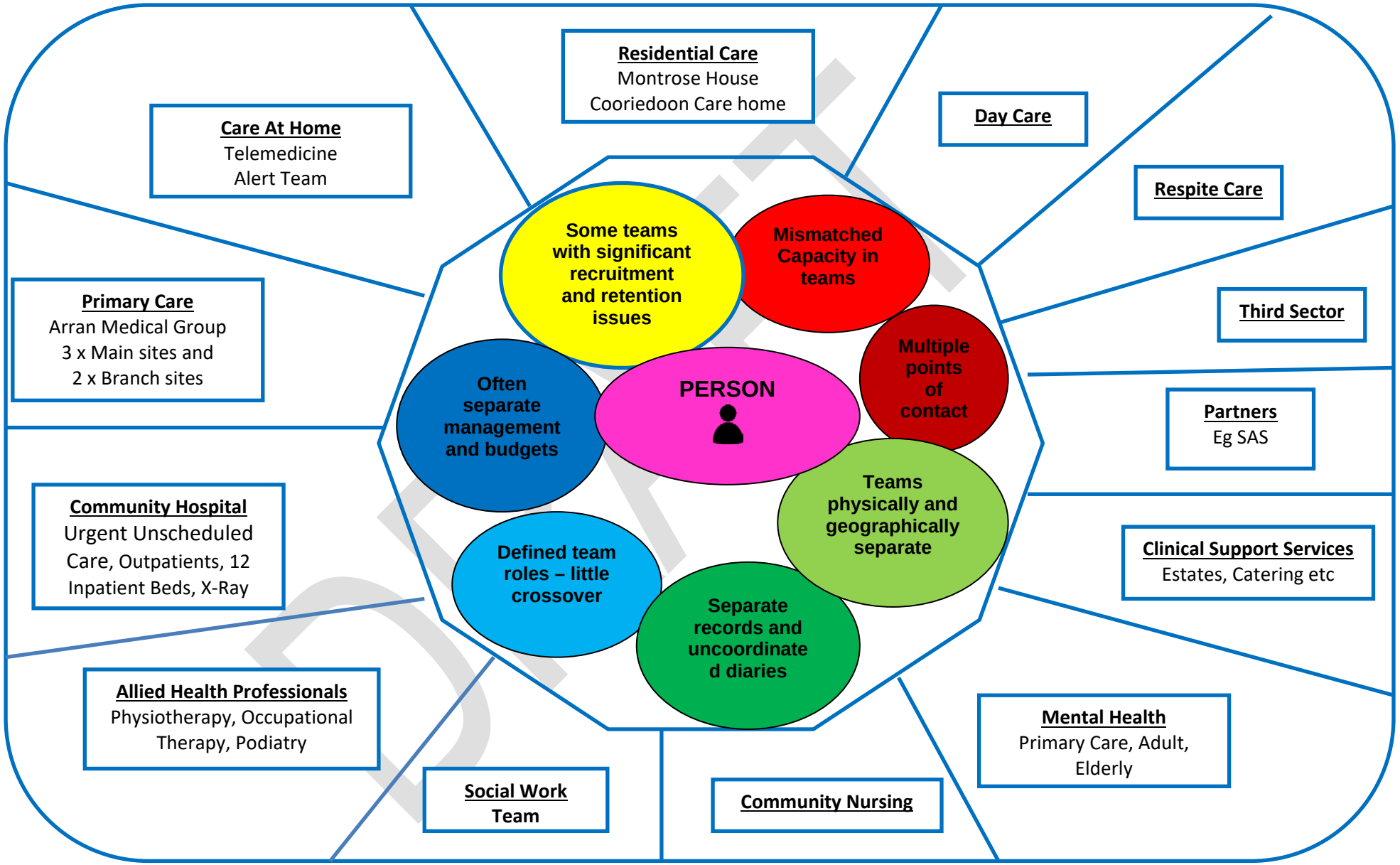
There are significant challenges with recruitment of staff in some parts of the system – largely reflecting the national picture e.g. Care at Home staff, GPs and nurses. This is an ongoing pressure on the island with numerous small teams, where one or two vacancies result in service back logs and waiting lists, over a short period of time. There is currently no "Arran bank" of staff and therefore many vacancies are filled by staff from the mainland. This is costly in terms of travel and accommodation and is not a sustainable model in the long term.

The Arran Locality Forum has been key in supporting the transformation of services on the island and has led the development of key priority areas in conjunction with the forum. These are; Transport; social isolation and support for people with multi-morbidity. Developing new ways of delivering and coordinating transport and helping with social isolation on Arran will be key to the success of the hub. Engaging the third and independent sector in developing the new model of care and supporting these priority areas will be important to the overall success of the transformation of services.

Another key aspect of sustaining services on Arran is staff accommodation. Many of the key workers required to deliver care on Arran are excluded from the current housing market due to affordability. Incorporating some staff accommodation in the hub plans will be crucial to ensuring delivery of services. At the same time exploring affordable housing provision with our partners will be important and will need to happen alongside the development of the hub.

The current provision of beds on Arran is split between AWMH and Montrose House. AWMH provides acute care while Montrose House is a council run residential Care Home. The separation of these two buildings makes it impossible to easily flex staff when challenges arise, and a key element of the new Model of Care is to bring these two sites together to provide the flexibility needed.

The illustration overleaf captures the fragmented model of care and separate service access points that patients have to navigate


Residential Care
Montrose House
Cooriedoon Care home
Care At Home
Telemedicine
Alert Team
Day Care
Respite Care
Primary Care
Arran Medical Group
3 x Main sites and
2 x Branch sites
Third Sector
Partners
Eg SAS
Community Hospital
Urgent Unscheduled Care, Outpatients, 12 Inpatient Beds, X-Ray
Clinical Support Services
Estates, Catering etc
Allied Health Professionals
Physiotherapy, Occupational Therapy, Podiatry
Mental Health
Primary Care, Adult, Elderly
Social Work Team
Community Nursing
Some teams with significant recruitment and retention issues
Mismatched Capacity in teams
Multiple points of contact
Often separate management and budgets
PERSON
Teams physically and geographically separate
Defined team roles – little crossover
Separate records and uncoordinated diaries

HSCP services on Arran are delivered from multiple sites. Some of these are modern, excellent facilities. Many are older, inadequate for the delivery of modern services and expensive to maintain (reference NHS Ayrshire & Arran estates report). Each of the buildings currently providing services are, with the exception of two newer GP Surgeries and the local authority residential home Montrose House, all older buildings which require significant work and there is backlog maintenance and overall lifecycle costs which could be avoided if a new Hub facility is provided.

2.2.1.3 Drivers for Change

There are key drivers to address the need for change on the island of Arran.

First and foremost is the requirement to complete and fully implement ongoing redesign work to create the proposed model of care. The current model of care is complex can be confusing to service users and those who deliver treatment, care and support. The many links and interdependencies that are needed to deliver the current service do not provide service users with clarity of access and in many cases the links are tenuous and rely on island staff to deliver care. With multiple providers, based in a variety of locations by a large number of professionals the services delivered can appear to be totally disconnected.

The current hospital cover arrangements that see 1 duty GP and minimal nursing staff out of hours to cover urgent unscheduled care, hospital and community during periods of increased demand can lead to delays in care as GP have to prioritise in-patients, urgent unscheduled care cases. The need to change GP OOH rotas is critical as prolonged shifts are no longer sustainable. They reduce the availability of GPs in hours and increase the need for other healthcare staff to be first point of contact for presentations.

This situation can be exacerbated with peaks and troughs across the workload in unscheduled care, particularly during holiday periods when the population of Arran rises significantly.

Individual teams are often small and as a result the sustainability of many services is highly vulnerable to staff illness, recruitment and retention issues, organisational change and other resource limits. In addition, teams are often geographically separate and work along traditionally defined roles resulting in multiple visits and lack of consistency of care and the driver for change of providing flexible and sustainable services through the creation of fully implemented MDT's and flexible roles within the teams is seen as the only way forward. While some work has been undertaken to move towards this goal, colocation and integration remain as the critical element of change.

There is currently little formal sharing of information between teams and a lack of understanding of each teams roles, capacity, and limits. Leadership is team based and there is no joint scheduling or coordination of resources on the island across the whole system and no shared understanding of impact of decisions about limiting capacity in one part of the system and knock on effects of that to other parts of the system. In addition, different teams use different recording systems and therefore there is no single shared client record, making consistency and co-ordination of care difficult and time consuming.

There are significant challenges with recruitment of staff in some parts of the system – largely reflecting the national picture e.g. Care at Home staff, GPs and nurses. This is an ongoing pressure on the island with numerous small teams, where one or two vacancies result in service back logs and waiting lists, over a short period of time. There is currently no Arran bank and therefore many vacancies are filled by staff from the mainland. This is costly in terms of travel and accommodation

and is not a sustainable model in the long term.

At the same time as the need for the model of care to change there are also estate and facility elements that form an underlying structure to support this. The changes here are focussed mainly on the Arran War Memorial Hospital whose critical Issues include:

- Arran War Memorial Hospital is extremely difficult to access with DDA compliance issues due to the level changes across site and particularly from the public transport drop off point.
- The main access road is very narrow and has tight corners.
- External areas on the hospital site are tight for all types of vehicle access and manoeuvring generally and as such this presents risks to the public and staff.
- The hospital is generally in a reasonable condition for its age but will require an increasing investment profile to address many of the issues highlighted in the life cycle reporting in particular. The delivery of improvement projects will be complex and expensive due to the overall site and building constraints. The reported backlog and overall life cycle investments requirements will in reality by at least three times, based on national norms, of those as reported to deliver the relevant improvements through actual projects.
- The building is fully utilised.
- There are a significant number of Functional Suitability issues noted with the facility that cannot be addressed within the existing floor plate and overall configuration constraints.
- Feasible improvements have already been carried out to improve functional suitability and utilisation but within a constrained footprint and tight overall site. The original in-patient extension is now nearly 50 years old.
- In patient accommodation is very inflexible due to the two multi bed wards in this very limited compliment.
- Patient flows are generally very poor, and this is due mainly to what are cramped conditions with poor adjacencies. This is also further reflected in privacy and dignity issues for patients visiting most areas of the facility.
- Further expansion options are extremely limited, and the potential benefits would be difficult and expensive to realise while still potentially creating other complex issues that would need to be resolved.
- There was scope identified for internal reconfiguration of the mothballed theatre suite.
- Single bed provision will continue to be very limited without significant investment in compliant new build – which is not feasible on the current site.
- The existing site and facility are not flexible enough for significant future service reconfiguration.
- Statutory compliance issues have been carried out in addressing the recommendations from specialist surveys and inspections.
- Improvement generally is only small due to the ageing and inflexible building.
- In addition to the hospital, Brodick Health Centre is the primary care facility with the greatest range of clinical compromises given the building age and overall configuration. These are as noted above and it should be emphasised the relatively very high overall life cycle costs highlighted point to the early re-provision of this facility.

Life cycle replacement is a major factor in the appraisal of the investment required to maintain the facility to an acceptable standard. The replacement of key components and particularly services infrastructure will affect other components and the work required to be carried out will impact on facility operations and involve significant out of hours working and potentially complex phasing strategies.

The risk profile for the operation of the hospital will increase significantly if there is not on-going

investment. The existing hospital was opened in 1922 and has been modestly extended since then. It is currently therefore 96 years old.

The key outputs from EAMS and the CPS along with site visits have been utilised to form a strategic overview of the current and future physical performance of the facility.

These data outputs effectively illustrate that:

- The existing hospital facility has significantly exceeded its lifespan in the context of modern healthcare delivery.
- The costs highlighted in this overview are extrapolated from the life cycle and backlog information included in EAMS reporting and as extrapolated via the CPS tool. It should be further emphasised that the costs indicated are base costs only and do not reflect the actual cost of delivering backlog and replacement/ renewal programmes of work in a live functioning hospital. Notionally real project delivery costs can be circa 3 times the figures included in EAMS reporting.
- The Arran War Memorial Hospital has been reasonably well maintained but this cannot disguise the fact that there requires to be on-going and increasing investment to ensure that this condition is maintained. As with any investment a tipping point is reached when a view has to be taken as to whether or not any planned and forecast investment is viable for the longer term. In addition, the risk profile will inevitable increase with the age of the facility and particularly if some investment decisions are delayed.
- The existing Arran War Memorial facility, whilst well-maintained for its age, has very poor clinical functionality. This will continue to be a huge burden to effective and sustainable service delivery if it is not addressed in advance of a new facility being developed.
- The reviews, as identified above, have concluded that there is no way to easily address clinical functionality issues within the hospital.
- Overall, the purpose of this IA is not to further determine/support the need for a replacement hospital in Arran, but rather to address core clinical functionality issues with the current facility in the most effective way possible given the age of the existing buildings. Also, to consider the impact of any change/investment in facilities on the medium-long term future of the existing facility and any developing plans for its replacement.

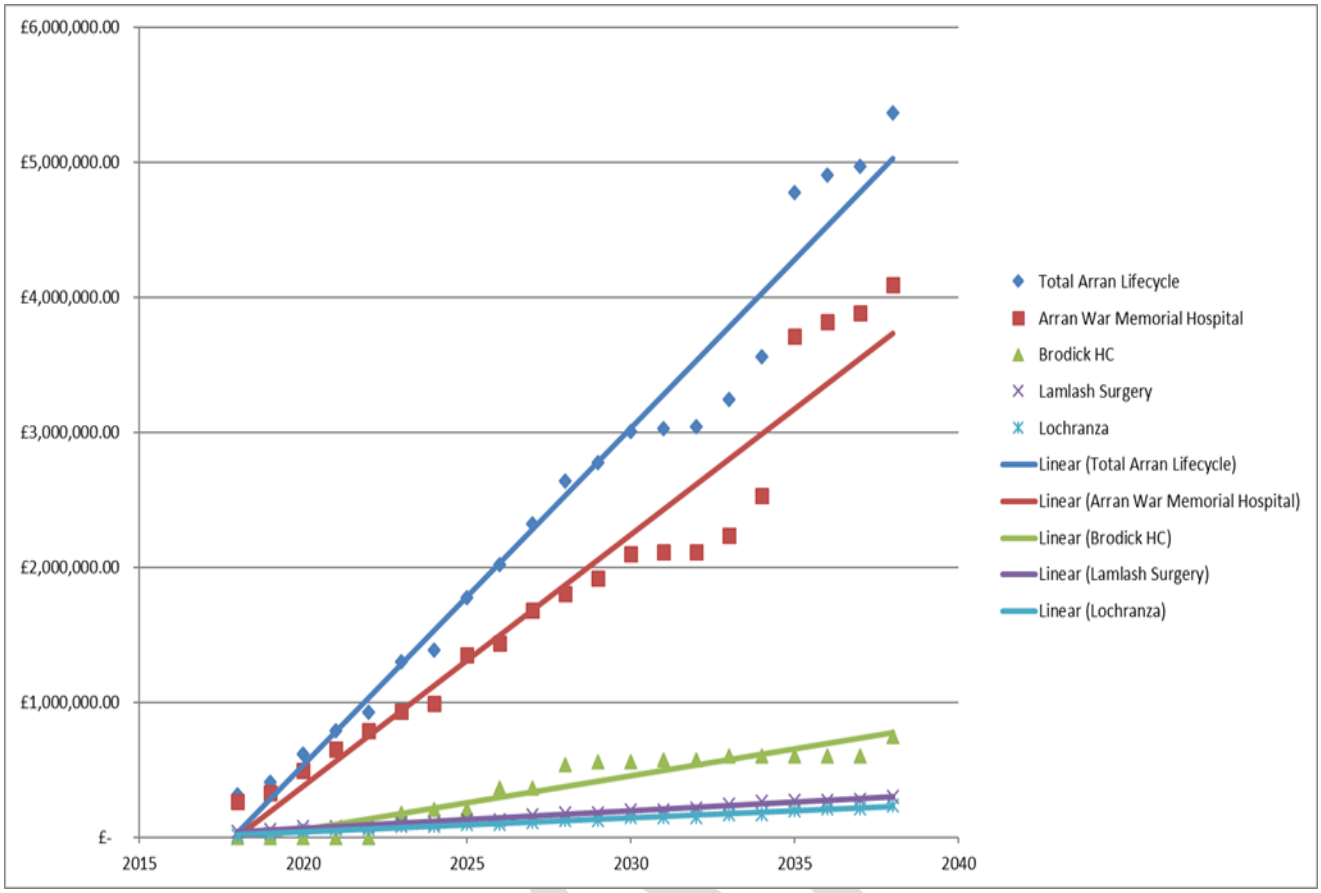
HSCP services on Arran are delivered from multiple sites. Some of these are modern, excellent facilities. Many are older, inadequate for the delivery of modern services and expensive to maintain (reference NHS Ayrshire & Arran estates report). Each of the buildings currently providing services, are all older buildings which all required significant work and there is backlog maintenance costs which could be avoided if a new hub is implemented. Each of the buildings currently providing services, are all older buildings which all required significant work and there is backlog maintenance costs

	Currently Recorded Backlog Maintenance					Life Cycle to 2038
	High	Significant	Moderate	Low	TOTAL	
Arran War Memorial	£0	£20,000	£406,117	£41,669	£467,786	£4,091,607
Lamlash Medical Centre	£0	£5,000	£8,000	£30,000	£43,000	£295,970
Brodick Health Centre	£0	£0	£27,707	£3,210	£30,917	£746,775
Lochranza	£0	£10,000	£29,293	£11,105	£50,398	£234,483

Surgery						
Total					**£592,101**	**£5,368,835**

The Life Cycle Costs are reported through the Capital Planning System managed models which synchronise all data gathering and collation which NHS Ayrshire and Arran are required to do through EAMS. Of the indicated Total Life Cycle cost £2,638,690 – ie circa 50% is applicable to the facilities within the next ten years.

Site Code	Block No	WoS Categories	Operational/ Non Operational	Block Name	GIA (m2)		Year 0	Year 1	Year 20	To Maintain	Cost/m2
A101H	00	Community	Operational	Arran War Memorial			£ 74,000.00	£ 3,090.00	£ 90,980.00	£ 399,594.00	#DIV/0!
A101H	01	Community	Operational	Main Block	1,457.90		£ 148,000.00	£ 44,290.00	£ 81,789.00	£ 2,028,610.00	£ 1,391.46
A101H	02	Community	Operational	Laundry/Boilerhouse/Generator	46.55		£ 23,000.00	£ 1,030.00	£ 5,418.00	£ 134,919.00	£ 2,898.37
A101H	03	Community	Operational	Bungalow	77.66		£ 3,000.00	£ -	£ 17,787.00	£ 123,186.00	£ 1,586.22
A101H	04	Community	Operational	Ambulance Station	13.00		£ 1,000.00	£ 14,420.00	£ 6,344.00	£ 252,519.00	£ 19,424.54
A101H	05	Community	Operational	Modular Building	306.48		£ 15,000.00	£ 1,030.00	£ 6,153.00	£ 888,779.00	£ 2,899.96
A131C	00	HC & Clinics	Operational	Brodick Health Centre	246.46		£ -	£ -	£ 145,656.00	£ 746,775.00	£ 3,030.00
A029B	00	HC & Clinics	Operational	Lamlash	158.68		£ 43,000.00	£ 11,330.00	£ 21,673.00	£ 252,970.00	£ 1,594.21
A026B	00	HC & Clinics	Operational	Lochranza	122.87		£ 10,000.00	£ 18,187.00	£ 20,176.00	£ 224,483.00	£ 1,827.00
					2,429.60	0.00	£ 317,000.00	£ 93,377.00	£ 395,976.00	£ 5,051,835.00	£ 2,079.29
							2018	2019	2038		10Years
					Total Arran Lifecycle		£ 317,000.00	£ 410,377.00	£ 5,368,835.00		£ 2,638,690.00
				Arran War Memorial Hospital			£ 264,000.00	£ 327,860.00	£ 4,091,607.00		£ 1,800,216.00
				Brodick HC			£ -	£ -	£ 746,775.00		£ 539,892.00
				Lamlash Surgery			£ 43,000.00	£ 54,330.00	£ 295,970.00		£ 174,473.00
				Lochranza			£ 10,000.00	£ 28,187.00	£ 234,483.00		£ 124,109.00
				AWM			£ 264,000.00	£ 63,860.00	£ 208,471.00		
				Brodick HC			£ -	£ -	£ 145,656.00		
				Lamlash			£ 43,000.00	£ 11,330.00	£ 21,673.00		
				Lochranza			£ 10,000.00	£ 18,187.00	£ 20,176.00		



The reported backlog and overall life cycle investments requirements will in reality by at least three times, based on national norms, of those as reported to deliver the relevant improvements through actual projects. On this basis, to effectively realise facilities that have zero backlog and properly managed life cycle replacement, the effective costs would be circa £7.5m within the next ten years.

2.2.1.4 Summary of all Need Factors

In consideration of the wide range of business strategies summarised here and others not specifically cited, a number of key global objectives for health and social care services on Arran are apparent that must be considered. These are:

- Flexible, equable, integrated and sustainable hospital, primary care and community services supported by the Integrated Joint Board
- An Arran population that is able to live healthier lives, at home or in a homely setting on the islands for as long as possible.
- The need to plan for all services – but especially acute, hospital-based services – in a local, regional and national context to ensure safety, optimum local delivery, minimal travel (especially off island) and sustainability.
- Urgent Unscheduled Care, assessment, diagnosis and a range of sub-specialist care being delivered through a sustainable local Rural General Hospital (RGH) or equivalent on Arran.

Along with all other Boards, it is recognised that NHS Ayrshire & Arran is working in a challenging context in which there is a need to balance delivery of quality services with ambitious improvement targets and standards, while also living within the financial realities facing public sector. The need for transformational change is recognised, alongside continuing to delivery safe and effective

services of the best quality possible.

In addition, Arran faces particular challenges associated with the sustainability of services and the recruitment and retention of staff, who often work in small teams or single-handed and often in rural areas. Care at Home services are a key area where services cannot meet the demand, particularly in the outlying rural communities.

Staff recruitment and retention is further exacerbated by a chronic shortage of affordable housing. Many homes on the island are used as second homes or for tourist rentals and turnover of homes in this area is very low. The Arran Economic Group had previously undertaken a survey that identified a need for an additional 200 affordable homes on the island. The Group has work ongoing around developing Arran as a place to Work, Live and Visit. This includes discussions with Scottish Government, and North Ayrshire Council. The NAC now has plans to build an additional 32 "housing units" to replace public/community homes.. The newly formed Arran Development Trust charity will apply for SG funding from the Regional Island Housing Fund and if successful this could support the addition of 30 new homes per year over the next 6 to 7 years. This work is critically supported by the integrated relationships that have been developed across the island.

Notwithstanding these challenges, which are being addressed through a range of on-going projects, it is important to recognise that all recent business strategies (including those developed locally, regionally and nationally) underline the requirement for hospital service delivery on Arran and the consequential requirement for a hospital facility to support this. The proposals contained in this IA can therefore be seen as the natural continuation of a structured, whole-system planning process that has been continuous but that can trace its specific ancestry to the 2020 vision of 2005 or earlier. Specifically, its intention is to present a strategy for delivering care through multidisciplinary integrated and co-located teams that are supported by a new Hub facility which will maintain the delivery of acute services in Arran through the effective use of otherwise essential investment wherever possible, recognising the finite lifespan of the existing buildings.

This IA also highlights very clearly, that this investment represents the last opportunity to mitigate significant clinical functionality concerns relating to the current facility through targeted investment.

In summary, it is possible to conclude that:

- Arran, like other areas across the country, is facing a growing range of challenges relating to the delivery of safe, sustainable and affordable health and social care delivery.
- The challenge in Arran is escalated by the issues relating to island geography including issues around recruitment and retention.
- There are too many disparate service delivery locations and facilities for an island/population of this size.
- The new model must have the ability to increase Out of Hours cover – which can only be achieved through a single 24-hour service and new flexible and innovative "mixed" rota from staff who are truly integrated and co-located in a single site including the development of new roles such as ANP.
- The new model can only be fully implemented by a solution that brings both inpatient and residential care beds together on one site.
- The impact and cost of transfer to the mainland is a major consideration on a patient by patient basis and at a strategic level.
- Regional planning is playing an increasing role in determining the future of acute services across Scotland, with NAHSCP and its planning partners actively engaged in the West of Scotland Regional planning discussions.

- Local, regional and national planning has done nothing to negate or change the requirement for an acute hospital facility in Arran.
- The push for more local service delivery, especially out-patient services and ambulatory care, facilitated by enhanced technology and techniques, will only add to the requirement for these services to be delivered on Arran.
- The existing hospital facility on Arran, the Arran War Memorial Hospital, has long since exceeded its lifespan and – based on national estates planning tools & guidance – requires complete replacement as soon as possible.
- The existing Arran War Memorial facility, whilst reasonably maintained for its age, has very poor clinical functionality – particularly in relation to the in-patient accommodation, outpatient functionality and urgent unscheduled care facilities. This will continue to be a huge burden to effective and sustainable service delivery if it is not addressed.
- While an ongoing small reconfiguration project will address some of the clinical concerns for Unscheduled Care and Radiography the planning exercise has concluded that there is no way to address these clinical functionality issues within the existing Hospital that fall short of its complete replacement. Also, given that the in-patient facilities are effectively spread across seven areas and there is restricted access to key hospital services, that replacement of these facilities effectively means replacement of the entire facility.
- This represents the use of "otherwise essential investment" to address a long-standing clinical functionality and capacity issue within the Hospital as a whole, whilst addressing concerns regarding in-patient areas.
- Overall, the purpose of this IA is to address core clinical functionality issues within the current facility, provide appropriate accommodation to fully implement multi-disciplinary teams in the most effective way possible given the estimated lifespan of the existing buildings and the current pressures on providing robust 24-hour care.

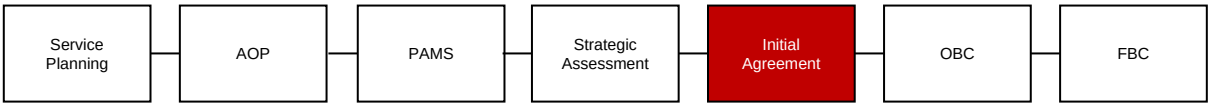
2.2.2 Organisations Goals

The proposed new model will provide a real and effective alternative to unnecessary hospital admission, facilitate early supported discharge and to support people to be as independent as possible and led the life they want in their home or homely setting.

In addition, there will be an increase in capacity as well as services working 7 days per week. The new model will address the balance of step-up and step-down services to meet local need and reduce pressure from unnecessary admission to the acute hospitals.

Whilst the exact contribution of Arran Integrated Island Model is difficult to predict with certainty - work has been done to estimate the following benefits.

Benefit	Measurement	Baseline	Target	Timescale
Creation of single management team	Management Numbers	11	9	2022/23
Reduction of Band 7 to 6 to create a single nursing team	Banding numbers			Oct 2019
Complex case management pilot	Complex cases supported by case management	0	15	2018/19
Creation of hub *Dependent on eventual Preferred option	Reduction in number of sites we deliver services	9	3/4	2022/3
Engagement to ensure Community support/buy-in for new approach	Num people engaged with Communication channels	0	500	Ongoing



The evidence suggests a reconfiguration of existing services, structures and leadership is required to improve access to Arran Integrated Island Services, reduce inefficiency, improve service user experience and help to meet the increased demand for health and social care. The Board therefore propose to implement an Integrated Island Services Model for Arran in line with Scottish Government policy.

This approach will provide integrated primary and community-based services for the assessment, treatment, rehabilitation and support for adults with long term conditions and older people at times of transition in their health and support needs.

The components of Intermediate Care across Arran are best delivered as a continuum of integrated local services with pathways that enable continuity of care and maximise independence for service users, blurring and expanding of roles for practitioners, develop trusting relationships between staff across different settings and provide opportunities for staff to rotate across teams and care settings.

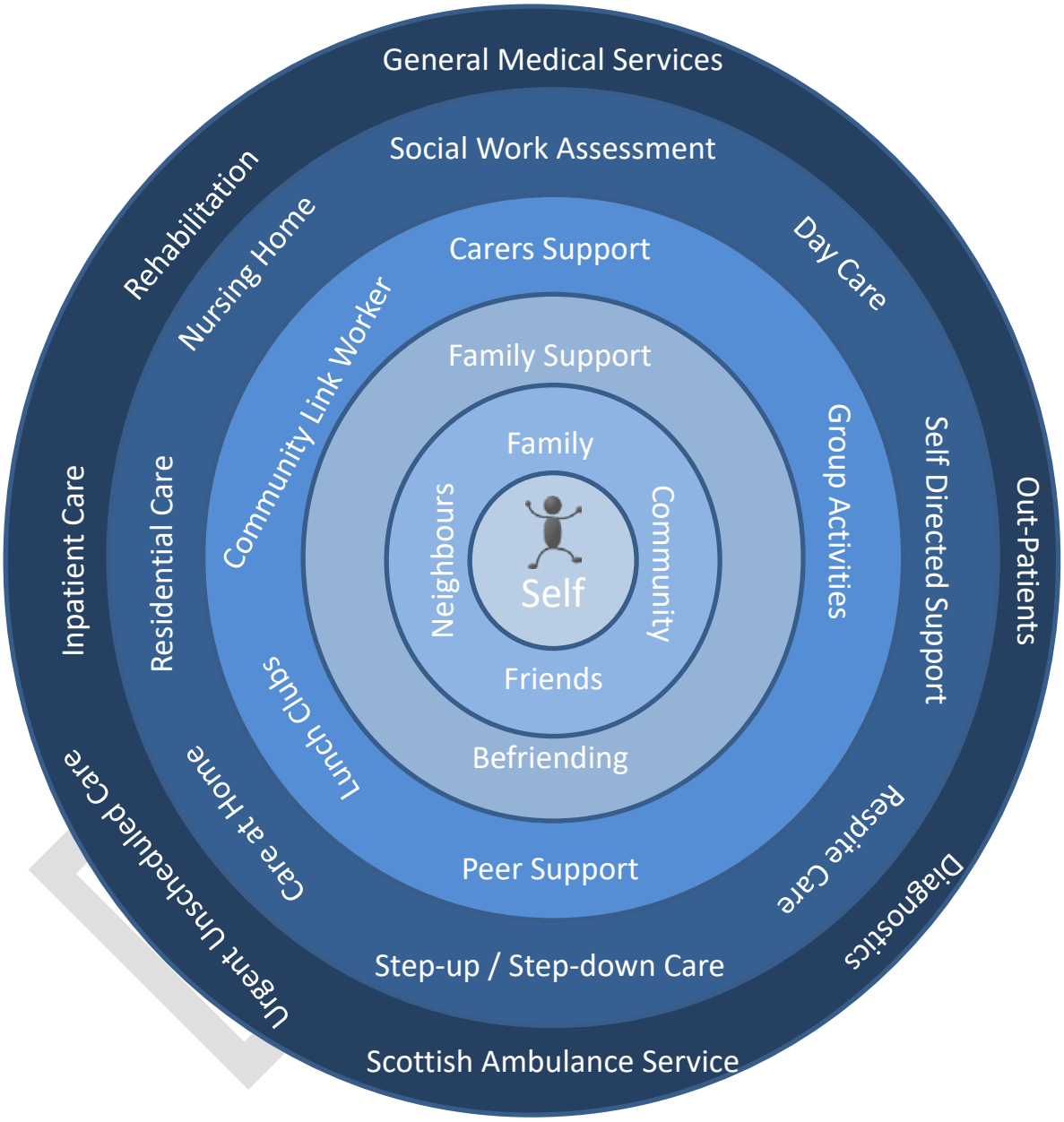
Without the proposed changes and new Hub facility some improvements could still be achieved but these would be limited and would not address the key concerns around 24hr care in the hospital and community. The integration of all partners would be more challenging and much of the inefficiency of being located on different sites would remain. The sustainability of the 24hr care rota would remain fragile without the flexibility and integration proposed across the multi-disciplinary team and all staff being located on one site to support robust backup and multi skilled role development.

The model is centred on the introduction of an Arran Hub (the hub) to provide a single point of contact for all health and social care services co-ordinated through a single, island-based management team, to maximise resources, improve care co-ordination and reduce duplication. The Hub will provide multi-disciplinary triage to ensure, assessment, treatment, rehabilitation and care provide an alternative to hospital admission. This will enable local people to maximise health & well-being to and stay as independent as possible and where acute or step up services are required, provide support to be discharged as early as possible. The key objective is to deliver a new model of care that integrates services. The development of a Hub will facilitate this on Arran. In addition, the project will

- Provide accommodation to enable the creation of and support for integrated teams
- Allow the development of a single assessment and care record
- Reduce number of public sector buildings on Arran
- Provide up to date IT and telephony to support teams, reduce duplication, encourage communications and support a single point of contact for local patients and staff
- Identify other agencies/services that would be interested in joining e.g.; Scottish Ambulance Service/Police
- Incorporate overnight accommodation for staff as required
- Integrate dental services into the main facility

The Arran Integrated Island Services model will provide a common framework wrapping services around the individual as outlined overleaf.

Arran Integrated Island Services Model



Core Principles that underpin Arran Integrated Services model:

- Delivered at home, if safe and appropriate, or as locally as possible
- Accessible, flexible and responsive through an island Hub that operates 7 days a week, ideally 24 hours a day
- Focused on support, treatment, rehabilitation, reablement and recovery
- Multidisciplinary Team meeting targeted at people at risk of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home.

- Based on holistic assessment to maximise independence, confidence and personal outcomes sought by the individual
- Linked with and complementing local community and specialist services
- Co-ordinated support (either on site or in reach) from multi-professional and multi-agency team with the required expertise in people with complex needs using single/common approaches.
- Time limited, with anticipatory care and discharge planning from day one
- Jointly commissioned by the partnership, in collaboration with the Care Inspectorate if there will be new roles for care providers
- Managed for improvement, gathering information on experience and outcomes and using this to inform service improvement.
- Less role boundaries
- Enhanced out of hours services
- A new, multi-disciplinary rota to enhance urgent unscheduled care /OOH care
- Less demarcations between services and facilities
- A single in-patient/bedded delivery location
- All 24-hour services delivered from the same, single defined location
- Access points for routine services at defined points/times across the island to meet day to day need
- Support from other agencies and services including Third Sector

The model is built around fast/rapid response stream services and slow stream services as detailed below:

Individual is too complex / unstable
Requires transfer to hospital mainland care:
Assess individual at urgent unscheduled care facility arrange for Transfer to definitive care:

- Acute Care of Elderly Practitioners in ED / CAU - Specialist AHP / ANP capacity to identify and assess older people who are frail or have complex support needs as they present to ED and CAU and to pull home, with support from enhanced Intermediate Care, or to step down, or right specialty bed.

Fast/Rapid Response
Individual cannot remain at home and requires rapid response
Step up to an Arran Integrated Services Hub:

- Assessment at Unscheduled Care service based at Community Hospital, care is overseen by ANP and Duty Doctor and either treated and discharged home with support or admitted for diagnosis and treatment plan.
- Bed based Care - a time limited episode of intermediate care provided in dedicated capacity within a care home, housing with care, or community hospital setting.

Slow Stream Services
Individual requires care and support, but this can be delivered at home or in a homely setting

Contact Single Point of Contact: Hub
- Intermediate Care and Rehabilitation Hub – The Hub provides a single point of access, screen, triage and signpost 7 days per week via a centralised telephone number(s) to a range of services. Including; Complex Care MDT Hospital (Health & Therapy Teams); Community rehabilitation (Domiciliary Physiotherapy, SLT, Community OT, Podiatry,

Dietetics, Adaptations); Community hospital – step up/stepdown facility; Falls Service; Reablement / homecare; Social Work, Complex cases; Telehealth Care. The services work with people who require assessment, treatment, rehabilitation and care, to provide an alternative to hospital admission, enable them to be discharged as early as possible from hospital, maximise health & well-being ensuring they stay as independent as possible.

- Reablement - a time limited episode of enabling support at home with an individual and their family to build confidence and encourage independence after an illness or decline in function.
- Intermediate care at home (provided by Complex Care MDT) – To provide rapid access to time limited assessment, rehabilitation and support by a multi-disciplinary health and social care team, to provide an effective alternative to unnecessary hospital admission, facilitate early supported discharge and to support people to be as independent as possible in their home or homely setting at times of transition in their health or support needs.
- Community Rehabilitation Teams - Community Rehabilitation will support individuals and communities to live the healthiest lives possible in their home /homely setting. This is delivered through early intervention approaches, self-management programmes and may be uni-professional, or coordinated multi-disciplinary rehabilitation. Community Rehabilitation will support people to be as independent as possible by enabling achievement of individual health and wellbeing goals. Community rehabilitation includes the following services; Domiciliary physiotherapy; Community rehabilitation occupational therapy; Community adult speech and language therapy; Community dietetics; Enablement podiatry and Health and Therapy Team/Day Hospitals
- Complex Care MDT/ Community Ward - a time limited episode of enhanced specialist care at home as an alternative to being treated in an acute hospital environment and where the care is overseen by a consultant / equivalent specialist (e.g. GPs with an interest). In addition, proactive, coordinated, anticipatory care management for people with complex chronic disease or frailty at high risk of future exacerbations and emergency admissions to hospital or to a care home. Care and support are coordinated for each individual by a lead professional generally for a number of months. The episode is generally overseen by a specialist practitioner working with a community Multi-Disciplinary Team.

To deliver this model, the business case proposes a considerable increase in capacity to provide more care in the individual's home. In addition, this will allow us to reduce the number of beds from 12 to 10 by 2022/3.

2.2.2.1 Investment Objectives

Having fully understood the existing arrangements for the service, the Board has sought to identify the current 'business gap'. This is the difference between 'where we want to be' (as suggested by the investment objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, difficulties and inadequacies associated with the status quo.

Our analysis has considered existing and future changes in the demand for services, and the location for their delivery, especially in light of the specific challenges associated with Arran's relatively unique situation. In summary it has also:

- Confirmed the need for continued business operations on the island.
- Identified historical and projected future activity in all key areas
- Identified deficiencies in existing provision
- Summarised user requirements in terms of the deficit between the current and future position

In reflection of the agreed baseline position/existing arrangements, a number of independently facilitated multi-stakeholder meetings have identified a number of specific benefits/investment objectives that any project/investment should seek to realise. These have been identified under defined heading that reflect national documentation and prompts.

- Person centred benefits
- Safety benefits
- Quality of care benefits
- Health of the population benefits
- Value & sustainability benefits
- Wider/Social benefits

Person Centred

At this (IA) stage, specific "person-centred" investment objectives include:

- Maintain hospital facilities on Arran that can support existing and future needs
- Improve way-finding and access to a defined reception points for Inpatients, Outpatients and Unscheduled Care patients.
- Improve access to all clinical areas – in particular for those with mobility issues
- Address patient confidentiality concerns associated within the existing urgent unscheduled care facility (Privacy & dignity issue)
- Enhance opportunities to maintain appropriate age and gender separation (Privacy & dignity issue)
- Reduce unnecessary overnight stays through improving flow and Step Up and Step-Down care
- Improve the physical condition of the healthcare estate
- Improve the functional suitability of the healthcare estate

Safety

Specific "safety" investment objectives include:

- Reduce adverse harmful events
- Improve patient observation and assessment levels
- Reduce risk of HAI through addressing facility issues (area, fabric, flow, etc)
- Reduce backlog maintenance
- Reduce significant and high-risk backlog maintenance
- Improve statutory compliance

Quality of Care

Specific "quality of care" investment objectives include:

- Improved overall management of care services through local control and flexibility inherent within the new Model of Care
- Reduce the number of children/vulnerable users being admitted to an adult in-patient ward
- Improved physical environment designed to support Dementia
- Improved provision of Unscheduled Care through better access and sustainable rotas to

provide OOH's cover
- Enhance the separation between medical and urgent unscheduled care through the provision of separate appropriate clinical areas

Health of the Population

Specific "health of the population" investment objectives include:

- Supports early referral to specialists
- Reduce "off-island" journeys
- Support of more patients in their own homes through multi-disciplinary team inputs

Value and Sustainability

Specific "value & sustainability" investment objectives include:

- Ensure that a sustainable service is supported through the creation of a new model of care that is delivered by integrated, co-located and flexible teams to provide the required 24-hour care requirement.
- Reduce the challenges being faced in recruitment and retention of staff across primary, secondary and social care.
- Ensure that an Arran Hospital is able to deliver effective services in a functional and appropriate facility with built in flexibility for current and future health care delivery.
- Optimise overall resource utilisation
- Improve financial performance including workforce efficiencies from co-location.
- Improve flexibility of all functional areas within the hospital.
- Reduce travel costs associated with patient transfer to the Mainland
- Improve space utilisation
- Closer working and interactions with Scottish Ambulance Service staff within the multi-disciplinary teams
- Increased opportunities for multi skilled role development and training programmes for General Specialists in addition to Advanced Nurse Practitioners and Paramedics
- Optimise overall running cost of buildings
- Improve design quality in support of increased quality of care and value for money
- Contribute to overall revenue savings after budgetary re-investment/re-alignment has occurred
- Rationalise FM and support services across the public sector by bringing teams together under single management on the island. (This does have challenges around TUPE issues and terms & Conditions)
- Reduction in number of sites providing Catering and Laundry services
- Reduce rising costs of accommodating visiting and on-call staff by the provision of inhouse accommodation.

Wider and Social

Specific "wider/social" investment objectives include:

- Improved access to Public Services
- Aid and improve recruitment and retention
- Keep activity, people, services and therefore money on the Island

- Bring capital investment to the islands, sustaining jobs and enhancing socio-economic factors
- Support sustaining a new model of care, with a consequential positive impact on the Island's economy and sustainability

These proposed investment objectives have been further reviewed and rationalised in terms of what they say about existing arrangements and future business need utilising the methodology advised in current capital planning guidance, thus:

Investment Objective	Support the implementation of a new Model of Care that will provide sustainability of a 24hr rota system that delivers flexible and appropriate support to all patients and service users that will provide sustainable care for people in their own homes for as long as possible.
Existing Arrangement	NHS and Council Social Care staff are currently located in multiple buildings and facilities across the island. Covering the Community, Hospital and Care homes places pressure on all groups with a resultant fragile service that can readily fail due to the lack of appropriate staff in the correct place.
Business Need	Provide a facility to support the creation of a single base for all partner staff to work in teams and provide more flexible care, support for complex rotas and 24hr rotas and improve all interactions across care groups.
Investment Objective	Maintain acute facilities on Arran that can support existing and future needs.
Existing Arrangement	The Arran War Memorial Hospital has an aging infrastructure and buildings whose lifespan has been exceeded with poor clinical functionality in key areas such as privacy/dignity; urgent unscheduled care /elective separation; ambulatory care capacity; observation issues and space standards.
Business Need	Ensure that hospital provision is able to deliver effective acute services that supports the delivery of care services with: 1) excellent clinical functionality 2) quality health care for all patient groups
Investment Objective	Ensure access to all clinical areas – in particular for those with mobility issues.
Existing Arrangement	Although the majority of patients on Arran are ambulatory, those requiring access to urgent unscheduled care services are brought in through the main reception area. Patients with mobility issues find it difficult to manoeuvre through narrow corridors and overall access to the Hospital is poor with a single carriageway access that has no pavement and no street lighting
Business Need	To provide equable access to all hospital facilities, provide dedicated urgent unscheduled care access with adjacent Radiography service not crossed by patients using other services, rationalise all patient journeys and ensure that reception and waiting areas are functional.
Investment Objective	Improve the functional suitability of the healthcare estate.
Existing Arrangement	At present the AWMH has serious functional suitability issues

	that include: a lack of single rooms; a lack of gender separation; and consequentially poor operational flexibility. In addition, the provision of unscheduled care has no private areas; lacks the required capacity; has no storage space; has no clean utility area; has no dirty utility area; has no waiting space; has no stage 3 recovery area; etc.
Business Need	To address clinical functionality and capacity deficits within a new facility that will in turn mitigate the wider clinical functionality issues experienced across the wider in-patient estate through appropriately re-distributing flow away from these.
Investment Objective	Reduce adverse harmful events.
Existing Arrangement	The existing facilities lend themselves to adverse harmful events and complaints for the multiplicity of reasons cited throughout the document.
Business Need	To ensure that any investment/re-design of services and facilities reduces recorded adverse incidents.
Investment Objective	Reduce risk of HAI through addressing facility issues (area, fabric, flow, etc)
Existing Arrangement	Poor quality, cramped facilities/pathways that lack key clinical locations such as clean utility, dirty utility and storage areas in combination with high utilisation challenge best practice infection control considerations.
Business Need	To ensure that a replacement facility mitigates existing HAI risks as far as possible within the footprint available.
Investment Objective	Improve the physical condition of the healthcare estate.
Existing Arrangement	The existing estate has challenges with functionality, infrastructure, backlog maintenance, expensive energy costs and lack of space.
Business Need	To utilise otherwise essential investment to improve the physical condition of facilities as well as their clinical functionality.
Investment Objective	Reduce backlog maintenance and address statutory compliance issues.
Existing Arrangement	Backlog maintenance and statutory compliance issues exist in a number of areas throughout the Arran War Memorial Hospital and other clinical sites on the island.
Business Need	To ensure that any investment in new/re-designed facilities addresses existing backlog maintenance/statutory compliance issues as far as possible.
Investment Objective	Improve design quality in support of increased quality of care and value for money.
Existing Arrangement	Existing facilities were designed when clinical needs and service delivery models on Arran were considerably different to what they are now.
Business Need	To deliver optimal design improvement that recognises the huge challenges presented by the existing estate whilst effectively balancing the cost of investment; improvements in clinical functionality; and overall lifespan of the existing structures.
Investment Objective	Aid recruitment and retention.

Existing Arrangement	Staff working in/thinking of working in Arran, accept that the majority of procedures/interventions undertaken on island will be ambulatory in nature. They also expect therefore that the islands will have capable, modern facilities geared to the delivery of ambulatory care.
Business Need	To develop ambulatory care facilities and capacity that better reflect the islands needs prior to the complete re-provision of hospital facilities in the medium-term.
Investment Objective	Keep activity, people, services and therefore money (including capital investment) on the Island thus sustaining jobs and enhancing socio-economic factors.
Existing Arrangement	Historical trends have been that the number of patients and services going off island is increasing. Aside from the issue of inconvenience, this means that money is also going off-island, undermining service and economic sustainability.
Business Need	To ensure that all service decisions consider wider economic impact as well as the specific effect on service capacity and sustainability. Thereby ensuring that historical trends are reversed as far as possible and existing services and communities are strengthened.

2.2.2.2 Benefits Register

In line with guidance a Benefits Register has been developed to support this IA and this will become and active driver and monitor for the project as it develops. Key questions that each benefit has to address include:

- Whether their assessment is qualitative or quantitative
- The developing measures that will be used to assess change/impact
- Baseline values for these measures where available (Where not currently available, processes are in place to ensure these are available)
- Target values for these measures following investment/change

Appendix D also highlights the basis for a benefits realisation plan that identifies how all of the identified benefits will be delivered for completion at OBC stage in line with current capital planning guidance. Attendees at the Benefits Workshop are listed at **Appendix E**. This includes the need to identify:

- Who benefits in each instance?
- Who is responsible for realising the objective?
- What the investment objective is
- Dependencies that reflect risks to benefits realisation
- Specific support needed
- Date of realisation

The key benefits identified to date include:

- Ensure that a sustainable service is supported through the creation of a new model of care that is delivered by integrated, co-located and flexible teams to provide the required 24-hour care requirement.
- Improved overall management of care services through local control and flexibility inherent

within the new Model of Care

- Improved provision of Unscheduled Care through better access and sustainable rotas to provide OOH's cover
- Improved communication and interaction across all partners through a single communication system with Single Point of Contact functionality
- Increased opportunities for multi skilled role development and training programmes for General Specialists in addition to Advanced Nurse Practitioners and Paramedics
- Fewer Single Points of Failure as a result of the activity within a multi-disciplinary team providing flexible service and cross working to improve overall patient care
- Improves access for patients with mobility issues to all clinical areas
- Reduces "off-island" journeys
- Reduction in the existing geographical inequalities in Care at Home provision
- Increased opportunities for 3rd Sector activity and engagement through true integration

As noted the full register of benefits ia attached at **Appendix D**

Some ongoing elements of the overall project which have already commenced or are already in detailed planning will include:

- **Urgent Unscheduled Care Services** – Phase 1 – Spring 2019 - the coordination through a "mini-hub" based at Arran War Memorial Hospital will enable all unscheduled presentations to be coordinated and managed. To support this there are four key components: GP and ANP clinics; patient transfer service; reconfigured urgent unscheduled care and new X-ray machine; enhanced nursing support for cancer patients, with phase one focusing on palliative care OOHs. All elements of this have been funded from a number of sources including Endowment fund, local charitable funds.
- **Complex Care** – Phase 2 - End October 2018 - the introduction of a "test of change" pilot encompassing MDT working, comprehensive assessment and outcome-based care planning, utilizing a new "generic role" has commenced. The planning and development of this pilot took a significant time to work through and agree the T+Cs of the role with key partners and stakeholders along with agreement on the Grade of the roles we are piloting. This pilot will inform the future island model. The PDSA for this Test of Change is available in **Appendix H**. This requires a small amount of resource to establish the pilot. The pilot will run for six months from Oct – Apr 2019 and if evaluation is positive will be rolled out at scale on Arran. This will need further reconfiguration of services, including the closure of one site to support. A previous test of change outlined the multiple and duplicated visits that people with complex care receive and it is believed that a MDT hub will help reduce this.
- **Single Point of Contact** – Phase 3 - March 2020 - roll out of EMIS to all health staff on Arran will be nearing completion. This will for the first time on Arran enable an overview of the team's capacity within the system to be coordinated. The single team will be supported by a single admin team allowing frontline care staff to be freed up from administrative tasks, including, booking of visits. In addition, by having a single care record, all health and social care staff will no longer need to duplicate information on different systems and share key information, putting the individual at the centre of everything we do.

2.2.2.3 Benefits Realisation Planning

While the identification of benefits has formed a base for the project, the team recognise that planning to realise the benefits must commence now also for the project to be successful.

Each benefit will identify the key recipient ie Public or Service and will be assigned an owner whose

responsibility it will be to ensure that the benefit is effectively delivered through monitoring against baseline values and projected timescale to deliver. Some benefits will be dependent on others and these links and dependencies must also be clearly articulated along with any specific support or resource required and the timescale that is anticipated for the benefit to fully deliver.

2.2.2.4 Risk Management and Strategy

The main risks associated with the project and the proposed 'counter measures' have been identified by the Board and are summarised in the Risk Register at **Appendix I**. The Risk Workshop Attendees are listed in **Appendix J.**

Whilst this list is comprehensive, in line with relevant business case guidance, the emphasis at IA stage is on the 20% of risks that are likely to account for 80% of the risk value.

These risks have been categorised into the following identified categories:

Risk Categories	Description
Business Risks	These are the strategic risks which remain (100%) with the public sector organisation regardless of the sourcing method for the proposed investment. They include political risks.
Service Risks	These are the risks associated with the design, build, financing and operational phases of the proposed investment. Dependent on procurement route they can be shared with business partners and service providers.
External Environmental Risks	These risks affect all organisations regardless of whether they are public or private sector. They include secondary legislation and general inflation.

The lists below include all risks scored 10 or more in the Risk Register. At this stage of IA development pro-active mitigation of these risks has commenced and will be further refined during development of the Outline Business Case. All other risks are included as noted at **Appendix I**. In summary,

Key business risks identified at IA stage include:

- Funding is not available for the delivery of a Hub facility with a subsequent impact on the costs of backlog maintenance, energy costs and facility availability and sustainability

Key Service risks identified at IA stage include:

- Demand for the service does not match the levels planned, projected or presumed (Either exceeds anticipated demand or falls substantially below this)
- The available space for Option 5A may require derogations from relevant design and technical guidance in key areas. Risk is that these may reflect unacceptable compromises -

dependent on Preferred Option

- Failure to implement the project results in a breakdown in the Homecare system due to the current fragility of the rota system which includes lack of early intervention, inadequate support to keep people at home, no Step-Up care, delayed discharges and increasing re-admission rates.
- Failure to implement the new model of care with fully integrated multi-disciplinary teams results in a breakdown of the 24-hour rota system including urgent unscheduled care services and Hospital cover
- Failure to implement the project limits the service ability to deliver the correct interventions when required
- Failure to implement the project will result in continuing challenges in recruitment and retention and ongoing costs for travel for mainland staff cover will continue to escalate.
- Failure to implement the project and provide adequate overnight accommodation for visiting staff will mean that ongoing revenue costs will increase
- Existing lack of affordable and available accommodation poses a major threat to staffing levels and the support of rotas
- Failure to implement a new communications strategy and infrastructure will result in the inability to create a Single Point of Contact.
- Failure to fully engage and maximise the benefits of wider public service inputs
- Failure to address the issues associated with multiple Terms and Conditions will jeopardise the ability to create flexible multi-disciplinary teams
- Failure to reduce the number of GP practice buildings sustains the current pressures on GP's to support 24hr rotas.
- Failure to implement the new model of care in full results in ongoing challenges and issues in delivering 24 hr care
- Failure to ensure that flexibility is built into designs for any new builds results in challenges in the future based on changing models of care
- Failure to undertake activity and capacity modelling across all services results in a model that is over or underutilised.
- Failure to achieve required revenue levels of funding to support the new model of care.
- Risk of losing existing staff when implementing the new model of care.
- Failure to develop common systems delays the implementation of the new model of care.
- Failure to implement the full new model of care after estate rationalisation/new build/disposal
- Failure to ensure the new model of care pro-actively supports self-care, 3rd sector organisations and carers results in ongoing pressures within primary, secondary and social care

Key External environmental risks identified at IA stage include:

- Currently accepted functional suitability compromises, e.g. relating to in-patient wards, become unacceptable, resulting in the need for more widespread change earlier than anticipated.
- Adverse publicity occurs due to an operational issue
- Communication strategy does not consider public perception / consultation feedback / media interest / parliamentary interest / organisational reputation
- The anticipated date for a complete replacement facility is missed, meaning that lifecycle costs utilised in the business case are wrong
- Failure to ensure that the business case provides sufficient detail to inform all regulatory bodies understanding of the new model of care proposed for Arran

- Failure to ensure that the business case presented contains detailed and appropriate costs for construction requirements
- Failure to ensure appropriate transport systems are developed to support the project could result in the continuation of existing issues with bus access resulting in high DNA figures across primary, secondary and social care, ferry & bus combinations on the mainland to facilitate onward travel for patients and no availability of buses or taxis out of hours.
- Lack or unaffordable appropriate land to develop new buildings limits developable options.

These risks, along with their relevant likelihood and impact, along with mitigation strategy and action already taken are summarised in the Risk Register at **Appendix I**.

The Risk Register also assesses the likelihood and impact of risks both prior to and following mitigation using the established NHS Scotland methodology that scores each element on a scale of 1-5 and identifies those risks that are seen as most significant.

Investment Objective	**All mandatory processes and Business Cases are successful and approved to deliver the project within the proposed timescales**
Existing Arrangement	NAHSCP are developing all required business case models in line with current SCIM guidance
Business Need	To deliver the proposed project to support the implementation of the proposed new Model of Care
Potential Scope	The project will deliver a service model and facility that addresses core service delivery and staffing pressures and facility functionality concerns whilst making best use of any existing structurally sound facilities.
Potential Benefits	As identified in the project benefits register (**Appendix D**)
Potential Risks	As identified in the project risk register (**Appendix I)**
Potential Constraints	NAHSCP's challenge to deliver agreement from all relevant stakeholder and partner bodies
Potential Dependencies	Ongoing liaison with all stakeholders to ensure proposed project will deliver the services required
Investment Objective	**All mandatory processes are successful and approved to gain required funding to deliver the project**
Existing Arrangement	NAHSCP does not have the required capital budget to complete the project
Business Need	To deliver a Hub facility that will support all the identified business needs
Potential Scope	The project will deliver a service model and facility that addresses core service delivery and staffing pressures and facility functionality concerns whilst making best use of any existing structurally sound facilities.
Potential Benefits	As identified in the project benefits register (**Appendix D**)
Potential Risks	As identified in the project risk register (**Appendix**

	I)
Potential Constraints	Lack of available and affordable space/site to support a preferred way forward.
Potential Dependencies	Ongoing liaison with all stakeholders and partners to ensure proposed model of care and the proposed new facility can be delivered within the funds requested
Investment Objective	**Implement the new Model of Care to deliver a sustainable and pro-active service to address all patient needs**
Existing Arrangement	The current dispersed and fragile structure of care delivery across all partner groups on the island hampers multi-disciplinary team working and flexible care for all
Business Need	Support more patients at home and manage complex care needs through co-ordinated, co-located and integrated MDT teams who provide a single point of contact across all services
Potential Benefits	The project will deliver a service model that addresses core service delivery and staffing pressures
Potential Risks	The proposed Model of Care does not fully address all current service delivery issues
Potential Constraints	Integration of teams across primary, secondary and social care will be based on colocation and analysis and change of T&C's if required
Potential Dependencies	Agreement across all partners to form the team structures

2.2.2.5 Constraints and Dependencies

Constraints

The parameters (limitations) within which the proposed investment must be delivered have been considered by the Board as an element of IA development and will continue to be reviewed as the project develops. At this stage they have been summarised as:

- The availability of sites/facilities to deliver services at present
- The availability of sites/facilities to support a preferred way forward
- The requirement for services to continue to be delivered throughout any development/construction process
- The "geographic Arran factor" as it relates to programme, costs and procurement challenges
- The limited viable procurement options present
- Funding which will be required in addition to the Board's current capital allocation along with appropriate capital contributions from other stakeholders ie Local Authority

Dependencies

The Board have also considered the actions required of others to ensure that the project is a success. Although these dependencies will continue to be monitored as the project develops, at present they include:

- Agreement with all stakeholders on the proposed model of care
- Agreement with all stakeholders on programme interfaces and phasing
- NHS Ayrshire & Arran, North Ayrshire Health and Social Care Partnership, North Ayrshire Council and Scottish Government approvals processes being completed and appropriate approvals – and funding – being agreed
- Statutory approvals issued through other agencies including warrants, permissions and other approvals required to take forward a preferred option
- An appointed design team generating a preferred option that is able to deliver the benefits required
- Availability/viability of appropriate land available for new build

Where appropriate, these dependencies have also been included in the project Risk Register along with a defined mitigation strategy and summary of actions undertaken to date.
In addition, as suggested in the relevant SCIM guidelines, the Board have also considered dependencies in the context of our developing investment objective template and present these in the amended table below. This confirms that specific dependencies for the project are limited and primarily related to:

- Scottish Government approval
- Availability of funding
- Proposed Model of Care

3 Economic Case

3.1 Stakeholder Involvement

The team on Arran have undertaken extensive engagement with stakeholders beginning in 2015/16 with the Arran Review of Services. The groups that were involved in stakeholder engagement over a substantial period of time include as follows:

Staff
Arran Locality Management team - followed up with staff briefings/meetings/newsletter
Arran Review of Service Steering Group
Transformational Leadership Group
Joint Property Steering Group
Infrastructure Programme Board
Capital Planning and Investment Group
Caring for Ayrshire Programme Board

Public and Users
Arran Elderly Forum
Arran Youth foundations – pupil forum
Arran Economic Group
Arran Locality Community Planning group
Arran Patient and Service User Group
Arran Community Voluntary Service

Groups involved in short listing of options are identified in **Appendix K**

Going forward the team will continue to engage at every step with the community and staff and all other relevant stakeholders to ensure that the project is aligned with expectations and realistic

outcomes.

3.2 Do Nothing/Do Minimum Options

In line with the relevant guidance, a review of a wide-range of historical documents as well as the evaluation and review of a number of on-going processes has identified 8 physical re-configuration options for inclusion on the "long-list" that include operational as well as physical alternatives. These were summarised as:

1. Do nothing
2. GP and community services only
3. Triple Hub
    - A – Retain AWMH
    - B - Replace AWMH
4. Twin hub
5. Single Combined Acute, Primary & Social Care Hub
    - A – Reconfigure and Extend Montrose House
    - B – New Build/Site
6. Single secondary and social care hub only

A description of each of these preliminary options along with the main advantages and disadvantages associated with them follows.

1. Do Nothing: The Status Quo	
Heading	**Rationale**
Description	Maintain existing disparate residential home, hospital, GP, community and social care services within existing facilities
Main Advantages	Requires no change. Requires no additional investment. Provides an opportunity to do something different at a later date To make alternative use of Montrose House.
Main Disadvantages	Maintains disparate teams. Does not bring all health and social care beds together. Does not address service sustainability issues. Does not address building issues. Under-utilisation of Montrose House continues. Could lead to a failure of 24-hour care system. Does not support full implementation of partnership integration. Clients continue to experience geographically disjointed services with multiple contacts.
Conclusions	This option will be carried forward regardless of the Options Assessment in order to provide a benchmark for value for money through the appraisal process.
2. GP and community services only	
Heading	**Rationale**

Description	Maintain existing disparate residential home, GP, community and social care services within existing facilities – do not re-provide hospital services
Main Advantages	No capital costs required. Revenue Savings from hospital operational use and elimination of backlog maintenance. Frees up staff from providing inpatient and treatment on a 24hr basis. Potential to re-invest revenue savings into additional community services. Potential to fully utilise Montrose House.
Main Disadvantages	No Inpatient Hospital provision. Requires alternative urgent unscheduled care services model. Under-utilisation of Montrose House continues. Increased risk to patient safety. Increased revenue requirement to support all patient transfers. Potential loss of staff i.e. multi skilled staff seeking posts on mainland. May lead to failure of 24-hour care system.
Conclusions	Having no Hospital facility on the island will necessitate all medical and urgent unscheduled care patients being transferred to the mainland for treatment with the resultant pressures on maintaining patient safety, clinical care and increased patient travel costs.
3a. Triple hub retaining AWMH	
Heading	**Rationale**
Description	Maintain residential home within existing facility. Re-provide GP, community and social care services within a new, separate, primary care hub. Retain existing AWMH
Main Advantages	Brings elements of health and social care teams together in a new primary care hub. Supports primary care re-design. Reduces new build requirements. Future Expansion of GP/Social Care hub to include additional elements if required. To make alternative use of Montrose House.
Main Disadvantages	Retains all issues/challenges associated with AWMH. Does not bring all health and social care beds together. Does not address service sustainability issues. Under-utilisation of Montrose House continues. May fail to obtain required capital funding for GP/Social Care hub. Additional revenue funding required to maintain existing AWMH building. May lead to failure of 24-hour care system. May fail to identify a suitable site for new build.

	Potential for abnormal development costs for any site obtained.
Conclusions	While this option makes progress towards the establishment of integrated and collocated teams it addresses none of the existing clinical functionality and backlog maintenance issues associated with the retention of AWMH or the sustainability issues associated ith multiple 24 hour service delivery locations
3b. Triple hub replacing AWMH	
Heading	**Rationale**
Description	Maintain residential home within existing facility. Re-provide GP, community and social care services within a new, separate, primary care hub. Re-provide acute facilities within a new, separate secondary care facility
Main Advantages	Brings elements of health and social care teams together in a new primary care hub. Supports primary care re-design. Addresses all current buildings issues associated with old AWMH. Potential for future Expansion of GP/Social Care hub if required. Future flexibility built in to new hospital facility. To make alternative use of Montrose House.
Main Disadvantages	Builds 2 new but separate health facilities. Does not bring all health and social care beds together. Does not address service sustainability issues. Under-utilisation of Montrose House continues. May fail to obtain capital funding required May fail to identify multiple suitable sites for new builds. Potential for abnormal development costs for any sites obtained.
Conclusions	This option does make progress with the implementation of the new model of care establishing co-located and integrated teams but does not support bringing all beds together to provide flexible support for 24hr rota's
4. Twin hub	
Heading	**Rationale**
Description	Maintain residential home within existing facility. Re-provide hospital, GP, community and social care services within a new, separate, primary & secondary care hub
Main Advantages	Brings elements of health and social care teams together in a new "health hub" including primary and acute care. Supports healthcare re-design. Address all current health building related issues Potential future expansion of "health hub" to include care home at a later date.

	Potential to make alternative use of Montrose House.
Main Disadvantages	Does not bring all health and social care beds together. Does not address service sustainability issues associated with 24 hr bedded care. Under-utilisation of Montrose House may continue. May fail to obtain capital funding required Potential to fail to identify suitable site for new build Potential for abnormal development costs for any site obtained.
Conclusions	This option does not fully address all the issues identified in the business case but delivers on a substantial element of those

5A. Single Combined Acute, Primary & Social Care Hub – Reconfigure/Extend Montrose House

Heading	**Rationale**
Description	Reconfigure and extend Montrose House to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility
Main Advantages	Brings all health and social care teams and services together in a new "hub". Supports overarching health and social care re-design. Addresses all current health building related issues. Fully supports the new Model of Care. Optimises service sustainability. Improves utilisation of Montrose House Could support more widespread service integration as appropriate. Provides the opportunity to flex staff across hospital and Care beds.
Main Disadvantages	Requires new models of care to realise sustainability, e.g. Combined rotas. May not provide sufficient space for future expansion if required. Existing footprint may lead to design compromise. Access may be challenging. Could be disruptive to Montrose House residents. Requirement to agree changes with NAC could identify unforeseen issues. Potential failure to complete land transaction. Cost of potential ground remediation. Potential failure to agree service changes with regulatory bodies, e.g. The Care Commission. Potential failure to obtain capital funding required.
Conclusions	This is a strong model which would bring all beds together on one site allowing for flexibility in staffing and bring all Primary and Social Care staff together to fully support the integration of a multi-disciplinary team. However this option requires an agreement with North Ayrshire

	Council, could compromise some design elements and Arran War Memorial Hospital would require to be disposed of.
5B. Single Combined Acute, Primary & Social Care Hub – New Build/Site	
Heading	**Rationale**
Description	Build a new facility to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility
Main Advantages	Brings all health and social care teams and services together in a new "hub". Supports overarching health and social care re-design. Addresses all current health building related issues. Fully supports the new Model of Care. Optimises service sustainability. No design/space compromise. Potential to support more widespread service integration as appropriate. Potential to flex staff across hospital and Care beds. Potential to support wider public/ urgent unscheduled care services integration. e.g. Police and ambulance. Potential to make alternative use of Montrose House.
Main Disadvantages	Likely to be the most expensive option. Requires a new site. Very limited suitable sites on Arran. Likely to take longer to realise. Leaves Montrose House – a new facility – vacant. Potential failure to obtain required capital funding. Potential failure to secure suitable site. Potential for abnormal development costs for any site obtained.
Conclusions	This is a strong model which would bring all beds together on one site allowing for flexibility in staffing and bring all Primary and Social Care staff together to fully support the integration of a multi-disciplinary team. Arran War Memorial Hospital and Montrose House would require to be disposed of.
6. Single secondary and social care hub only	
Heading	**Rationale**
Description	Bring together GP, community services and existing care home beds) into a single, integrated service delivery model and hub. (Don't re-provide hospital services
Main Advantages	Brings elements of health and social care teams together in a new primary and social care hub. Supports primary and social care re-design. Reduces new build requirements. Improves utilisation of Montrose House – the assumed venue.

	Frees up staff from providing inpatient and urgent unscheduled care treatment on a 24hr basis. Potential re-investment of revenue savings to provide additional community services.
Main Disadvantages	No Inpatient Hospital provision. Requires alternative urgent unscheduled care model. Could be disruptive to Montrose House residents. Potential failure to obtain required capital funding. Increased risk to patient safety. Increased revenue requirement to support all patient transfers. Potential loss of staff i.e. multi skilled staff seeking posts on mainland. Potential failure of 24-hour care system.
Conclusions	Having no Hospital facility on the island will necessitate all medical and urgent unscheduled care patients being transferred to the mainland for treatment with the resultant pressures on maintaining patient safety, clinical care and increased patient travel costs.

3.3 Service Change Proposals

Services in Arran will be re-designed so that Hospital Care, Primary Care, Community Care and Urgent Unscheduled Care services will be sustainable and can be delivered on Arran now and in the future. In order to achieve this existing services must be redesigned to create the flexibility, colocation and integration of existing providers.

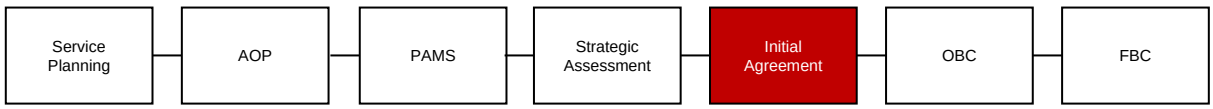
The Arran Service Review created a vision for a "new model that increases support for an ageing population with increasing multi-morbidity, delivered by an enhanced and extended multi-disciplinary team that are truly integrated and co-located. This will result in a more responsive service resulting in fewer admissions and reducing delays in discharge with re-establishment of independent living in a person's own home, wherever possible."

This new service will include:

- Single Management Structure
- Single Team
- New Model of Care
- Single Care Record
- Single Point of Contact - SPOC
- Hub

The creation of a Single Point of Contact, flexible roles within fully integrated MDT's will provide the basis to address the current pressures on GP services, Community Nursing, Care at Home and OOH's and Unscheduled care by providing the right care at the right time in the right location for all service users.

Meeting the needs of the local community and providing care by a range of staff with generic skills in their own homes or in homely settings is another key aim of the new model. This will require transformational change across services and will tackle issues of silo working, break down old interfaces and empower self managed teams to deliver a joined up service.



To underpin this approach we will develop a single IT and telephone system which will support a single care record and therefore enable multi-disciplinary assessment to be made through a Single Point of Contact (SPOC). This will enable greater coordination of care and flexibility, which is crucial for maximising service delivery.

In addition, we propose to reduce the number of sites that services are currently delivered from, this will enable centralisation of services and at the same time address the inadequacy of some sites, and associated costs of running multiple sites.

There will be an opportunity for partners: Scottish Ambulance Service, Police Scotland, pharmacy and the third sector to engage in the new model of care and to collocate and integrate with the model where appropriate.

The new model will provide a real and effective alternative to unnecessary hospital admission, facilitate early supported discharge and to support people to be as independent as possible and led the life they want in their home or homely setting.

It is anticipated that this will reduce the length of stay in hospital beds from an average of 9 days to at least an average of 7 days and provide more care at home will significantly reduce the cost to health and social care services in purchasing long term care beds.

In addition, there will be an increase in capacity as well as services working 7 days per week. The new model will address the balance of step-up and step-down services to meet local need and reduce pressure from unnecessary admission to the acute hospitals.

3.4 Options Appraisal

NHS Ayrshire & Arran considered a range of key Critical Success Factors for each option identified, in line with the Govt's preferred 'Five Case Model' as an element of its consideration of the available options - as relevant to the IA phase – and these summarised in the tables below.

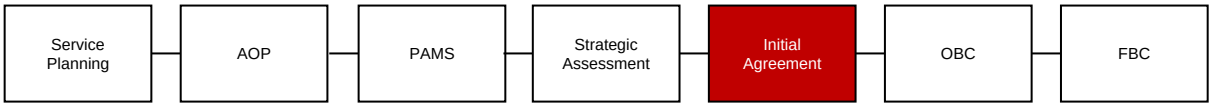
Key CSF's	**Broad Description**
Strategic fit and business needs	How well the option: • meets agreed investment objectives, related business needs and service requirements • provides holistic fit and synergy with other strategies, programmes and projects.
Potential VFM	How well the option: • Maximises the return on the required investment (benefits optimisation) in terms of economic, efficiency, effectiveness and sustainability • Minimises associated risks
Potential Achievability	How well the option: • Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change • Matches the level of available skills which are required for successful delivery

Supply-side capacity & capability	How well the option: • Matches the ability of the service providers to deliver the required level of services and business functionality • Appeals to the supply side
Potential affordability	How well the option: • Meets the sourcing policy of the organisation and likely availability of funding • Matches other funding constraints

Options Assessment

An Options Assessment was undertaken by stakeholders on Wednesday 16th January, 2019 that looked at each option in more detail and this has provided the basis for the short-listing process as intimated in relevant SCIM guidance is summarised in the table below. Details of the attendees is contained in **Appendix K**

Option	**1**	**2**	**3a**	**3b**	**4**	**5A**	**5B**	**6**
Description	Do Nothing	GP and community services only	Triple hub retaining AWMH	Triple hub replacing AWMH	Twin hub	Single Combined Acute, Primary & Social Care Hub – Montrose House	Single Combined Acute, Primary & Social Care Hub – New Build	Single secondary and social care hub only
Scoping Options	Discount	Discount	Discount	Discount	C/F More	Preferred	Preferred	Discount
Service Solution	Discount	Discount	C/F Less	C/F Less	C/F Less	C/F More	Preferred	Discount
Service Delivery	Discount	Discount	C/F Less	C/F Less	C/F Less	Preferred	Preferred	Discount
Implement ation	Discount	Discount	C/F More	C/F More	C/F More	C/F More	C/F More	Discount
Funding	Discount	Discount	C/F More	C/F Less	C/F Less	Preferred	Preferred	Discount



3.5 Indicative Costs

There is a requirement at IA stage to provide indicative prices for each of the short-listed options. This has been done by North Ayrshire Health and Social Care Partnership with the support of the services of an appointed Cost Advisor, Currie & Brown.

At this stage in the process, their costs for Option 4, 5A, 5B are based upon the early version of the Schedule of Accommodation created following discussion and consultation with relevant stakeholders and block diagrams used as indicative potential options as well as the programme plan developed in support of the project. The Schedule of Accommodation used is attached in **Appendix L**

The costs for Options 4, 5A and 5B (Twin Hub new build/Montrose House reconfigure and extend/New Build) at this early stage are based on current health developments that are similar to the new hub facility irrespective of eventual solution and site options. This is deemed wholly appropriate as the facility(s) have a similar footprint (at least in terms of the services delivered).

This approach has also been supported by the Board's appointed healthcare planners, who have experience of the development of other similar health facilities and who, on balance, believe this is a more appropriate methodology.

The following assumptions from Currie & Brown apply to each of the options and include:

- Rates inflated using TPI as MIPS and PUBSEC no longer in use – TPI based on 2Q 2010 at 218 and 2Q 2020 at 354
- Location factor based on 15% Arran factor
- Allowance included for circulation and plant
- Abnormal (incl. 15% external works, 5% BREEAM and section 6 compliance, 5% SHTM compliance) assumed at 25%
- Assumed Tender inflation from 2Q 2020 to 2Q 2022
- Assumed construction inflation from 2Q 2022 to 2Q 2023
- Includes 17% Optimism Bias
- Excludes Client Direct costs (e.g. Land etc.)
- Excludes Clinical Services costs
- Excludes Non-Clinical Operating costs
- Excludes Net Contribution costs
- Excludes Transitional costs
- Excludes Externalities
- Excludes enhancements to standard design
- Excludes demolition, asbestos, contaminated material and decant costs
- Excludes dealing with Japanese knotweed or similar
- *VAT* is deemed to be non-recoverable until the project has been reviewed by the Boards VAT advisors
- Lifespan of the building is 60 years
- Based on draft Schedule of Accommodation V6 dated 18/3/19

The indicative costs associated with the short-listed options are summarised in the table below and attached in detail at **Appendix M (i)** and Life Cycle Costs at **Appendix M (ii)** and NPV calculations at **Appendix M (iii)**

Costs in £millions	Option 1. Do Nothing	Option 4 Twin Hub	Option 5A Single/Montrose	Option 5B Single/New Build
Capital cost (or equivalent value)	**Circa £7.1m**	**Circa. £30.10m**	**Circa. £28m**	**Circa. £39.70m**
Whole of life capital costs	Low- £23,956,000 High - £27,018,000	Low - £15,785,000 High - £19,543,000	Low - £10,335,000 High - £12,796,000	Low - £14,137,000 High - £17,503,000
Whole of life operating costs	N/A	£0.87m	£0.72m	£1.27m
Estimated Net Present Value of Costs	N/A	£30.93m	£26.97m	£42.95m

3.6 Assessment of Short Listed options

In consideration of all of the issues, business needs, risks, opportunities, inter-dependencies and other relevant considerations, the options short-listed for consideration at IA stage are therefore:

Option 1. Do Nothing (The Status Quo): Continue to deliver services in the same way from existing facilities without change.

Option 4. Descriptor Twin Hub - Maintain residential home within existing facility. Re-provide hospital, GP, community and social care services within a new, separate, primary & secondary care hub

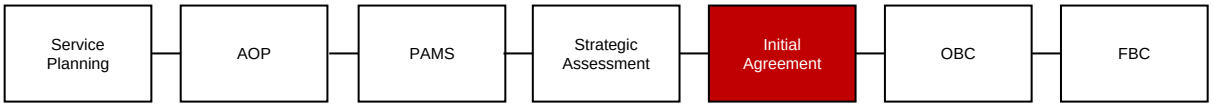
Option 5A - Single Combined Acute, Primary & Social Care Hub – Reconfigure/Extend Montrose House -Reconfigure and extend Montrose House to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility

Option 5B - Single Combined Acute, Primary & Social Care Hub – New Build/Site - Build a new facility to bring together hospital and residential home beds plus GP, community and social care services into a single, integrated service delivery model and single physical "hub" facility

3.7 Preferred Strategic Service Solution

The Board has assessed the potential business scope and the associated service requirements to the project in terms of a continuum of business needs, ranging from "core" (minimum) requirement through "core plus desirable" (intermediate) requirement to "core plus desirable plus optional' (maximum) requirements. This is in line with identified best practice.

At this stage, core denotes 'the things that we must have'; desirable 'the things that we are prepared to consider on a cost/benefit basis'; and optional 'the things we that we might accept' providing they are exceptionally low cost.



Sustainability priorities should typically fall into the first, 'core' category, as they should have been justified environmentally, socially and economically.

These business needs have been summarised as shown below.

	Minimum	**Intermediate**	**Maximum**
Potential business scope	Restructure teams and services, if and where possible, to better support 24hr rotas for essential services (community services, urgent unscheduled care services and inpatient beds, primary care, residential care), accepting that what has already been done in terms of changes to service and practice have largely already achieved the small amount possible.	Establishment of a single Hub to bring all Primary, Secondary and Social Care staff together in integrated and flexible multi-disciplinary teams	Establishment of a single site that provides the ability to flex staff across Inpatient and residential care beds and also supports full integration and co-location of MDT's
	Continue current	Achieve efficiency within administration and support services to streamline care and better meet the expected rise in need.	A fully integrated and flexible admin and support team under single management
	Significantly Increase the capacity of community care by collocating services so that more efficient staffing/rotas will allow a move of staff from bedded facilities to community roles.		
	Within current restrictions attempt to facilitate a workforce model that is realistic in the face of a shrinking working age population and rising need.	Deliver sustainable overnight rotas with staff able to flexibly work between community, inpatient and residential care. Develop hybrid roles and multidisciplinary working.	
Key Service Requirements	Reduction in sites for the delivery of Primary and Social Care	Reduction in sites for the delivery of Primary and Social Care	Reduction in sites for the delivery of Primary and Social Care

	Explore any ways to provide a more sustainable model within the confines of disparate bases and uncoordinated service delivery Mitigate, where possible, the current clinical functionality issues within AWMH	Formation of collocated, integrated and flexible multi-disciplinary teams to support 24 hr care Replacement of AWMH Creation of a Single Point of Contact Creation of a single communication system Creation of a Single Record	Formation of collocated, integrated and flexible multi-disciplinary teams to support 24 hr care Replacement of AWMH with collocated beds from Montrose House Creation of a Single Point of Contact Creation of a single communication system Creation of a Single Record

There will be a phased approach to the introduction of the New Model of Care over the next two to three years whilst the SCIM proposals are taken forward and we move towards the new Arran Integrated Service Model. This will involve reconfiguration of existing services and sites in a stepped approach to transforming island services. The phased approach has two key components the development of a "mini hub" for unscheduled care and the introduction of a complex care MDT team delivering care in the individuals own home. Alongside these changes to service delivery will be enable work streams for introduction of a Single Point of Contact, Single Care record and IT.

3.8 Design Quality Objectives

NAHSCP is required to follow SCIM requirements for the NDAP process in the implementation of Capital projects.

NAHSCP's approach is to achieve good design to support cost effective and future proof facilities that improve the patient experience. This can be achieved through good, cost effective design within its built environment and is committed to improving the quality of life for people who use its premises as patients, staff, visitors and the local community by enhancing and creating buildings and spaces that are healthy for present and future generations and environmentally sustainable.

NAHSCP wishes to get maximum benefit from its investments in healthcare facilities. The design of this redeveloped facility and its environment should promote best working practice, be welcoming and accessible to people from all walks of life and all abilities, and generate a sense of wellbeing, belonging, and place to all who use it. The building quality and materials should optimise whole life value and seek to minimise the environmental impact of the development and enhance the wellbeing of users.

A Design Statement has been prepared for this Initial Agreement stage to support the design assessment process which will take place at the Initial Agreement, Outline Business Case and Full Business Case stages of approval. This requirement is mandated through NHS CEL 19 (2010) and supported by the Scottish Government's Policy on Design Quality for NHSScotland. The Design

Statement is included in **Appendix F.**

The core objectives that have to be met by the new Hub Facility project are:

- To facilitate those specific aspects of the new Model of Care in the creation of integrated and co-located teams which will deliver efficient and multi-disciplinary services seamlessly for all service users.
- To support the development of new sustainable rotas that will provide 24h hour coverage by the most appropriate team members.
- To support the new team structures with innovative digital access across all partners.
- To support the "Single Point of Contact" for all service users with new protocols and processes to direct care in the most effective way.
- To replace the existing accommodation which will improve access to services, patient flow and efficiency.
- To reduce the risk to the health and safety of users, both staff and patients through improved facilities incorporating better segregation and staff and patient facilities.
- To ensure the new Hub is delivering care from a facility which is more compliant with legislative, statutory and sizing guidance requirements.
- To provide equality for all patients.
- To enable inpatient, outpatient and unscheduled care services can be delivered more effectively according to clinical needs and not constrained by availability of current clinical facilities.
- To provide staff with a working environment conducive to delivering the best health care and aiding recruitment and retention.
- To provide the new Hub with the physical capacity to modernise services, optimise patient flows, staff skills and respond to anticipated local population health needs.
- To deliver facilities in line with the aspirations as set down in the project Design Statement.
- To support the design development through the use of the Design Statement in conjunction with AEDET reviews at each stage.

As part of the project development, an AEDET assessment, independently facilitated, was carried out by a group of stakeholders on the existing facilities relative to the Design Statement.

On the advice of HFS, the AEDET Benchmark scoring was progressed on the basis of a review of all the island facilities proposed to be replaced as per the Options being taken forwards. As the retention of NAC's Montrose House Care Home facility is a key component of both Options 4 (Twin Hub with Montrose House retained and replacement facilities for AWMH, Brodick, Lamlash and Lochranza) and 5a (as Option 4 but with replacement facilities as a new extension to Montrose House to create a combined single hub), two AEDET Benchmark scores were done – one without Montrose (effectively to cover Option 5b – single hub replacement facility for AWMH, Brodick Lamlash, Lochranza and Montrose House) and one with it included (as per Options 4 and 5a).

The resultant AEDET Benchmark and AEDET Target outputs are presented in **Appendix G.**

The delivered project will also be specified to comply with relevant statutory and design and technical guidance documentation. Any proposed derogations from guidance will be reviewed as appropriate and accepted or not and with a clear audit trail of decision-making being required at every stage. Guidance will be sought from HFS as required. Documentation will be specified generally on the basis of the following table.

Mandatory Requirements	

Design and Technical Guidance	
NHSScotland policy letters (DLs,CELs, CMOs)	Scottish Government: Health and Social Care; Chief Medical Officer directorates
Scottish Health Planning Notes (SHPN)	Health Facilities Scotland
Scottish Health Facilities Notes (SHFN)	Health Facilities Scotland
Scottish Health Technical Memoranda (SHTM)	Health Facilities Scotland
Health Building Notes (HBN)	Dept of Health (England)
Health Technical Memoranda (HTM)	Dept of Health (England)
Health Facilities Notes (HFN)	Dept of Health (England)
Other relevant design and technical guidance in support of the above or additional to it may be incorporated as relevant.	Procurement and Construction Policy note: NB: Construction quality in particular. HSE and other Health and Safety guidance CIBSE BRE Sustainability design and specification guidance. Dementia design and specification guidance. Others
Statutory Requirements	
	Planning permission Building Regulations compliance Equality Act compliance Health and Safety Executive (HSE) compliance Construction (Design and Management) Regulations compliance
Other Mandatory Requirements	
	Activity Data Base (ADB) Achieving Excellence Design Evaluation Tool (AEDET) – As noted above.http://www.dh.gov.uk BREEAM Healthcare – as noted

In addition NHSA&A have identified sustainability objectives that the project must deliver against and based on the core driver to deliver a new model of care and replace the existing accommodation in order to improve access to services, patient flow and efficiency, the sustainability objectives for the project are:

- To provide patients with a sustainable service in a fit for purpose and patient centred environment.
- To provide an environment that is sustainable in responding to different patient groups specific needs.
- To provide staff with a working environment conducive to delivering the best health care in a sustainable environment that also supports the long-term sustainability of the workforce in supporting recruitment and retention.
- To provide an easily maintained facility with good quality finishes and materials.
- Where feasible, to set criteria and standards surpassing those required by current regulations
- To challenge the market to provide innovative solutions that minimise the environmental

impact of buildings
- To raise the awareness of the benefits of buildings with a reduced impact on the environment
- To support NHS Ayrshire & Arran's and North Ayrshire Council's progress towards corporate environmental objectives
- To provide staff with digital technology that supports Agile working and overall productivity

The sustainability strategy for the project has included a review of compliance with CEL19(2010) based on all new build above £2m are required to obtain a BREEAM Healthcare/ or equivalent 'Excellent' rating.

Based on the above requirement and given that the project is for a new facility, it is considered that BREEAM is required. This will be reviewed early in OBC stage in collaboration with Health Facilities Scotland and Architecture and Design Scotland and a pre-assessment will be carried out.

The following checklist will be used for the project based on BREEAM requirements:

- Commissioning
- Health and wellbeing
- Daylight
- Occupant thermal comfort
- Accoustics
- Indoor Air and Water quality
- Lighting
- Energy
- Transport
- Water
- Waste
- Pollution
- Land use and ecology
- Materials

4 Commercial, Financial and Management Cases

4.1 Commercial Case

4.1.1 Procurement Route likely for Preferred Solution

Contractor procurement will have more challenges due to the scale of the project and the geographical uniqueness of the island of Arran. When the final assessment of procurement is undertaken any lessons learned from other island developments will be taken account of where available.

A review has been carried out of potential contractor procurement and this will be reviewed again at OBC stage.

The procurement routes being considered will include:
- Frameworks Scotland 2 – Major contractors will likely sub-contract works locally due to geography and project scale.
- Hub South West – Public/Private Partnership covering South West Scotland

- Scape – Active in the north region and islands generally.

At this stage no final decision has been made on a specific procurement route however it is likely that the preferred procurement option for contractor would be to use Hub South West subject to NHSScotland and Scottish Government endorsement and project fit – geography and scale.

Key elements of this IA have been supported through Hub South West Strategic Support Services by Higher Ground Health + Care Planning (Healthcare planners) supported by Core Associates (Architectural & Design consultants) and Currie and Brown (Cost Advisers). Up to now project management has been led by NHS Ayrshire & Arran.

HGHCP have supported strategic work relating to scenario planning and key elements of the business case process including option development and analysis as well as supporting workshops to determine the project risks and benefits. They have also worked with the wider advisor team with inputs in respect of facilities (Core Associates) and costing (Currie and Brown). It is planned that similar inputs are provided moving forwards.

Consultant advisor appointments moving forward will be made as required. These consultant advisors will be appointed on a stage by stage basis through to Post Project Evaluation.

4.1.2 Procurement Timetable

A high-level programme for the project has been compiled by the Board that considers all required planning activities/timescales, approvals/business case and construction elements. This includes estimated timescales for the further submission of Outline Business and Full Business Case's required to deliver the preferred way forward whilst ensuring service continuity and is presented as **Appendix O**.

This programme will be kept under continual review and modified/updated/enhanced as appropriate as the project moves forward.

Key dates in the overall Programme include:

Activity	Completion / Target Dates
NHS A&A, NAHSP & NAC Approvals Complete Integration Joint Board meeting Infrastructure Programme Board Caring for Ayrshire Programme Board Corporate Management Team Performance Governance Committee NHS Board meeting	30th August 2019 20th June, 2019 8th July 2019 21st August 2019 17th September 2019 10th October 2019 2nd December 2019
Initial Agreement submission to Scottish Government Capital Investment Group	11th December 2019
Initial Agreement considered at Scottish Government Capital investment Group	10th February 2020
Initial Agreement re-formatted and updated	May 2020
Infrastructure Programme Board	6th July 2020
Caring for Ayrshire Programme Board	8th July 2020
Performance Governance Committee	30th July 2020
NHS Ayrshire & Arran Board	17th August 2020
Scottish Government Capital Investment Group	September 2020

Taking account of the Covid-19 Pandemic and its impact on all services, the remaining timetable has been adjusted to incorporate not only the actual delays through the first half of 2020 but also acknowledges the likelihood that other activity and engagement going forward in developing the OBC will take longer to allow for ongoing social distancing etc. These dates will be reviewed on an ongoing basis and adjusted where required.	
OBC Commences	September 2020
OBC complete	June 2021
Governance	June – September 2021
FBC Commences	September 2021
FBC complete	May 2022
Construction commences	June 2022
Construction complete	June 2024/5

4.1.3 Scope of Services & Works

Any required physical elements of the solution(s) will be delivered by hub South West Ltd, in conjunction with their construction and design team supply chain. Hub South West Ltd will be responsible for providing all aspects of the design and construction to comply with the Board's required schedule of accommodation, construction requirements, and clinical output specifications.

Soft facilities management services (such as domestic, catering, portering, portable appliance testing and external grounds maintenance) will be provided by NHS Ayrshire & Arran. Hard facilities management services (such as security, planned and preventative maintenance and lifecycle replacement) will also be provided by NHS Ayrshire 7 Arran.

Group 1 items of equipment, which are generally large items of permanently installed plan or equipment will be supplied and installed by hubCo. Future maintenance and replacement will be by NHS Ayrshire & Arran, subject to any items requiring rectification within the defects liability period.

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 Grampian, installed by hubCo and future maintained by NHS Ayrshire & Arran Board.

Group 3-4 items of equipment are supplied, installed maintained and replaced by NHS Ayrshire & Arran.

4.2 Financial Case

NHS Ayrshire and Arran have submitted financial plans to Scottish Government in line with issued guidance from the Scottish Ministers. This plan shows the Board reaching a breakeven position at the end of year three. Current forecast for end of Year 1 (19/20) is an overspend of £14.75m.

Scottish Government have provided funding to assist in completing the Initial Agreement for submission to SG. Future funding is expected as a result of the bid progressing through the SCIM process to the SG Capital Investment Group.

4.2.1 Affordability

North Ayrshire Health and Social Care Partnership recognises the importance of a sustainable and balanced financial plan and the impact this can have on the ability of the Integrated joint Board to sustain the quality of services offered to the local population.

NHS Ayrshire and Arran has, for a number of years, needed to make efficiency improvements over and above the National 3% target to achieve financial balance, provide investment to sustain local services and to address ongoing pressures such as the requirement of short-term locums in both primary and secondary care. Achieving these efficiency improvements on a recurrent basis continues to be a significant challenge especially in clinical areas where a number of services operate on de minimis staffing levels.

The Board's immediate focus has been on developing recurrent proposals for 2019-20 to bridge the in year gap.

Currently the project would require the use of Capital Resource funding made available by SG, as other funding routes are not currently available. Revenue consequences will be fully identified in the Outline Business Case which will require support and approval from the NHS Board.

4.2.2 Capital Costs

A high level capital cost appraisal has been prepared and is presented in the table below showing the options shortlisted for this proposal

DIRECT CAPITAL COSTS FOR RE-PROVISION OF SERVICES				
		Proposed	Proposed	Proposed
		Solution 1	Solution 2	Solution 3
	Do Nothing	(Option 4)	(Option 5A)	(Option 5B)
New Build Square Metre	2,035	3,360	2,752	4,488
Refurbishment Square Metre			529	
	£	£	£	£
CAPITAL COST ANALYSIS				
Building	0	9,808,737	9,008,936	12,898,405
Year 0 - 20 Backlog Maintenance	5,368,835	0	0	0
Communication Areas	0	891,347	870,357	1,190,558
Plant	0	1,134,442	1,107,727	1,515,255
Furniture, Fixtures and Equipment	0	1,183,453	1,098,702	1,560,422
Legal/Technical/Financial Advisers	536,884	2,281,188	2,117,825	3,007,822
Optimism Bias	0	2,766,321	2,568,216	3,647,486
Abnormals @35%	0	3,254,495	3,021,431	4,291,160
Assume Inflation - Tender/Construction	0	3,773,085	3,502,883	4,974,938
VAT	1,181,144	5,018,613	4,659,216	6,617,209
TOTAL CAPITAL INVESTMENT	**7,086,862**	**30,111,681**	**27,955,294**	**39,703,255**

The options identified indicate capital funding for circa £25m to £35m, dependent on eventual preferred option, investment presented in this Initial Agreement must be seen in the context of this global spend as:

- A modest (in national terms), highly effective investment - representing otherwise essential expenditure - that will strengthen Health and Social Care provision on Arran whilst dramatically improving the quality and lifespan of the clinical environment required to support it
- An investment in a new Model of Care supported through integration that is supported and underpinned by local, regional and national planning

- An investment that will, in recognition of the impact of service re-design/transformation in a local and regional context, target spend on areas that represents an increasing element of local service provision.
- An investment that will replace the Arran War Memorial Hospital, ensuring that it is able to deliver the full range of acute care required in Arran and will bring inpatient provision for Health and Social Care together.
- An investment that has a local impact on backlog maintenance but provides a functional and flexible acute hospital on Arran for the future.
- An investment that will allow the closure of some facilities to reduce the number of delivery locations and support the implementation of the new Model of Care.

4.2.3 Revenue Costs

Indicative Revenue costs are shown in the table below.

NON CLINICAL REVENUE COSTS FOR RE-PROVISION OF SERVICES						
			Current/ Do Nothing	Proposed Solution 1 (Option 4)	Proposed Solution 2 (Option 5A)	Proposed Solution 3 (Option 5B)
New Build Square Metre			2,035	**3,360**	**2,752**	**4,488**
Refurbishment Square Metre					**529**	
			£	**£**	**£**	**£**
ANALYSIS OF NON-CLINICAL COSTS						
Catering		Presume Same patient numbers no additional cost	84,978	84,978	84,978	84,978
Rates		£36 per m² New	30,360	120,960	99,000	161,568
Energy		£30 per m² New (Assumed no Income)	43,761	100,800	82,560	134,640
Domestic		£45 per m²	119,781	151,200	123,840	201,960
Maintenance		£29 per m² New	25,930	97,440	79,810	130,152
Portering		£12 per m² New	38,462	40,320	33,027	53,856
Laundry			8,800	8,800	8,800	8,800
Capital Charges		Depreciation (based on 50 years new/10 years Equipment) 4/5A/5B	78,949	715,845	664,581	943,866
TOTAL RUNNING COSTS FOR NEW PROJECT			**431,021**	**1,320,343**	**1,176,596**	**1,719,820**
CURRENT COSTS FROM EXISTING COSTS SHEET			0	454,923	454,923	454,923
ADDITIONAL RECURRING COSTS			**0**	**865,420**	**721,673**	**1,264,897**

4.2.4 Disposal of Assets

Dependent on the outcomes of further project development it is anticipated that there will be a number of properties becoming surplus to requirements and therefore disposals would be undertaken related to the eventual service solution.

These include:

- Arran War Memorial Hospital (AWMH)
- Brodick Health Centre
- Lamlash Medical Centre
- Lochranza Surgery (Branch Surgery)

As a result of market conditions, it is currently NHS A&A's policy not to factor in any asset sales into its financial plans until sales are guaranteed. Therefore this IA does not make any assumption that

disposal of surplus sites can contribute to funding any development. Any resulting sales of existing properties could hopefully be re-invested into key estate priorities.

It is however important to note that the property market on Arran remains buoyant and it is likely that capital receipts can be obtained against the planned disposals.

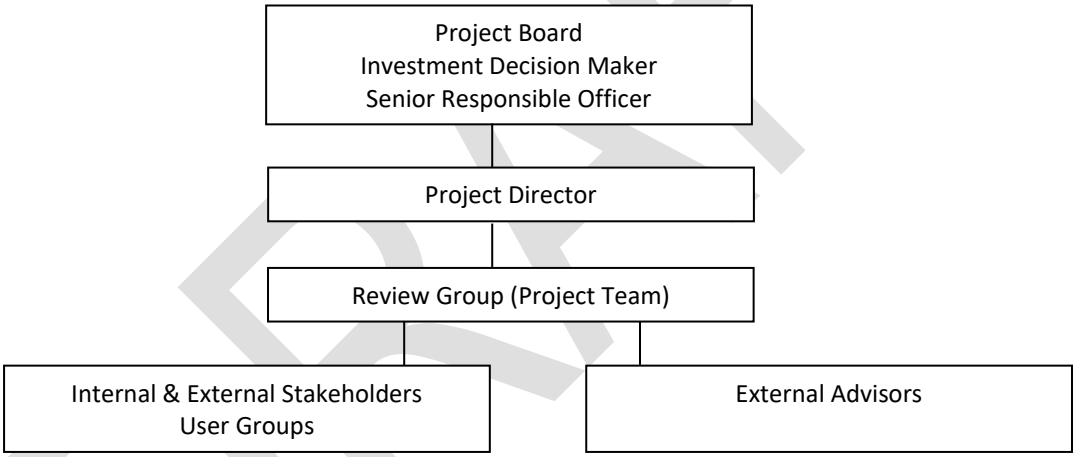
4.3 Management Case

The project will continue to be managed using the existing Review Group established on Arran. This team have both internal and external stakeholders, patient and service user representation, along with external stakeholders. As work progresses additional support will be made available from specific teams across the various partners. In particular, Capital planning, Business support, Estates, Finance and HR.

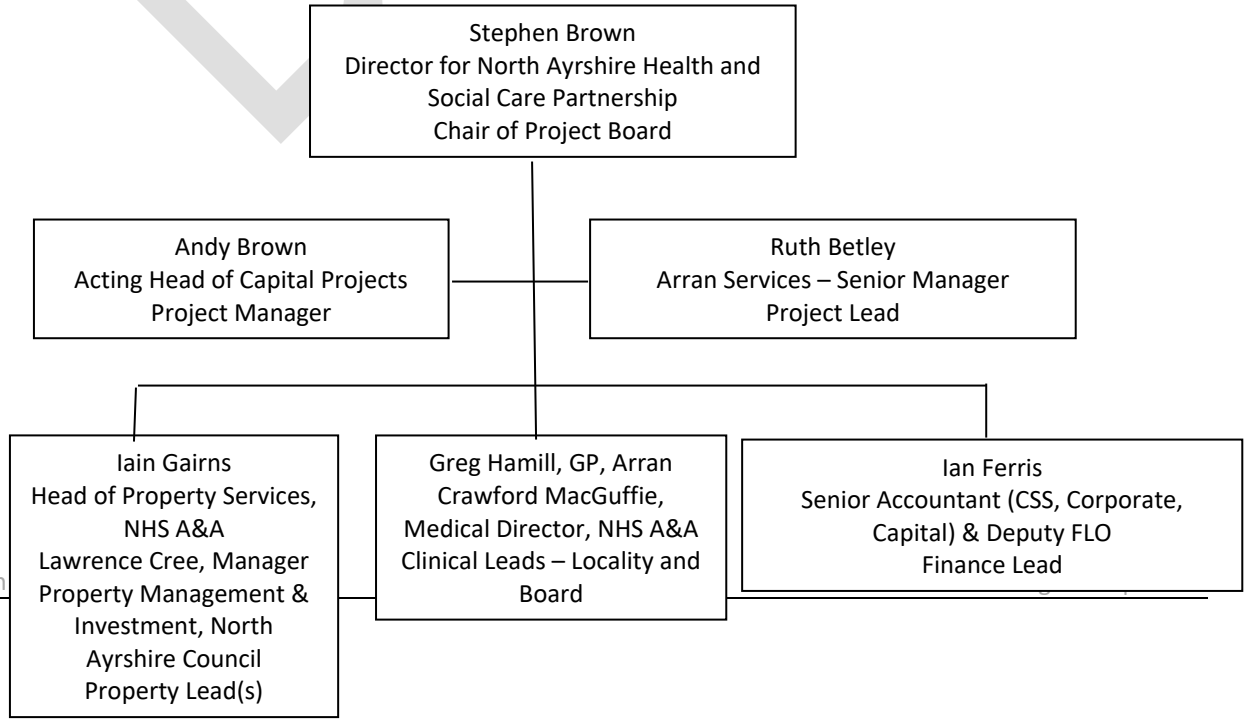
The work of the Review Group is overseen by the Project Board as part of the overall Governance requirements.

4.3.1 Project Governance

The work of the Review Group is overseen by the Project Board as part of the overall Governance requirements. The structure is shown below:



Key members of the Review Group are shown in the diagram below.



Other Project Team Members
Ailsa Weir, Senior Charge Nurse, AWMH, NHS A&A
Vicki Yuill, Chair, Locality Partnership
Colin Adams, Social Services team Leader, North Ayrshire Council
Christine Stewart, Community Nursing Team Leader, NHS A&A

4.3.2 Roles and Responsibilities

Overall terms of responsibility will include:

ROLE	RESPONSIBILITY
Investment Decision Maker(s)	Collective and final responsibility for the approval of the Investment
Senior Responsible Officer (SRO)	Personal accountability and overall responsibility for the delivery of the successful outcome
Project Director	Leading, managing and co-ordinating the Project Team on a day today basis.
Project Board	Provides the SRO with stakeholder and technical input to decisions affecting the project.
Project Team(s) (Steering and Technical Groups)	Takes forward the decisions of the Project Board and develops the operational elements of the project.
Stakeholder Forums and User Groups	Provides the Project Team and Board with

Other Project Team Members
Ailsa Weir, Senior Charge Nurse, AWMH, NHS A&A
Vicki Yuill, Chair, Locality Partnership
Colin Adams, Social Services team Leader, North Ayrshire Council
Christine Stewart, Community Nursing Team Leader, NHS A&A

A summary of key personn
responsible for delivery of

Name	Project	Skills
Stephen Brown	SRO Director Integration Joint Board	Stephen is a social worker who took up his first post in the City Centre Team in Glasgow at the age of 23. He has spent his entire career since then within the public sector. He joined North Ayrshire Council as a Senior Social Worker in 1999 and has been a Local Manager, Reception Services Manager and Senior Manager within Children and Families Services throughout that time. With the establishment of the North Ayrshire Health and Social Care Partnership in 2014, he was appointed Head of Service for Children, Families and Criminal Justice and also became Chief Social Work Officer to the Council. After being appointed as Interim

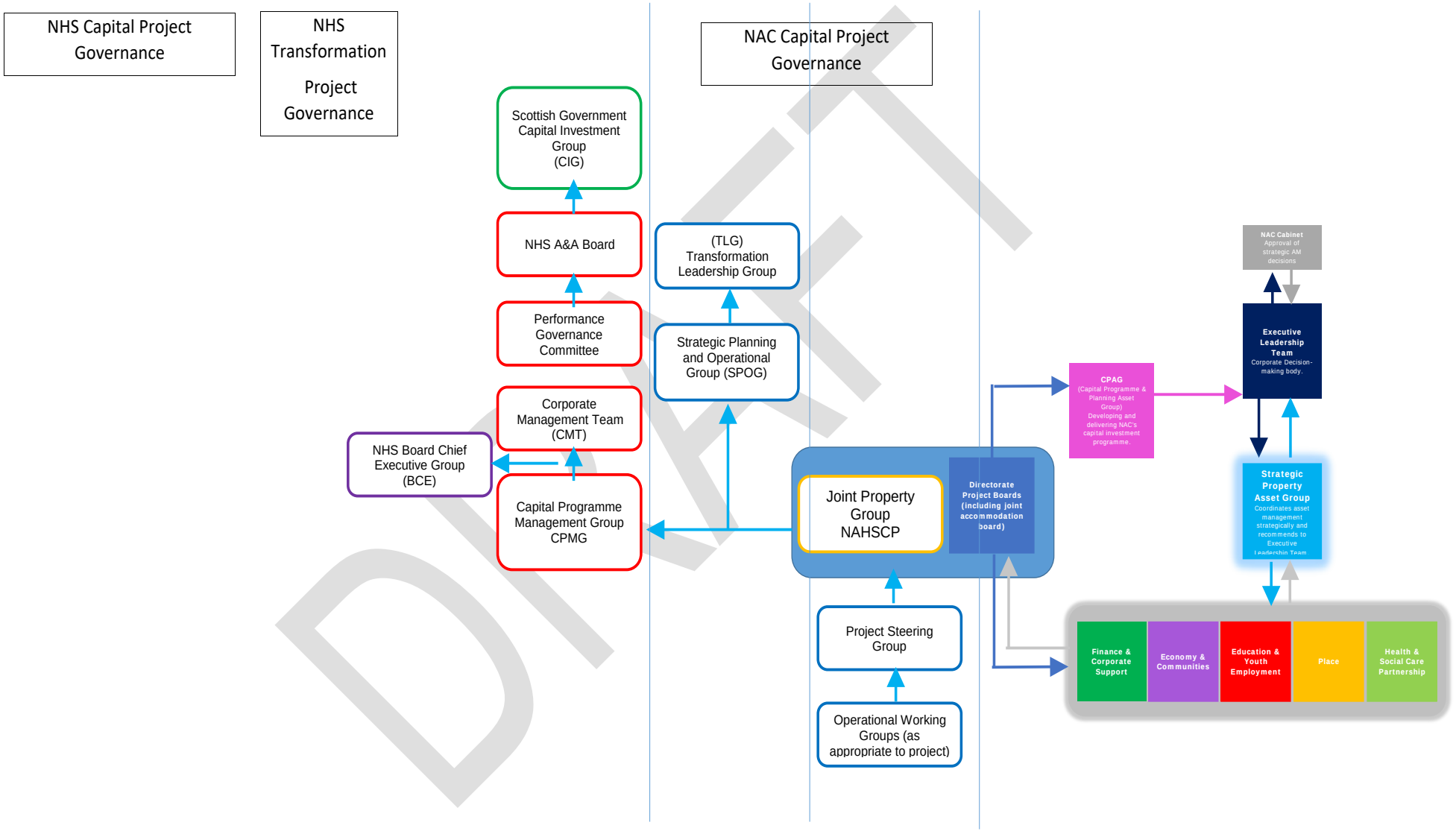
		Director of the Health and Social Care Partnership and Chief Officer to the Integration Joint Board in April 2017, Stephen was confirmed as Director/Chief Officer in March 2018.
Andy Brown	Interim Head of Capital Planning, NHS Ayrshire & Arran	Has been employed within capital developments of NHS Ayrshire & Arran for almost 27 years latterly as the Interim Head of Capital Planning. Over the past 27 years he has project managed and directed numerous important developments form minor alterations/extensions through to major capital and revenue funded buildings to improve the delivery of healthcare in Ayrshire & Arran. Trained as an Architectural Technologist he has delivered capital projects successfully during his career in NHS Ayrshire & Arran with the latest being the Building for Better Care programme which was subject to Gateway Review and close internal and external governance.
Ruth Betley	Project Lead	The Senior Manager for Arran Services with over 30 years NHS experience in both operational and strategic roles. Key areas of expertise include delivery of major redesign of older people's services, merging of primary care GP surgeries on Arran, planning and opening of a new GP surgery on Arran, commissioning of a new hospital; development of teams, change management and leadership across health and social care. As Director of Modernisation in a Primary Care Trust had lead responsibility for overview and commissioning of a new hospital. As Assistant Director in a large Acute hospital had lead responsibility for business planning and service redesign
Iain Gairns	Property Lead NHS	Head of Property Services, Strategy & Partnerships for NHS Ayrshire and Arran. Key areas of expertise include, Strategic Asset Management, Property acquisition and Disposal, and Healthcare Facilities Management. Other work includes national groups, such as the Scottish Property Advisory Group, NHS Property Transaction Group and Chair of the NHS Estate Asset Management System and Capital Planning System Project Board. He is also the Estates lead for the NHS Ayrshire & Arran, Whole System Estate Plan.
Laurence Cree	Property Lead LA	The Senior Manager for Property at North Ayrshire Council and is responsible for delivery of the Council's capital programme, estates functions, asset management, maintenance and property related statutory compliance. Laurence has experience in delivering projects, particularly where partnership working is a central aspect of the scheme, and will provide the link to the relevant governance structures of the Council
Greg Hamill	Clinical Lead - Local	Dr Hamill has been a GP on Arran since 2002. Like many Rural GPs he has a broad range of clinical skills and in addition to primary care works in urgent unscheduled care services , Out of Hours, Inpatient care, Pre-hospital BASICs response, Police surgeon roles, as well as providing minor surgery and an urgent unscheduled care clinic . He has significant experience working with all the health and social care teams on the Island. He has led several significant developments in primary care on Arran including modernisation of practice systems, subsequent merger of the three island practices into Arran Medical Group (AMG) and the emergence of Arran as a training centre for Rural GPs. He is a Student Tutor and GP Trainer and coordinated the successful Arran GP Rural Fellowship. He has been the finance, contracts and HR lead for AMG for several years and was the clinical lead on the construction of two new GP premises

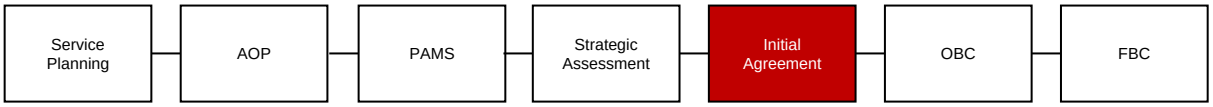
		in Whiting Bay and Shiskine in 2007/8, Clinical lead in the Review of GP Out of Hours services in 2011 and The Arran Review of Services 2015/16. He is currently the Clinical Lead on Arran for North Ayrshire HSCP (since 2017).
Crawford MacGuffie	Clinical Lead - Board	A consultant in Emergency Medicine and Joint Medical Director in NHS Ayrshire and Arran. He is passionate about continually improving services and was the clinical lead for the redesign and rebuild of the Emergency Department at University Crosshouse in 2004. Clinical lead roles followed for the development of the first Clinical Decisions Unit in Scotland in 2005 and the first Emergency Nurse Practitioner service in Scotland in 2007. He was the Clinical Director for Emergency Medicine in Ayrshire and Arran from 2005-2008 before taking up the Associate Medical Director role. Since then he has been the clinical lead for Unscheduled Care and the Board's Capital Development Programme, Building for Better Care, which oversaw the delivery of a new Combined Assessment Unit at University Hospital Crosshouse and a new Emergency Department and Combined Assessment Unit at University Hospital Ayr, between 2013 and 2018.
Iain Ferris	Finance lead	Employed by NHS Ayrshire and Arran for 35 years and is currently employed as Senior Accountant for CSS, Corporate Services and Capital. Key areas of expertise include Management and Capital Reporting, Business Case Development, Capital Projects, and PFI's. Involved fully in all Capital projects driven by the Board, previous works have included the financial involvement in Woodland View, Girvan Community Hospital, Building for Better Care (Phases 1 &2).
Ailsa Weir	Senior Charge Nurse	Senior Charge Nurse at Arran War Memorial Hospital and has held this position for the last 12 years and currently has a team of 26 nursing staff that cover in-patient wards, urgent unscheduled care services, out-patients and day-cases. This role not only encompasses the management of nursing staff but also ensuring that high quality patient care is delivered safely at all times in the hospital. Ailsa has worked in the NHS for over 30 years in both Greater Glasgow and Ayrshire and Arran and within a variety of clinical specialities.
Vicki Yuill	Chief Executive Officer for Arran Community and Voluntary Service	As part of the Third Sector Interface she provides strategic representation for the third sector within the realms of Children's Services and Health and Social Care. Within this role Vicki holds a seat on the integrated Joint Board and the Children's Services Strategic Partnership providing a voice for third sector organisations across North Ayrshire and Arran. These connections are developed through engagement at forums, briefing papers, one to one meetings and networking events. At a local level Vicki is the Chair of the HSCP Arran Locality Forum and the Senior Lead officer with the Arran Locality Partnership. Vicki also holds a seat on the Community Planning Partnership as the Third Sector Representative alongside other community planning partners.
Colin Adams	Team Manager – Social Services	Collin Adams is the Team Manager for Social Services on Arran, which is one of the few generic social work teams left. He has previous experience in managing Children and Family teams in various local authorities and of managing a Young Carers service where he was an active member of the Scottish Young Carer's Services Alliance. He has been a qualified social worker for 17 years having been in a management role for the last 13. Previously in work in the third sector he was involved in project work aimed at helping local groups employ a schools and youth worker through

		establishing local charitable trusts.
Christine Stewart	Community Nursing – Team Leader	Responsible for ensuring co-ordination and delivery of a quality nursing service in the community setting. Christine has over 30 years experience working as a District Nurse caring for patients with a range of conditions and complexities and is keen to develop and promote new ways of multidisciplinary working help meet the increasing challenges of delivering health and social care to individuals in their own homes.

The overall governance for the North Ayrshire Health and Social Care Partnership project includes both NHS and Local Authority routes and is shown overleaf and is attached in **Appendix O**.


Service Planning
AOP
PAMS
Strategic Assessment
Initial Agreement
OBC
FBC


NHS Capital Project Governance
NHS Transformation Project Governance
NAC Capital Project Governance
Scottish Government Capital Investment Group (CIG)
NHS A&A Board
Performance Governance Committee
Corporate Management Team (CMT)
NHS Board Chief Executive Group (BCE)
Capital Programme Management Group CPMG
(TLG) Transformation Leadership Group
Strategic Planning and Operational Group (SPOG)
Joint Property Group NAHSCP
Directorate Project Boards (including joint accommodation board)
Project Steering Group
Operational Working Groups (as appropriate to project)
CPAG (Capital Programme & Planning Asset Group) Developing and delivering NAC's capital investment programme.
NAC Cabinet Approval of strategic AM decisions
Executive Leadership Team Corporate Decision-making body.
Strategic Property Asset Group Coordinates asset management strategically and recommends to Executive Leadership Team
Finance & Corporate Support
Economy & Communities
Education & Youth Employment
Place
Health & Social Care Partnership



4.3.3 Next Steps

Ongoing liaison with all external and internal stakeholders and clinical groups will continue to further refine the service redesign requirements. All proposals will be scrutinised by the Infrastructure Programme Board and Scottish Government representatives as well as Architecture and Design Scotland and Health Facilities Scotland to refine proposals for those services and where they need to be located and delivered across Arran.

The Project Board has and will continue to be appraised of the currently identified high level risks associated with this project as set out in this IA. Proactive monitoring and review of all risks will act as a critical control within the project.

As with risk management as noted above, benefits realisation will also require proactive management of the stated benefits envisaged for this project are to be fully realised. A more detailed benefits realisation plan will be developed during work on the Outline Business Case and overseen by the Project Board. This plan will clearly describe each benefit including the success measured and will also show who has the accountability for its realisation and the timescales in which this will be achieved

There has been a high level of appropriate stakeholder engagement which commenced in 2018 to date.

The Stakeholder groups that have been identified and engaged will continue to be reviewed and updated where appropriate to ensure widespread representation and engagement at all times.

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

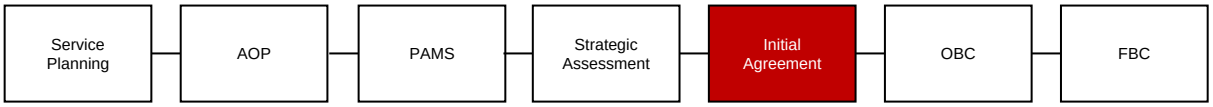
Condition surveys and potential for adaptation or disposal reports on all of the key premises will need to be developed through the AEDET.

Benefits realisation workshops, benchmarking for project evaluation planning and further public engagement across Arran communities will also need to be further developed

5 Conclusion

NHS A&A believe that this Business Case supports and further develops all of the stated objectives of the original Strategic Assessment.

The overriding outcome for the proposed changes in the delivery of the proposed model of care requires, as a minimum, bringing all beds, both inpatient care and long term care, onto one physical location that will support the multidisciplinary teams in developing strategies to deliver care in the community by providing robust 24 hr cover for beds and urgent unscheduled care. This could be achieved through some of the options discussed in this Business Case. To achieve the wider benefits the Board believe that the development of a new integrated Hub on the island of Arran would provide improved access to a wider range of services from a single location. The new service delivery model will provide an enhanced range of integrated services, supported by the introduction of a Single Management Structure with supporting Single Point of Contact and enhance the development of new professional and flexible roles in the multi-disciplinary teams.



The infrastructure solutions to support the delivery of the service will reduce backlog maintenance, improve the age and quality of the healthcare estate, and introduce new technology to improve access and patient experience. The reduction from multiple sites to a single site model will deliver better value in terms of both revenue and capital costs in the longer term. The new model of care will deliver a number of benefits that will Improve support to allow people to live independently, increase the ability to be cared for at home for the proportion of people with complex care needs, support the prevention of admission to hospital with earlier intervention and crisis intervention and support at home.

The proposal will significantly facilitate health and social care integration and the development of a more effective flexible and resilient team as well as improving the efficiency and effectiveness of health and social care estates.