NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Transforming Care in Clydebank

Initial Agreement

November 2015

Transforming Care in Clydebank

Transforming Care in Clydebank: Initial Agreement

1. Overview

1.1. West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Overall, West Dunbartonshire has a worse general level of health than the Scottish average – this is also the picture within Clydebank. Clydebank has high levels of poverty and an increasing elderly population high numbers with long term conditions. This is driving growing demand for health and social care services alongside an increasing imperative to co-locate teams, integrate services and deliver seamless care.

1.2. With changing demographics and increasing levels of need, over the next ten years the health and social care landscape will change significantly. Those changing demographics (including an ageing population), an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

1.3. In accordance with the Public Bodies (Joint Working) Act 2014, Greater Glasgow & Clyde Health Board (NHSGGC) and West Dunbartonshire Council established their local integration joint board – known as West Dunbartonshire Health & Social Care Partnership (WD HSCP) Board – in July 2015. The new WD HSCP arrangement has been built on the successes and experience of the predecessor community health & care partnership (CHCP) that had been operating effectively since October 2010. The approved HSCP Strategic Plan sets out the key priorities and commitments for health and social care for the area – and includes support for a replacement health and care centre to deliver improved outcomes for the communities of Clydebank.

1.4. Community health services in Clydebank serve 50,000 people and currently operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic. All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

1.5 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the “Do Nothing” option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is “money hungry”. The asbestos that is integral to the building’s structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national quality strategy or of a standard acceptable to either the NHSGGC or the WD HSCP Board. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million.

1.6 A new integrated facility for Clydebank already has widespread stakeholder support, including from local politicians and the local Community Planning Partnership. Such a replacement health and care centre build would enable the

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

1.7 Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank. As such, the proposed new health and care centre is not just about the construction of a new asset, but more importantly how such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Clydebank area more broadly.

1.8 This paper sets out an initial proposal and outline costs for the development of a new integrated health and care centre for Clydebank and the wider community of West Dunbartonshire. NHSGGC has made provision within its capital resource limit for this project dependant on confirmation of Hub funding; and the revenue costs are break even at this time.

1.9 The development will be led by WD HSCP, which is responsible for the provision of all community health and social care services in West Dunbartonshire. As well as complying with the requirements of the Scottish Capital Investment Manual (SCIM), the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as recommended in the latter project's Office for Government Commerce (OGC) Gateway Review.

1.10 In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. Given the background to this project, the Scottish Government's Capital Investment Group agreed that Scottish Futures Trust should be invited to engage with NHSGGC to examine the available options against the project's benefits realisation and investment objectives. Following this process, the Queen's Quay Regeneration Development site in Clydebank was confirmed as the optimal available site for delivering on the project's investment objectives. Furthermore, the terms of the site's provision by the Council means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In locating the new facility on this prime site, the regeneration benefits of the project will be considerably enhanced and further deliver a positive effect on the heath and wellbeing of the people of Clydebank.

2. Purpose

Strategic Case

2.1 NHSGGC is the largest NHS Health Board in Scotland and covers a population of 1.2 million people. NHSGGC's annual budget is £2.8 billion and it employs over 40,000 staff. NHSGGC's stated purpose is to deliver effective and high quality health services, to act to improve the health of the population and to do everything it can to address the wider social determinants of health which cause health inequalities.

2.2 The NHSGGC Clinical Services Strategy was approved in January 2015, providing a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- Safe and sustainable.
- Patient centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable, provided within the funding available.
- Accessible, provided as locally as possible.
- Adaptable, achieving change over time.

The strategy is entirely in line with NHS Scotland's strategic priorities, particularly in relation to the 2020 Vision and the Quality Strategy.

2.3 The Scottish Government's Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The approved Integration Scheme for West Dunbartonshire details the 'body corporate' arrangement by which the Health Board and the Council have agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire is known as the West Dunbartonshire Health & Social Care Partnership Board (WD HSCP Board), which was established on 1st July 2015 (the integration start day on which the new arrangements officially commenced). The WD HSCP Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS Acute Services); and through the Chief Officer, who is responsible for the operational management of WD HSCP.

2.4 The WD HSCP Strategic Plan sets out the key actions that will be taken forward to deliver the National Health and Wellbeing Outcomes (for adults) prescribed by the Act. Given that children and families health and social care services and criminal justice social work services have also been delegated to the WD HSCP Board, the specific National Outcomes for Children and Criminal Justice are also addressed within the Strategic Plan. Across all of service areas, the WD HSCP's delivery model reflects a collective commitment to:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives

- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

2.5 Scottish Ministers have confirmed that Strategic Plans will take account of all resources available to the WD HSCP, including capital assets owned by the NHSGGC on behalf of Scottish Ministers; and that the responsibility for such capital assets and the associated running costs will continue to sit with NHSGGC.

2.6 WD HSCP Board and NHSGGC are key partners within Community Planning West Dunbartonshire. Its aim is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business there. Its 2014-17 Single Outcome Agreement (SOA) for West Dunbartonshire focuses on the following interconnected priorities:

- Employability and Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

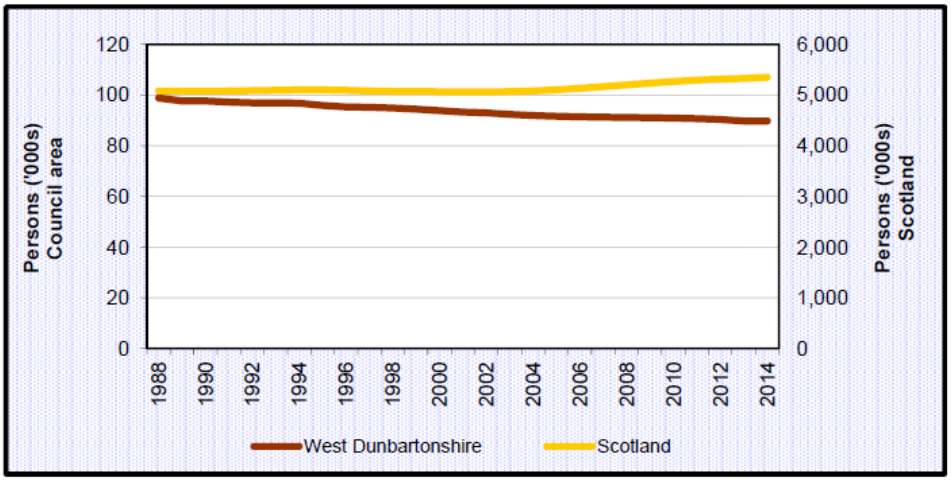
2.7 Community health services in Clydebank serve 50,000 people and currently operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic. All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which they operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

2.8 The current arrangements do not support the transformations in services that our local population requires. The option that best supports the strategic direction of the Health Board, the WD HSCP Board and the local Community Planning Partnership is to bring all of those existing services – as well as "new" (including shared care) provision that has traditionally been provided within NHS Acute Hospitals outwith the locality – into a single and modern facility.

<u>Economic Case</u>

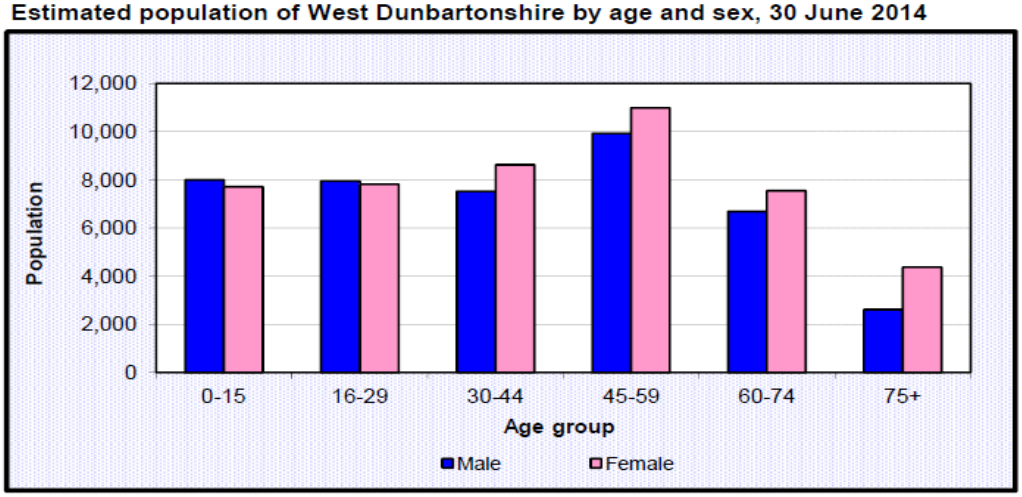
2.9 According to the National Records for Scotland, in 2014 population for West Dunbartonshire was 89,730 - a decrease of 0.1 per cent from 89,810 in 2013. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland. The graph overleaf shows that the local population has been declining in numbers whilst the overall Scottish population has been increasing.

Estimated population of West Dunbartonshire and Scotland, 1988-2014



2.10 In West Dunbartonshire, 17.6 per cent of the population are aged 16 to 29 years. This is smaller than Scotland where 18.3 per cent are aged 16 to 29 years. Persons aged 60 and over make up 23.6 per cent of West Dunbartonshire. This is smaller than Scotland where 24.0 per cent are aged 60 and over. The graph below shows that West Dunbartonshire's population overall is skewed more towards older age groups This means a potentially smaller proportion of working aged people against a higher proportion of older people who are likely to have greater health and social care needs – unless action is taken to successfully attract working age families into the area.

Estimated population of West Dunbartonshire by age and sex, 30 June 2014



2.11 West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Over the next ten years the health and social care landscape will change significantly. The changing demographics, an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

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

- Improve local access to a greater range of modernised services.
- Increase integration of multi-disciplinary teams and services.
- Improve safety and quality of facilities in which services delivered and based.
- Increase capacity and adaptability of facilities in which services delivered and based.
- Contribute to economic regeneration of Clydebank as a whole.

2.13 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the "Do Nothing" option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is "money hungry" - backlog maintenance is costed at £557,090. The asbestos that is integral to the building's structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million.

Commercial, Financial and Management Cases

2.14 As confirmed through discussions with the Scottish Government and Scottish Futures Trust this Project will be developed based on the hub revenue financed model. A high level time line has been produced as follows:

Submission of Initial Agreement	January 2016
Site Options Appraisal	September 2015
Submit Outline Business Case	August 2016
Submit Full Business Case	July 2017
Financial Close	October 2017
Construction	January 2018

2.15 The Governance and Project Management arrangements are based on previous Hub approved schemes; and local experience from recent health and care centre developments in Eastwood and Maryhill will help us improve these areas. As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been further informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as recommended in the latter project's OGC Gateway Review.

Summary of Objectives

2.16 In delivering the national, health board and local priorities above, a new Clydebank Health and Care Centre – built to the right specification and in the right location - will:

- Improve (one stop) local access to a greater range of modernised services – including additional acute outreach services.
- Increase integration of multi-disciplinary teams and health and social care services.
- Improve safety and quality of facilities in which services delivered and staff are based.
- Increase capacity and adaptability of facilities in which services delivered and based, including for community groups, third sector partners and carer's organisations involved in the co-production of supported self care.
- Contribute to economic regeneration – and revitalisation - of Clydebank as a whole.

3. Strategic Background

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

We are confident that the anticipated benefits described above and throughout the Initial Agreement will be realised, and that this will deliver genuinely improved outcomes for the people of Clydebank.

3.2 Who is Affected?

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Organisation	NHSGGC and the WD HSCP Boards are fully supportive of this proposal, with Keith Redpath (HSCP Chief Officer) taking the lead role in its development as Senior Responsible Officer and chair of the Project Board. NHSGGC Board members approved this proposal at the Quality & Performance Committee meeting on 20th January 2015. WD HSCP Board member's endorsed this proposal within their approved Strategic Plan that was approved at their meeting of 1st July 2015. This proposal is also incorporated into the NHSGGC Property Asset Management Plan.	This Initial Agreement has been approved by the Project Board in November 2015, and submitted to the following for approval: Hub Steering Group (November 2015); NHSGGC Capital Planning Group (December 2015); and NHSGGC (December 2015).
Service or Department	The project is jointly co-ordinated within WD HSCP by Chris McNeill (Head of Community Health & Care) and Soumen Sengupta (Head of Strategy, Planning & Health Improvement). Their shared responsibilities include: • Overall direction and guidance for the project to ensure it continues to meet the stated business requirements. • Oversee the development of the Initial Agreement and Business Cases. • Chair monthly Design and Delivery Group meetings. • Liaise with corporate support/technical specialists, both internal and external.	This Initial Agreement was approved by the Project Board in November 2015.

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	• Supervise identified project managers to ensure that the project produces the required products within the specified time, cost, quality, scope risk and benefits. • Ensure the preparation of highlight reports, and engaging with all services, stakeholders and external suppliers involved. • Advise the Project Board of any deviations from the project plan.	
Staff / Resources	Staff affected by this proposal include those working within the following areas of service: • Six general practices. • Allied Health Professional services. • Outreach clinics (e.g. Maternity Services and Acute Clinics). • Primary Care Mental Health. • District Nursing. • Older People's Mental Health. • Primary Care Mental Health. • Community Older People's Team. • Hospital Discharge Team. • Single Point of Access Receiving Team. Engagement is being undertaken across these areas to ensure that staff perspectives inform the design of the build; recommendations to the Project Board; and communication with the wider workforce and other stakeholders.	Staff representatives have participated in the Design and Delivery Group and Project Board meetings. Their feedback was incorporated into this proposal as it was developing. The most recent Design and Delivery Group dates were: • 11th September 2015 • 6th October 2015 • 20th October 2015 The most recent Project Board dates were: • 12th October 2015 • 30th November 2015
Patients / service users	Patients and service users representatives who this proposals affects and with whom engagement has been undertaken include: • The HSCP Locality Engagement Network for Clydebank • Community Planning Partners • West Dunbartonshire Carers Centre • West Dunbartonshire Councils for Voluntary Service • West Dunbartonshire Access Panel	Patient / service user and carers groups have participated meetings and workshops. Their feedback has been incorporated into this proposal as it was developing.

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	Their involvement in its development includes being part of Site Options Appraisal Workshops and the Design and Delivery Group, making recommendations to the Project Board and involved in the design statement planning stages. The Project Communication and Engagement Plan is based on the Plan devised with the community for the recently completed Vale Centre for Health and Care, the engagement process and outcomes from which were recognised as national best practice following its OCG Gateway Review.	
General public	We have begun this process by adopting a coproduction approach as reflected by our Delivery Group. Our stakeholders are required to feed back to their constituent parts and seek the opinions of their members and feed these into the Design and Delivery Group. In addition, we are committed to consulting the wider community at different stages of this proposal, through such groups as the local Access Panel and the Community Planning Partnership Community Alliance. We will use a range of methods to consult including: • WD HSCP website and other relevant websites. • Information screens in Health Centres and other public offices. • Through engagement with group meetings. • Use of local media to keep the wider community informed of its progress and invite further comments. Once the Outline Business Case has been agreed we will develop an Arts Strategy, which will provide the opportunity for further involvement of potential service users of and the general public to shape the design, layout and surrounding environment. *See Appendix G - Communication and Engagement Plan*	Outcomes from engagement with community groups and other stakeholders have influenced the proposal by shaping and ordering the strategic priorities. This has also been fed back to those involved via the Design and Delivery Group.

NHS Scotland's Strategic Priorities

3.3 The Scottish Government has set out its vision for the NHS in Scotland in the strategic narrative for 2020.

> **Our vision is that by 2020** everyone is able to live longer healthier lives at home, or in a homely setting.
> We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

3.4 Underpinning the narrative is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective. The quality outcomes and 2020 vision are the major national drivers of NHS targets and strategic direction for the period 2013-16 and beyond, including the HEAT targets for which the Health Board will be held to account each year. NHS Scotland's strategic investment priorities are aligned to the Quality Strategy as:

- Person centred.
- Safe.
- Effective quality of care.
- Health of population.
- Value and sustainability.

3.5 We will deliver these priorities through our commitment to the NHSGGC Clinical Services Strategy; the West Dunbartonshire Community Planning Partnership Single Outcome Agreement; and the national outcomes reflected within the WD HSCP Strategic Plan, i.e.:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and Social Care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

3.6 To ensure that we are responding to the core strategic investment priorities, we will monitor the effectiveness of our new ways of working based on the following table.

NHS Scotland Strategic Investment Priority	How the proposal responds to this priority	As measured by
Person Centred	Enable speedy access to modernised and integrated Primary Care and Community Health and Social Care Services. Improve access to primary care services that are person centred, safe and clinically effective. Self-management of Long Term Conditions (LTCs) will increase the proportion of people with intensive needs being cared for at home.	Improved GP Access – 48 hour access / advance booking Reduced hospital bed days on key LTCs (COPD/Asthma/ Diabetes/CHD) Reduced hospital bed days lost to delayed discharges Levels of homecare provision
Safe	Multidisciplinary team working will support holistic care and anticipatory care plans (ACPs). Rationalisation of services into a single location will reduce lone working for staff, particularly out of hours. A new-build would be easier to clean, thus supporting the Patient Safety Programme.	Number of ACPs in place Reduced number of instances of staff lone working, particularly out of hours. Reduced Healthcare Acquired Infections
Effective Quality of Care	Co-locating multi- disciplinary services - including integrated health and social care teams - within a new facility will improve the care journey and experience for patients, carers and visitors, giving one stop access and improved accessibility to an increased range and improved quality of services. This will include the delivery of pre and post acute services; and allow for expansion in post discharge rehabilitation and reablement.	Fewer delayed discharges (including Adults With Incapacity - AWI) Fewer hospital bed days: COPD/Asthma/ Diabetes/CHD

NHS Scotland Strategic Investment Priority	How the proposal responds to this priority	As measured by
Health of Population	Service users will benefit from a single point of access to integrated community teams. This will improve service co-ordination and ensure that service users receive the best possible care from the professional with the skills best suited to their needs. Enable GP led multi-disciplinary teams to develop Anticipatory Care Planning and review for a range of conditions, particularly in Older Adult Mental Health, the frail elderly, those with long term conditions and maternity services. Delivering shared care services – this is particularly important in Clydebank following the closure of the Western Infirmary and the long distances to the nearest Ambulatory Care Hospital.	Number of ACPs in place Increased number of patients with supported self-management Inter-service referral rates increased. Reduced time lag for diagnostic results. Earlier diagnosis for key conditions
Value & Sustainability	Operating out of a reduced number of buildings will be more energy efficient which will reduce the carbon footprint and running costs. A new-build to modern standards will significantly reduce this further. Delivering a safe high quality physical environment for patients, clients and staff – visible investment in the health of Clydebank people sends a message that we value their health and that they should too. Staff working agile will be equipped with the latest technology allowing them access to the same information they would have in the office but now electronically from patient's home or whilst agile. Improved Information Governance through use of latest technology (which therefore reduces the likelihood of data breach).	Emissions data Running costs (taking account of previously used but now decommissioned buildings too) Proportion of staff working agile Number of data breaches.

Strategies to which the Proposal Responds

3.7 This proposal directly responds to the NHS Quality Strategy that care should be person centred, safe and effective. Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

3.8 NHSGGC's purpose as set out in the Health Board's Corporate Plan 2013-16 is to deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.

3.9 The proposal also supports the NHSGGC Clinical Services Strategy; the West Dunbartonshire Community Planning Partnership Single Outcome Agreement; and the national outcomes reflected within the WD HSCP Strategic Plan.

3.10 The development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC – as a pro-active member of the local Community Planning Partnership - could make to the wider regeneration plans of the Council for Clydebank.

External Factors

3.11 In considering the need to work differently we have re-assessed our ability to respond to a range of key national resources, including:

- Reshaping Care for Older People.
- Getting It Right for Every Child.
- The Delivery Framework for Adult Rehabilitation in Scotland.
- National Unscheduled Care Programme.
- Scottish Patient Safety Programme.
- Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities.
- Best Preventative Investments for Scotland – What the Evidence and Experts Say.
- Creating Places - Policy Statement on Architecture and Place.
- A Long-Term Vision for Active Travel in Scotland 2030.
- Achieving a Sustainable Future: Regeneration Strategy.

3.12 NHSGGC and the WD HSCP Board strongly recognise that the determinants of health and health inequalities go far beyond health and care services, and new ways of working needed to be developed. Our evidence-based approach has been to work collaboratively with a wide range of local Community Planning Partners, in addition to developing our own services – and that approach will be re-emphasised through the delivery of this project, not least in relation to its contribution to the regeneration of Clydebank.

3.13 The aim of the Community Planning West Dunbartonshire is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business here. Single Outcome Agreements are the means by which the Community Planning Partnership agrees its strategic priorities for the local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

3.14 The 2014-17 Single Outcome Agreement for West Dunbartonshire focuses on the following interconnected priorities:

- Employability and Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

3.15 As a key partner within Community Planning West Dunbartonshire, we are committed to:

- Ensuring that community planning takes a streamlined approach to delivering outcomes.
- Demonstrating an appreciation that our priorities and outcomes are inter-connected.
- An emphasis on early intervention and prevention across all of our priorities.
- Pro-active and rigorous self-evaluation and scrutiny of activities across community planning partners as a driver for continuous improvement.

3.16 With changing demographics and increasing levels of need, over the next ten years the health and social care landscape will change significantly. The changing demographics, including an ageing population, an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we will have to work in different ways to maximise the assets that are inherent in our communities. This will include patients themselves and the scope for appropriate and supported self-management; carers as equal partners in care; third sector organisations and services, and the full range of Community Planning partners who have a stake in improving health and reducing inequalities.

3.17 By working in more integrated ways, we envisage taking advantage of new technologies that will:

- Support a single patient/client record that allows practitioners to see the person in entirety rather than as a presenting illness or an episode of care.
- Streamline pathways through community health and social work and hospital based services.
- Improve communication across multi-disciplinary teams, or across the supports needed for patients with multi-morbidities.
- Streamline appointment booking.
- Use text messaging for appointment reminders as a matter of course, to reduce Did Not Attends (DNAs).
- Transfer diagnostics and other test results quickly and securely, thus improving accuracy and timeliness of diagnosis.
- Improve opportunities for agile working, thereby freeing up space for clinical or therapeutic uses rather than administrative functions.
- Promote new forms of collaboration that reduce the need for physical meetings and travel.
- Support culture change to enable greater organisational agility.

3.18 There is also potential for a new-build health and care centre to become a community hub, thereby further contributing to social regeneration in Clydebank.

3.19 Clearly the health issues and inequalities evident in Clydebank remain a significant challenge and focus. Overleaf is a summary of key statistics taken from the Scottish Public Health Observatory (ScotPHO) Health and Well-Being Profiles 2014, which illustrates some of the challenges faced in improving health and wellbeing in West Dunbartonshire.

ScotPHO
Period: 2013

Health & Wellbeing Profiles (West Dunbartonshire)

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Domain		Indicator	Period	Number	Measure	Type	National Average	'Worst' Scotland Comparator 'Best'
Life Expectancy & Mortality	1	Male life expectancy [18]	2011	n/a	74.1	yrs	76.6	
	2	Female life expectancy [18]	2011	n/a	78.7	yrs	80.8	
	3	Deaths all ages [12]	2012	1,060	1,387.4	sr4	1,187.5	
	4	All-cause mortality among the 15-44 year olds. [12]	2012	45	141.0	sr4	105.3	
	5	Early deaths from CHD (<75) [12]	2012	62	81.9	sr4	60.7	
	6	Early deaths from cancer (<75) [12]	2012	162	212.7	sr4	173.4	
Behaviours	7	Estimated smoking attributable deaths [3,13,16]	2012	184	413.2	sr4	325.9	
	8	Smoking prevalence (adults 16+) [3,14]	2013	142	27.0	%	23.0	
	9	Alcohol-related hospital stays [15]	2013	832	975.9	sr4	704.8	
	10	Deaths from alcohol conditions [17]	2011	29	32.8	sr4	23.8	
	11	Drug-related hospital stays [12,15]	2012	99	113.9	sr4	116.6	
	12	Active travel to work [3,14]	2013	23	11.0	%	16.0	
Ill Health & Injury	13	Patients registered with cancer [12]	2012	575	714.7	sr4	634.1	
	14	Patients hospitalised with chronic obstructive pulmonary disease (COPD) [12,15]	2012	572	705.8	sr4	659.9	
	15	Patients hospitalised with coronary heart disease [12]	2012	445	553.8	sr4	440.3	
	16	Patients hospitalised with asthma [12]	2012	108	116.8	sr4	91.2	
	17	Patients with emergency hospitalisations [12]	2012	7,438	8,653.4	sr4	7,500.2	
	18	Patients (65+) with multiple emergency hospitalisations [12]	2012	904	6,142.6	sr4	5,159.5	
	19	Road traffic accident casualties [12]	2012	47	53.3	sr4	63.2	
Mental Health	20	Population prescribed drugs for anxiety/depression/psychosis [3]	2013	17,783	19.8	%	17.0	
	21	Patients with a psychiatric hospitalisation [12]	2012	278	322.0	sr4	291.6	
	22	Deaths from suicide [17]	2011	15	16.4	sr4	14.5	
Social Care & Housing	23	Adults claiming incapacity benefit/severe disability allowance/ employment and support allowance	2013	6,085	6.8	%	5.1	
	24	People aged 65 and over with high levels of care needs who are cared for at home [3]	2013	399	40.7	%	34.7	
	25	Children looked after by local authority [3]	2013	347	18.3	cr2	14.4	
	26	Single adult dwellings	2013	17,439	38.9	%	37.7	
Education	27	Average tariff score of all pupils on the S4 roll [13]	2012	n/a	182.0	mean	193.0	
	28	Primary school attendance	2010	6,227	94.4	%	94.8	
	29	Secondary school attendance	2010	5,075	90.1	%	91.1	
	30	Working age adults with low or no educational qualifications [3]	2013	10,500	18.6	%	12.6	△
Economy	31	Population income deprived	2013	17,310	19.3	%	13.2	
	32	Working age population employment deprived	2013	10,165	17.4	%	12.2	
	33	Working age population claiming Out of Work benefits	2013	10,985	18.8	%	13.0	
	34	Young people not in employment, education or training (NEET). [3]	2013	460	10.6	%	7.8	
	35	Children Living in Poverty	2012	4,645	22.8	%	15.3	
	36	People claiming pension credits (aged 60+)	2013	2,490	11.9	%	7.7	
Crime	37	Crime rate	2013	5,208	58.0	cr2	40.5	
	38	Prisoner population [3,13]	2012	199	273.5	sr4	171.2	
	39	Referrals to Children's Reporter for violence-related offences [3]	2013	16	2.1	cr2	2.1	
	40	Domestic Abuse [3]	2012	1,518	168.0	cr9	113.1	
	41	Violent crimes recorded [3]	2013	139	15.5	cr9	12.7	
	42	Drug crimes recorded [3]	2013	1,090	121.4	cr9	66.9	
Environment	43	Population within 500 metres of a derelict site	2013	54,800	60.7	%	29.7	
	44	People living in 15% most 'access deprived' areas	2013	5,034	5.6	%	15.0	
	45	Adults rating neighbourhood as 'a very good place to live' [3,14]	2013	n/a	45.0	%	55.0	
Women's & Children's Health	46	Teenage pregnancies [12]	2011	136	49.2	cr2	44.6	
	47	Mothers smoking during pregnancy [12]	2012	244	24.9	%	20.0	
	48	Low birth weight [12]	2012	19	2.0	%	2.0	
	49	Babies exclusively breastfed at 6-8 weeks [12]	2012	144	15.0	%	26.5	
	50	Child dental health in primary 1	2013	597	61.1	%	66.7	
	51	Child dental health in primary 7	2013	269	32.9	%	47.7	
	52	Child obesity in primary 1	2013	108	11.3	%	10.1	
Immunisations and Screening	53	Breast screening uptake [12]	2011	2,799	69.3	%	72.5	
	54	Bowel screening uptake [12]	2011	7,543	51.8	%	55.1	
	55	Immunisation uptake at 24 months - 5 in 1 [12]	2013	1,030	97.9	%	98.2	
	56	Immunisation uptake at 24 months - MMR [12]	2013	995	94.6	%	95.3	

Notes:

3. Data available down to council (local authority) area only.
12. Three-year average number, and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis; please see the technical report for more information.
16. Two-year average number, and 2-year average annual measure
17. Five-year average number, and 5-year average annual measure
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies

Spine Chart Key:

% =percent
cr2 =crude rate per 1,000 population
cr9 =crude rate per 10,000 population
mean=average
sr4 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.
yrs =years

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- △ No significance can be calculated

3.20 West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Overall, West Dunbartonshire has a worse general level of health than the Scottish average – this is also the picture within Clydebank. The indicator that shows this most explicitly is average life expectancy which is 3 years below the national average for men and 1.8 years below the national average for women. Much of this is due to the significantly higher levels of death from Cancer, Coronary Heart Disease (CHD) and Cerebrovascular Disease (CVD). There are statistically significant higher level of deaths attributable to smoking and alcohol and a greater prevalence of smoking and women smoking while pregnant. Clydebank has high levels of poverty and an increasing elderly population high numbers with long term conditions. This results in a growing demand for health and social care services alongside an increasing imperative to co-locate teams, integrate services and deliver seamless care.

3.21 The development of the West Dunbartonshire Integration Scheme, which forms the governance basis of the WD HSCP Board, afforded an opportunity for us to consider how we work with communities. We are committed through that Scheme to work with two localities within West Dunbartonshire: Clydebank; and Alexandria & Dumbarton. Our new ways of working will apply across the whole of West Dunbartonshire, with staff and services within each locality learning from the other.

3.22 A new-build facility would fit well with the locality model that has been put in place, and would contribute significantly to partnership working to grow and diversify the local economy; and attract and stabilise the population through continuous improvements to:

- The quality of design in the built environment.
- Better quality housing.
- Vibrant town centres.
- More and better jobs.

3.23 As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OGC Gateway Review:

"*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of (West Dunbartonshire) CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care*".

In praising the above, the Gateway Review highlighted that this learning should be used on other similar projects and with other project teams.

4. Why is this Proposal a Good Thing?

4.1 There are many reasons why we need to do things differently:

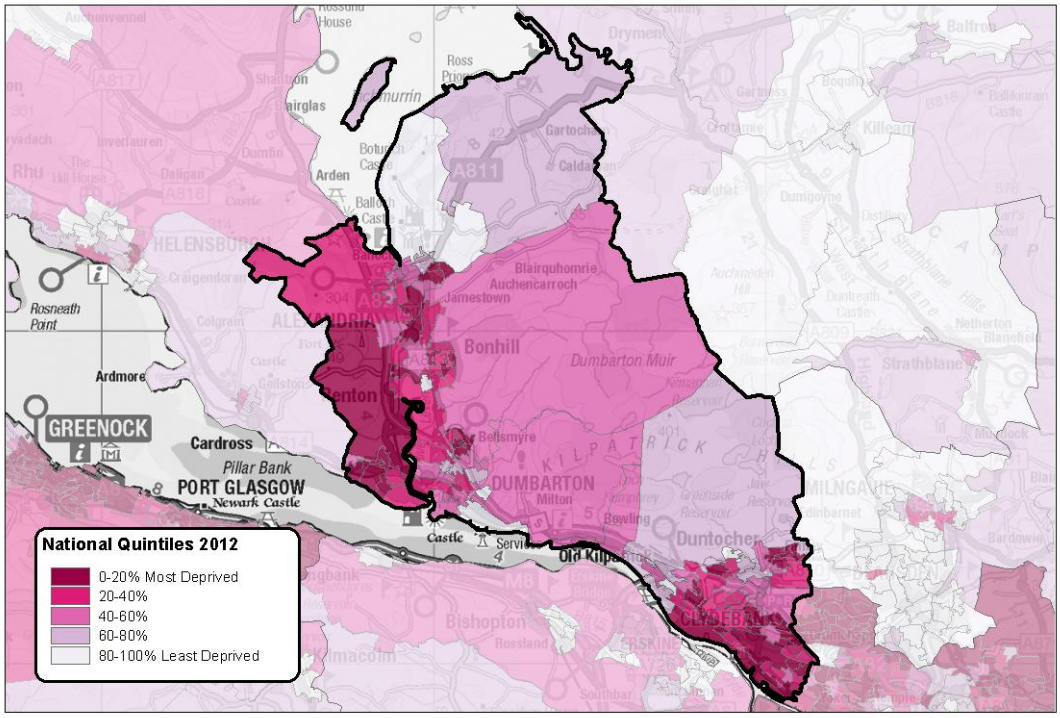
- To support effective and high-quality care, promoting patient centred services delivered within a "one stop shop".
- To help ensure that professional relationships are forged and sustained to robustly tackle inequalities and challenge any associated stigmas.
- To promote inter-disciplinary learning and continuous improvement.
- To provide a facility that is easier to clean, making healthcare acquired infections much less likely, and therefore making care and treatment safer.
- To support integrated working across partners within our local Community Planning Partnership.
- To provide a platform for sustaining and expanding clinical services, in line with the future model of primary care and the NHSGGC Clinical Services Strategy.
- To enable shifting the location of services out of hospitals and into communities, helping to make sure that people receive the right care at the right time, in the right place and delivered by the right person. Such an approach represents better use of our resources (supporting value and sustainability) and the aspirations of the WD HSCP Strategic Plan.

<u>What are the Current Arrangements?</u>

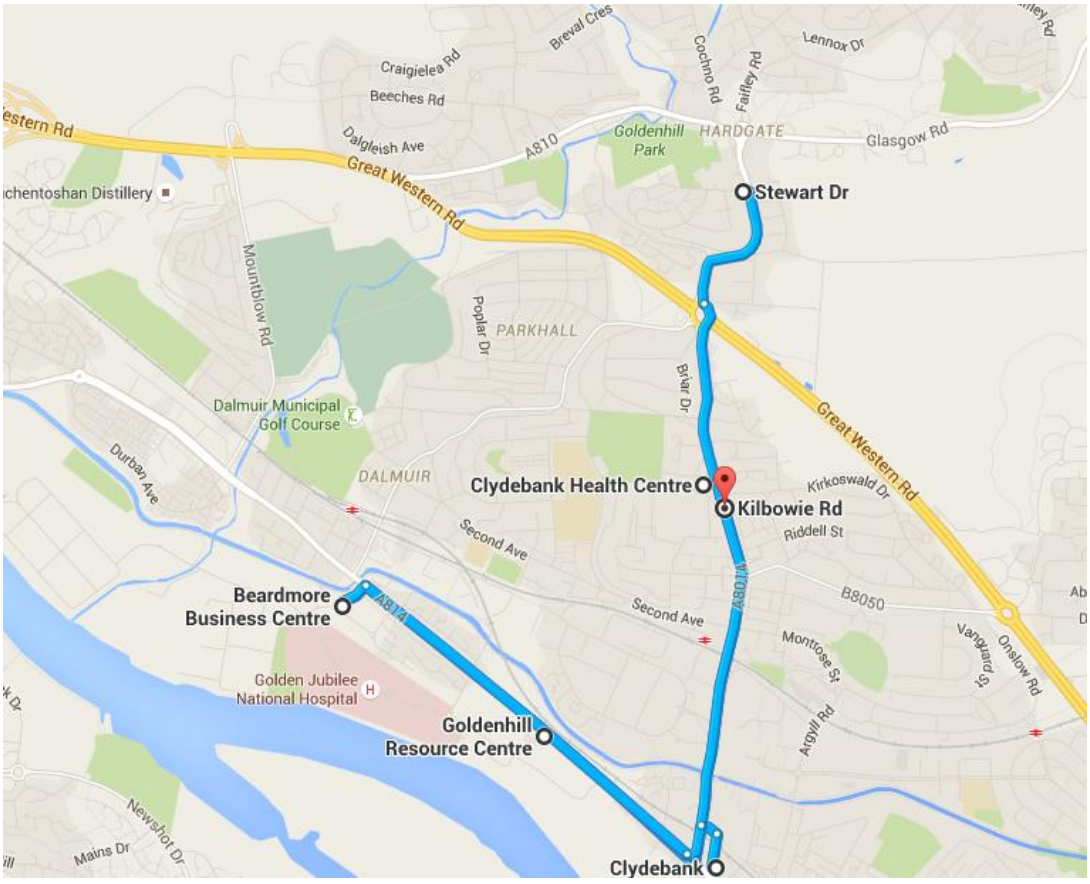
4.2 Community health services in Clydebank serve 50,000 people and operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic.

Clydebank Health Centre – 3808m^2	238 staff 6 GP practices – total registered list size of 41,585. Allied Health Professional (AHP) Services Outreach clinics (e.g. Maternity Services; Acute Clinics) Primary Care Mental Health District Nursing Older People's Mental Health Services Primary Care Mental Health Team Community Dental Health
Hardgate Clinic – 560m^2	60 staff Community Older People's Team and Adult Services Older People's Mental Health Consultant Base
Kilbowie Road (WDC) – 100m^2	30 staff Range of integrated services, including Hospital Discharge Team and Single Point of Access Receiving Team
Beardmore Resource Centre – 360m^2	40 staff Learning Disability Services
Goldenhill Clinic – 360 m^2	30 staff Adult Mental Health Services

4.3 Most patients who use the present Clydebank Health Centre facility reside within the boundaries of the West Dunbartonshire local authority.



4.4 The five sites previously mentioned are located as follows.



4.5 All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

4.6 The main Clydebank Health Centre is in significantly poor repair (particularly the roof with frequent water ingress) despite considerable, costly and on-going repair work in previous years (backlog maintenance is costed at £557,090). The building allows no further expansion of GP and other services; and requests to host additional and much-needed outreach services have to be denied. The access to the centre is also increasingly problematic: it is located on a site that has restricted parking close to a school entrance; and is on a steep hill with difficult access for patients, staff and supplies. Most problematically, the significant asbestos contamination throughout the structure and fabric of the building not only limits the scope for making any improvements to the building itself and is exponentially driving up costs of repair/refurbishment at a level that is unaffordable to sustain, but is also now viewed with concern by the Health & Safety Executive.

4.7 Upgrading the current Clydebank Health Centre has been considered but is not feasible, because of the size of the site; the limitations/constraints of the building design/layout; and critically, the aforementioned significant asbestos contamination throughout the structure and fabric of the building. Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national Quality Strategy; or of a standard acceptable to either NHSGGC or the WD HSCP Board.

4.8 Through the Property Asset Management System we were involved in a feasibility study from late 2013 to early 2014. That process identified Clydebank as being in need of a replacement health centre. The accommodation has no room to expand due to the footprint and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern community and primary care provision. This has in turn limited the ability of GP practices to provide a full range of services. In addition there is no flexibility to extend the range of wider community services provided from the site. More than a year has passed since that process was concluded, so it was timely to revisit our options through the SCIM process. As part of that SCIM process, we carried out an Achieving Excellence Design Evaluation Toolkit (AEDET) workshop in September 2015 (the outputs detailed in Appendix A).

4.9 New ways of working, supported by a new-build health and care facility, will improve the patient care pathway through the provision of integrated services which will provide seamless care supported by a range of agencies working in partnership for people with complex health and social problems. This will also apply to the improvement of services for people with a range of diseases which cause premature death or reduce people's functioning or quality of life (e.g. CHD, cancer and diabetes); support the drive to address health issues at the earliest time possible; and also reduce attendances at Accident & Emergency Services.

4.10 Early intervention and prevention are priorities for NHSGGC and the WD HSCP Board as we focus on chronic disease management in and supporting greater self-management through community care and primary care.

4.11 The high rates of mental illness in West Dunbartonshire have been recognised for a number of years, with integrated mental health services established even before our CHCP arrangements were put in place. Our mental health services work well but the indicators in the table below show that we are still above the national average for mental illness in the community as well as psychiatric hospitalisations.

4.12 Our new models of working will maximise the opportunities for patients to access Tier Zero services provided by local Third Sector organisations, thereby supporting early intervention and patient empowerment. We believe that this will represent significant progress in generating the culture change needed for truly person-centred care. .

4.13 The term *shifting the balance of care* has traditionally been used to describe structured programmes to reduce the number of hospital beds in favour of less expensive care home beds. However, the use of this term now more frequently also encompasses supporting people to remain in their own homes, moving other services out of hospital if they don't need to be there; and into communities where they can be less intimidating and easier to access.

4.14 By putting services in logical locations based on the patient's perspective, we will promote better engagement – particularly of the most vulnerable – and bring about better outcomes. We believe that if we work differently, our services will help reduce inequalities, promote independence and will be quicker, more personal and closer to home. The shift needs to ensure that fewer people are cared for in settings which are inappropriate for their needs, and that staff as well as patients understand the patient pathways across all services, and can navigate them easily. More carers will be supported to continue in their caring role and more people will be able to die at home or in their preferred place of care.

4.15 Clearly as people grow older the likelihood of them needing some additional support can increase. In West Dunbartonshire, the data show relatively poor healthy life expectancy, linked inextricably to inequalities. Wider social changes have an impact on our demographic profile too, including the growth in single person households (impacting on the need for and availability of familial or unpaid carers), and the growth in numbers of people with dementia.

4.16 Our proposed new ways of working will aim to deliver better quality, appreciating of the assets that are inherent in our older people themselves (in terms of their abilities to engage in supported self-management of LTCs); communities (such as the caring potential of neighbours, or the social networking opportunities that can often be developed with a little support from statutory or voluntary sector partners); and family members who often want to be equal partners in care, but might require some additional input to make this possible. Co-location of teams (e.g. district nursing and homecare) will enhance team working ensuring effective communication and timely discharge from hospital. This will also allow patients to be seen by the right practitioner at the right time and in an accessible local environment.

4.17 It should be noted that hospital admissions are above the national average for COPD and for emergency admissions. Our proposed new way of working will aim to reduce this by providing more comprehensive patient pathways that access the full menu of supports that will be appropriate for each individual patient.

4.18 Having a comprehensive range number of services under one roof will reduce travel and improve access for service users and staff (noting that many staff are local residents). We see high staff sickness absence rates within key staff groupings within the WD HSCP, and if our staff can themselves access support more easily, attendance rates should improve - meaning full capacity to support the wider community as well.

4.19 Good practice requires us to measure our performance over time, to ascertain if what we do and how we do it is making a difference (either positively or negatively). In developing our future delivery model we have identified a suite of key performance measures to gauge our impact. The following tables provide a selection of high level indicators for the previous CHCP to provide an overview of demand and performance.

Indicator	2013/14	2014/15	
	Value	Value	Target
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review	76.1%	76.1%	75%
Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	92.6%	92.2%	90%
Primary Care Mental Health Team average waiting times from referral to first assessment appointment (Days)	28	16	14
Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013	2	0	0
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	5	1	0
Average waiting times in weeks for musculoskeletal physiotherapy services	9	16	9
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95%	95%	91.5%
Number of patients in anticipatory care programmes	1,024	1,645	1,200
Percentage of identified patients dying in hospital for cancer deaths	27%	29%	35%
Percentage of identified patients dying in hospital for non-cancer deaths	49.6%	38%	40%
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	41%	39.2%	40%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%	100%	100%
Crude rate of people aged 75+ in receipt of Telecare per 100,000	22,666	23,994	22,410
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	51%	55%	55%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98.2%	98%	96%
Number of patients on dementia register	613	638	672

Indicator	2013/14	2014/15	
	Value	Value	Target
Total number of homecare hours provided as a rate per 1,000 aged 65+	642.3	590.5	695
Percentage of homecare clients aged 65+ receiving personal care	82.7%	93%	82%
Percentage of people aged 65 and over who receive 20 or more interventions per week	51.3%	31%	45%
Percentage of people aged 65 or over with intensive needs receiving care at home	40.71%	40.2%	51%
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	87%	86%
Number of carers of people aged 65+ known to CHCP	1,348	1,446	1,680

4.20 The following tables show at a high level, a comparative snapshot of the different (former) CH(C)P areas demand for and impact on NHS Acute Services, in particular delayed discharges, emergency attendances and admissions (noting that the time periods are different than for the previous table).

Crude rate of new A&E attendances per 100,000 against the agreed local targets

	Apr 14 - Mar 15	2014-15 Target	Variance %
East Dunbartonshire CHP	1589	2888	-45.0%
East Renfrewshire CHCP	1896	2888	-34.3%
Glasgow City CHP	2784	2888	-3.6%
Inverclyde CHCP	3066	2888	+6.2%
Renfrewshire CHP	2787	2888	-3.5%
West Dunbartonshire CHCP	1815	2908	-37.6%

Relative number of Emergency Admissions aged 65+ per 1,000 (Apr 14 - Mar 15)

	Rate of unplanned admissions per 1,000
East Dunbartonshire CHP	248
East Renfrewshire CHCP	225
Glasgow City CHP	315
Inverclyde CHCP	313
Renfrewshire CHP	305
West Dunbartonshire CHCP	282

Relative percentage of GP referrals to A&E

	Apr 14 – Mar 15
East Dunbartonshire CHP	10.0%
East Renfrewshire CHCP	13.8%
Glasgow City CHP	10.0%
Inverclyde CHCP	6.8%
Renfrewshire CHP	6.8%
West Dunbartonshire CHCP	9.7%

4.21 Improving quality, efficiency and effectiveness is a major strategic priority for the HSCP in line with the national Clinical and Care Governance Framework; and overseen by our Clinical and Care Governance Group, which is chaired by our Chief Officer and co-vice chaired by the HSCP Clinical Director and the Council Chief Social Work Officer. Our focus will continue to be on ensuring that care is person-centred, safe, and clinically and cost effective. A key part of this is ensuring all service users, carers and staff have the opportunity and confidence to share their experience and that we listen, learn and report back the changes implemented as a result. We need to continue our shift towards defining clearer quality outcomes; and embedding this in our performance management systems, focusing on experience of care as well as treatment.

What is the Need for Change?

4.22 The proposal is to develop new ways of working that maximise the connections between a wide range of professionals, providers and other supports. The best way to do this, is through a modern purpose built facility designed to deliver the investment objectives (4.23).

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
Future service demand	Existing capacity is unable to cope with current or future projections of demand. There is no natural flow between clinical areas to maximise a multidisciplinary approach.	Multidisciplinary working is has been impeded by the constraints of the layout. Patient demand cannot be met due to constraints of accommodation.
Dispersed service locations	Existing service arrangements affect service access and travel arrangements. Currently managing the upkeep and backlog maintenance of old buildings, most of which are no longer fit for purpose.	Service access is currently fragmented for this locality when compared with other catchment areas.
Ineffective service arrangements	The current Health Centre was built at a time when the NHS was more focused on less complex episodes of illness and treatment; and less recognition of the need for privacy, respect and dignity as integral to the delivery of health services. It is no longer acceptable to have key services on upper floors if the lifts are unreliable, for example and while we have this situation, some sections of our communities have poorer access to services.	More integrated approaches are not supported by dispersed teams, particularly when the patient has to navigate across a number of sites and locations to access the range of supports needed.
Service arrangements not person centred	The existing Health Centre facility does not have interior flexibility to re-shape clinical areas and accommodate related teams or services. This means that patients need to navigate an often complex array of locations to receive multi-disciplinary support. As more and more people are living with multiple LTCs and wishing to be more active	People will be discouraged from engaging with our services as it can be complicated and expensive. This increases the risks of individuals coming to services late in their disease progression; treatment options being more limited, and outcomes being less good than they could have been.

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
	in the management of their own health, our existing service arrangements present more barriers than solutions.	
Accommodation with high levels of backlog maintenance and poor functionality	Increased safety risk from outstanding maintenance. Clydebank Health Centre is now nearing the end of its useful life in terms of suitability for service provision. There has been a programme of works to address the need to remove asbestos, and therefore more routine works have had to be de-prioritised, further adding to the backlog (backlog maintenance is currently costed at £557,090).	There is currently no room to expand the facility due to footprint of the building and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern primary care health provision.

What Do We Want to Achieve?

4.21 Our refreshed HSCP arrangements in West Dunbartonshire benefit from the successful joint working and service delivery developed through the previous CHCP arrangements. We believe that there is much more to achieve in Clydebank through working differently, with a wide range of partners and with the people of Clydebank themselves. However our current accommodation in Clydebank does not support the levels of integrated working that we want to achieve; and we believe that a new development will provide the right environment for transformation in the medium and flexibility for the future.

4.22 As well as complying with the requirements of the Scottish Capital Investment Manual (SCIM), the local approach to addressing the above has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OCG Gateway Review.

4.23 The investment objectives for the project are as follows:

Effect of that cause on the organisation	What needs to be achieved to overcome this need? (Investment Objectives)
Stifling effect of inequalities on population of Clydebank	The primary determinants of health are well recognised as being economic, social and environmental. Within West Dunbartonshire we are formally committed to a determinants-based approach to health inequalities, with our local-term goal being to have tackled population-level health inequalities as a result of our having collectively addressed its root causes through the local Community Planning Partnership – by stimulating sustainable economic growth and employment; promoting educational attainment and aspiration; and supporting community cohesion and self-confidence. *INVESTMENT OBJECTIVE 1:* *Contribute to economic regeneration of Clydebank as a whole.*

Effect of that cause on the organisation	What needs to be achieved to overcome this need? (Investment Objectives)
Existing service arrangements affect service access and travel arrangements	Our current arrangements have developed based on the location of buildings rather than the natural flow of services and how they should be used. Patients frequently have to travel between locations to access the full range of support they need, and staff use up valuable clinical time travelling between these locations too. The location of the current health centre means that travelling by car is the most convenient mode for most, and for those without access to a car, the alternatives are costly and inconvenient - and this disproportionately affect those most vulnerable to poor health outcomes. To overcome this, we require improved access to primary care and associated services that are patient centred, safe and clinically effective. *INVESTMENT OBJECTIVE 2:* *Improve local access to a greater range of modernised services.*
Inefficient service performance	Since our CHCP arrangements were put in place in 2010 there has been a much greater emphasis on joint working. This has not just been with the Council, but also the wider community planning partnership and local voluntary sector organisations. To help us build on this approach, key services (including but not restricted to health services) need to be located together, and their relationships with good overall health and wellbeing made explicit. *INVESTMENT OBJECTIVE 3:* *Increase integration of multi-disciplinary teams and services.*
Service is not meeting current or future user requirements	Current arrangements dispersed over a number of locations do not meet modern requirements or expectations for good, supportive care that promotes independent living. To meet user requirements for equitable and clear service pathways and connections, we need facilities that can provide a natural flow of services, and reinforce the services' relationships with each other. To achieve this, we need a modern fit for purpose accessible facility that will facilitate and promote interagency and interdisciplinary working, and address health inequalities by having better integrated teams. Community and primary care staff – including those working within general practice - need access to professional development and training, and facilities to support this would be built into new arrangements. *INVESTMENT OBJECTIVE 4:* *Increase capacity and adaptability of facilities in which services delivered and based.*
Increased safety risk from outstanding maintenance and inefficient service performance	Improve safety and effectiveness of accommodation by providing accommodation that will deliver improved energy efficiency, reducing CO2 emissions in line with the Government's 2020 target and contributing to a reduction in whole life costs. Meet statutory requirements and obligations for public buildings. The current backlog maintenance is compounded due to the asbestos in the current building, making repairs so costly that there is insufficient capital funding to undertake most repairs. The roof leaks in many places and parts of the interior drop off from time to time, occasionally causing injury to patients or staff. *INVESTMENT OBJECTIVE 5:* *Improve safety and quality of facilities in which services delivered and based.*

Measureable Benefits

4.25 By addressing these needs:

- We will local access to a greater range of modernised services. We will reduce travel costs for patients; and travel costs to the organisation through removing the need for staff to be moving between premises as part of their work. Staff time spent travelling will also be reassigned to clinical or client work, thereby increasing patient/client-facing capacity.
- We will increase integration of multi-disciplinary teams and services. Patients will be more likely to access all components of their care plan if this can be done under one roof - so quality of care will improve, DNAs will reduce and outcomes will be maximised.
- We will increase capacity and adaptability of facilities in which services delivered and based. Pressure on hospital services will be reduced as the new model will provide access to shared care and acute outreach clinics within the new Centre.
- We will improve safety and quality of facilities in which services delivered and based. We will be able to decommission a number of disparate buildings that currently deliver components of support but are no longer fit for purpose. This should reduce revenue costs and capital charges in the future, and remove running costs that are generally high due to the age and poor repair of many of these buildings.
- We will contribute to the economic regeneration of Clydebank as a whole, and thus the wellbeing of communities as a whole. The development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC – as a pro-active member of the local Community Planning Partnership - could make to the wider regeneration plans of the Council for Clydebank.

4.26 These benefits are important because they will help us to deliver our ambition of transforming care, and they are in line with NHS Scotland's 2020 Vision. In particular, by addressing these needs and delivering the investment objectives, we will create a mixed-economy campus environment that fosters a culture of putting the patient/client at the centre of every interaction. Services will find it easier to work across disciplines, and staff will gain a better understanding of what other supports need to be in place from a whole person perspective, and importantly, how to ensure that their patients can access everything they need to achieve the best possible outcomes.

4.27 This improved access will particularly focus on those most vulnerable to poor outcomes (SIMD1), and by achieving these improvements we will also improve the overall health of our population, given the large proportion that are from the most deprived quintiles.

4.28 These benefits directly support the aims of:

- The NHS Quality Strategy.
- The NHSGGC Corporate Plan and Clinical Services Strategy.
- The WD HSCP Strategic Plan.
- The West Dunbartonshire Community Planning Partnership Single Outcome Agreement.

4.29 Patients/service users and staff will experience the following:

- Improved access to and range of services.
- Improved patient, carer and visitor experience.
- Greater integration of service provision.
- Greater integrated team working.
- Improved quality of care, including meeting decontamination requirements.
- Better use of information and communication technology.
- Improved physical work environment for staff.

- High quality education and learning facilities for staff and students.
- Improved environmental management and sustainable development contribution.
- Modern parking and drop off facilities, plus enhanced access for pedestrians, cyclists and those using public transport.
- Improved space utilisation and enhance adaptability for future change.

Risks

4.30 The main project risks and mitigation factors are identified at a high level at the Initial Agreement stage. As the project develops through the Outline Business Case and Full Business Case stages a more detailed and quantified risk register will be prepared. The main risks at this stage, along with mitigating actions, are highlighted in Appendix D.

Constraints or Dependencies

4.31 The proposal to develop the new service model is planned to be delivered via funding from the Hub initiative. As such it must meet the criteria for award of funds from the Hub initiative, and meet the timescale set by the Hub West Steering Group.

4.32 A summary of the key constraints identified is noted as follows:

- *Financial*
  Improvements must be delivered within the finances available, and the Project Board need to be assured that capital and ongoing revenue funding is in place and is sufficient.

- *Quality*
  Compliance with all current health guidance must be delivered.

- *Sustainability*
  Achievement of BREEAM (Building Research Establishment Environmental Assessment Methodology) Health “Excellent” for new build.

- *Dependencies*
  This Initial Agreement focuses on the case for a new way of working that brings together a wide range of services related to health and care outcomes; and that reduces the number of disparate service delivery locations. Taking this option forward is dependent upon the transfer and rationalisation of those services onto a single site.

5. Preferred Solution

The Do Nothing Option

5.1 All of the services across the five sites identified earlier are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

5.2 The main Clydebank Health Centre is in significantly poor repair (particularly the roof with frequent water ingress) despite considerable, costly and on-going repair work in previous years. The building allows no further expansion of GP and other services; and requests to host additional and much-needed outreach services have to be denied. The access to the centre is also increasingly problematic: it is located on a site that has restricted parking close to a school entrance; and is on a steep hill with difficult access for patients, staff and supplies. Most problematically, the significant asbestos contamination throughout the structure and fabric of the building not only limits the scope for making any improvements to the building itself and is exponentially driving up costs of repair/refurbishment at a level that is unaffordable to sustain, but is also now viewed with concern by the Health & Safety Executive.

5.3 Through the Property Asset Management System we were involved in a feasibility study from late 2013 to early 2014. That process identified Clydebank as being in need of a replacement health centre. The accommodation has no room to expand due to the footprint and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern primary care health provision. This has in turn limited the ability of GP practices to provide a full range of services. In addition there is no flexibility to extend the range of wider community services provided from the site.

Strategic Scope of Option	Do Nothing
Service provision	Do Nothing does not meet any of the investment objectives noted at 4.24. The existing centre is inadequate, of poor fabric with poor access and unfit for future service provision.
Service arrangements	The service arrangements envisaged for the new way of working cannot be accommodated in existing premises. The service arrangements we aspire to are designed to maximise the relationships between different services that impact on health outcomes, so are crucial to the investment objectives.
Service provider and workforce arrangements	To do nothing will prevent the new ways of working for the workforce i.e. agile working, new improved electronic systems and referral access to other services. Current arrangements will not deliver a reduction in referrals to hospital services.
Public and service user expectations	The public and service user expectations are very clear that there is a need for premises that will provide improved access to services and patient centre care. Service user expectations for supported self-management are difficult to realise when supports are located in a number of buildings that are not within easy reach of each other. A key investment objective is therefore to have services co-located, and the Do Nothing option cannot deliver this.

Service Change Proposals

5.4 Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national Quality Strategy; or of a standard acceptable to either NHSGGC or the WD HSCP Board. In order to deliver the intended benefits the proposals for a new Centre are being developed and designed to enable and support:

- Improved services meeting the local demographic needs.
- Service redesign, of which it is an integral part.
- Easy access, especially by public transport.
- Opportunities for greater collaboration with partners.
- Visibility of the importance of wellbeing.
- Leverage for wider area regeneration.

5.5 As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OGC Gateway Review: "*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of (West Dunbartonshire) CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care*". In praising the above, the Review highlighted that this learning should be used on other similar projects and with other project teams.

5.6 We have adopted a coproduction approach as reflected by our Design and Delivery Group. Our stakeholders are required to feed back to their constituent parts and seek the opinions of their members and feed these into the Design and Delivery Group. In addition, we are committed to consulting the wider community at different stages of this proposal, through such groups as the local Access Panel and the Community Planning Partnership Community Alliance. We will use a range of methods to consult including:

- WD HSCP website and other relevant websites.
- Our information screens in Health Centres and other public offices.
- Through engagement with group meetings.
- Use of local media to keep the wider community informed of its progress and invite further comments.

5.7 As part of the development of the Outline Business Case, we will begin to engage with stakeholders and contractors – most notably the architects – to develop key themes for an Arts Strategy, which will provide the opportunity for further involvement of staff, service users and the local community to contribute creative ideas for the design, layout and surrounding environment.

5.8 In terms of deliverability, we are confident that replacing the current estate with a rationalised and integrated health and care centre will result in sufficient revenue savings to cover future revenue costs of a new-build.

Developing a Shortlist

5.9 In considering how the new way of working can be achieved, it has already been identified that the current Clydebank Health Centre has limitations that will significantly compromise delivery. The specific limitations have been considered and detailed at the AEDET

workshops, and a range of solutions have since been discussed at the Project Board, based on the investment objectives and the parameters defined SCIM. It has been agreed that to do nothing is not a feasible option due to the poor repair of the existing building; its considerable and growing backlog maintenance; and the growing needs of the local population. The table highlights the main points from the Project Board deliberations.

Strategic Scope of Option	**Proposed Solution 1** Extend existing facilities within constraints of existing sites	**Proposed Solution 2** New Health Centre on existing site	**Proposed Solution 3** Develop new build integrated facility on new site
Service provision: *Changes to the functional size and layout would support activity that could provide different outcomes and benefits. (Investment Objectives 2, 3, 4 and 5)*	The existing footprint is too small to allow changes to the extent that would be needed.	The existing footprint is too small to allow changes to the extent that would be needed.	A new build would be on a site that is large enough to allow changes to the extent that would be needed.
Service arrangements: *Changes to service activity and demand to achieve the model could be undertaken to fit the proposed solution. (Investment Objectives 2, 3 and 4)*	Accommodation constraints would require a reduced version of the model, and alternative arrangements would have to be made for increasing demands for provision.	Accommodation constraints would require a reduced version of the model, and alternative arrangements would have to be made for increasing demands for provision	A new build would be designed to deliver the new model for the existing population, with potential population growth or growth in need factored in.
Service provider and workforce arrangements*: The new working model includes partnership with statutory and voluntary sector providers and a focus on agile working whenever possible. (Investment Objectives 3 and 4)*	There is insufficient space in the current building for partners. The current configuration is not supportive of agile working.	The current car park footprint would not support a building large enough to accommodate current services plus partners. A new health centre could be configured to support agile working.	A new build would be customised to support and accommodate these aspects of the model way of working.
Supporting assets: Improved outcomes can potentially be achieved through maximising the connections and relationships between the supporting assets and contributing to	The opportunities to maximise the impacts and synergies between supporting assets cannot be readily achieved in the constrained environment of the	The opportunities to maximise the impacts and synergies between supporting assets cannot be readily achieved in the constrained environment of the	A new build would be customised to support and accommodate these aspects of the model way of working; and built on a location with

Strategic Scope of Option	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
wider regeneration. (Investment Objectives 1, 2, 3, 4 and 5)	current health centre, which is isolated from other public sector developments.	current health centre land footprint, which is isolated from other public sector developments.	strong links to other regeneration developments.
Public & service user expectations: Requirement for public buildings are clean, safe, fit for purpose, support wellbeing and promote community confidence. (Investment Objectives 1, 2, 3, 4 and 5)	The current building has a significant maintenance backlog that will only grow in the future. Repairs are becoming more expensive due to asbestos issues.	The current site does not have sufficient footprint to allow a building that will meet all of these aspirations.	A new build would be designed and customised to support and accommodate these aspects of the model way of working.

Indicative Costs

5.10 While developing a short-list of proposed solutions, the Project Board has considered indicative costs. As part of this process the Do Nothing option was also costed (as this cannot be considered a cost-neutral option, not least as the backlog maintenance is currently costed at £557,090).

Costs in £millions	Do Nothing Carry on with existing arrangements	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
Capital cost (or equivalent value)	0	£9.6m	£19.3m	£19.0m - £20.1m
Whole of life capital costs	£16.4m	£47.6m	£66.6m	£65.6m
Whole of life operating costs	£6.6m	£8.2m	£9.9m	£9.9m
Estimated Net Present Value of Costs	£14.6m	£26.1m	£30.3m	£29.2m - £30.8m

5.11 The breakdown of the whole of life capital and operating have been, where relevant, been developed using similar cost categories used in the Generic Economic Model, and as described in the Option Appraisal Guide i.e.:

- Property and opportunity costs – included.
- Capital and lifecycle costs – included.

- Clinical services costs – current assumption is that there will not be any extra costs but any savings identified in the future will be included at Outline Business Case stage.
- Non-clinical operating costs - current assumption is that there will not be any extra costs but any savings identified in the future will be included at Outline Business Case stage.
- Building running costs – included.
- Net contribution / costs - GPs (subject to clarification / guidance).
- Transitional costs – there will be no decant or double running costs.
- Externalities – there are no externalities.

5.12 In line with the Generic Economic Model we have excluded VAT and inflation, and as per the Green Book, the level of appraisal is proportionate to the size and stage of the project.

5.13 The capital costs noted have been prepared based on high level costs using £/m^2 rates using historic information. Allowances have been made for demolition of the existing health centre in Proposed Solution 2 since this would be required to create a car park. Option 2 also makes allowance for additional preliminary costs to reflect prolongment of the contract period by 12 weeks to deliver the demolition and car park works.

Initial Assessment of Proposed Solutions

5.14 The table below sets out the key approaches considered to deliver the investment objectives.

Strategic Scope of Option	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
Advantages (Strengths & Opportunities)	Retains services on a site known to patient population.	Retains services on site known to patient population. Site owned by NHSGGC.	All investment objectives can be met. Facility can be purpose built without disruption to delivery of existing services. Ideally identify a site that is part of a broader public realm development and can be developed on a co-operative basis.
Disadvantages (Weaknesses & Threats)	Key investment objectives can only be met in a limited manner. Limited space around building. Any development would reduce parking further. Internal modification very difficult/expensive due to clasp construction and the need to manage asbestos. Very disruptive to achieve.	Key investment objectives can only be met in a limited manner. Limited space around building. Any new-build would need to occupy car park and would be constrained in its design. Site would not achieve increased parking numbers required. Costs would be high due to constrained working area and prolonged due to phased nature of contract.	Procurement of land may bring risks to costs / timescales unless can identify a site that is part of a broader public realm development and can be developed on a co-operative basis.

Does it meet the Investment Objectives (Fully, Partially, No, n/a)			
Investment Objectives	**Proposed Solution 1 Extend existing facilities within constraints of existing sites**	**Proposed Solution 2 New Health Centre on existing site**	**Proposed Solution 3 Develop new build integrated facility on new site**
Investment Objective 1: Contribute to economic regeneration of Clydebank as a whole.	No	No	Yes
Investment Objective 2: Improve local access to a greater range of modernised services.	No	No	Yes
Investment Objective 3: Increase integration of multi-disciplinary teams and services.	No	No	Yes
Investment Objective 4: Increase capacity and adaptability of facilities in which services delivered and based.	Partial	Partial	Yes
Investment Objective 5: Improve safety and quality of facilities in which services delivered and based.	No	Partial	Yes

Are the indicative costs likely to present value for money and be affordable? (Yes, maybe / unknown, no)			
	Proposed Solution 1 Extend existing facilities within constraints of existing sites	**Proposed Solution 2 New Health Centre on existing site**	**Proposed Solution 3 Develop new build integrated facility on new site**
Value for Money and Affordability	No - This option does not meet the investment objectives.	No - This option does not meet the investment objectives.	Yes - This option is capable of delivering all of the investment objectives. A review of potential sites has been undertaken by key stakeholders from NHSGGC Capital Planning, WD HSCP and leads from the Council's planning and technical team. Five potential sites were identified for rating against an agreed scoring matrix with Scottish Futures Trust (Appendix B).
Preferred / Possible / Rejected	**Rejected**	**Rejected**	**PREFERRED**

5.15 From the table above it is clear that Proposed Solutions 1 and 2 would not meet all of the investment objectives – and, at best, they would result in a compromised design solution due to the limitations of the land available to develop. The site is defined by existing roads, with no opportunity for expansion or for a parallel build whilst the current health centre continues to operate. On this basis these options were rejected.

5.16 Proposed Solution 3 has the ability to meet the investment objectives and is identified as the preferred option, since it is the only option that delivers all of the investment objectives and is able to do so in a manner that can provide an optimal design solution and be delivered in a manner that offers value for money.

Design Quality Objectives

5.17 In September 2015 an AEDET assessment of the existing Clydebank Health Centre building was carried, facilitated by Health Facilities Scotland. The workshop was attended by clinical and other staff, managers, and public (including carers) representatives. The outcome of this was documented in an AEDET Assessment which is included in Appendix A, with the summary provided overleaf.

5.18 The AEDET assessment highlighted the areas where the existing building worked well:

- Internal space has been well utilised.

5.19 The AEDET assessment also highlighted those areas where the existing building was seen as being inadequate, notably:

- Lack of space.
- Poor quality environment internally – staff and patients/service users.
- Poor layout internal.
- Poor access to the building.
- Sustainability

5.20 A follow-on workshop series was undertaken later in September 2015 to develop a Design Statement for any new facility. This was facilitated by Architecture & Design Scotland, and was attended by broadly the same group of stakeholders who undertook the AEDET Assessment. The Design Statement is included in Appendix E. The workshop highlighted the key aspects that any new design should deliver:

- To be clearly accessible for the communities that it is designed to serve.
- To be straightfoward to navigate for all, with clear wayfinding and lines of sight.
- To foster a safe and calming environment, including through good use of natural light and ventilation.
- To promote a sense of community amongst staff within and across disciplines/services, encouraging dialogue, collaborative working and joint learning.
- To convey a welcoming and considerate impression, internally and externally – to express a “civic feel”.

Category	Benchmark	Target
Use	1.2	4.5
Access	1.1	4.7
Space	1.7	4.8
Performance	1.0	4.6
Engineering	1.3	3.6
Construction	0.0	4.2
Character and Innovation	1.4	4.7
Form and Materials	1.4	4.9
Staff and Patient Environment	1.3	4.6
Urban and Social Integration	1.6	4.9

6. Readiness to Proceed

Commercial Case

6.1 The Commercial Case assesses the possible procurement routes which are available for a project. Normally these include Frameworks Scotland, Non Profit Distributing (NPD) and Hub revenue models. NHSGGC have consulted with Scottish Futures Trust and the advice is that the project should be developed based on the Hub revenue financed model. A summary of the key project dates is provided in the table below.

Submission of Initial Agreement	January 2016
Site Options Appraisal	September 2015
Submit Outline Business Case	August 2016
Submit Full Business Case	July 2017
Financial Close	October 2017
Construction	January 2018

6.2 The approach to the management and methodology of the project is based on the overriding principles of the Hub initiative where NHSGGC and WD HSCP will work in partnership with the appointed Private Sector Development Partner to support the delivery of the project in a collaborative environment that the "Territory Partnering Agreement", and "DBFM (Design, Build, Finance, and Manage) Agreement" creates.

6.3 A Project Board has been established to oversee the initiative and is chaired by the WD HSCP Chief Officer, who is also the Project Sponsor. The Project Board comprises representatives from the senior management of WD HSCP and NHSGGC (including Capital Planning and Finance); the services that will be operating within the new Centre; and West Dunbartonshire Council. The Project Board represents the wider ownership interests of the project and maintains co-ordination of the development proposal.

6.4 The Project Board reports to the NHSGGC Hub Steering Group, which oversees the delivery of all NHSGC Hub projects. It includes representatives from other Project Boards within NHSGGC, Capital Planning, Facilities, Finance, Hub Territory and Hub Co.

6.5 While the Project Board will provide strategic leadership and oversee delivery, a Design and Delivery Group has also been established to manage the day-to-day detailed information and tasks required to brief and deliver the project.

6.6 The project will be supported by a series of sub-groups and task teams as required and identified in the Guide to Framework Scotland published by Health Facilities Scotland.

6.7 The representatives from NHSGGC Capital Planning and Finance have been involved in a number of Hub developments - including the Eastwood and Maryhill Projects - and have a wealth of experience to provide this development. As well as complying with the requirements of the SCIM, the local team within the HSCP leading this project has benefited from their experience and positive learning in successfully delivering the Vale Centre for Health and Care (as acknowledged in the latter project's OGC Gateway Review).

6.8 In relation to the appointment of the Design Team this work is ongoing at present with progress to date noted below:

- Architect – Anderson Bell Christie
- Cost Adviser – Sweett Group
- Structural Engineer – MSPS

- Mechanical & Electrical –TUV Sud – Wallace Whittle

Financial Case

6.9 NHSGGC has received conditional approval that a replacement Clydebank Health and Care Centre will be funded as a bundled project with Greenock Health and Care Centre funded via the West of Scotland Hub Initiative, subject to approval through the business case process.

6.10 NHSGGC has made provision within its capital resource limit for this project dependant on confirmation of the Hub funding.

6.11 The table below represents indicative capital and revenue costs and funding the project. The revenue costs are break even at this time. Future development of the revenue implications will be undertaken in the development of the Outline Business Case. There are no financial contributions from external partners in this project.

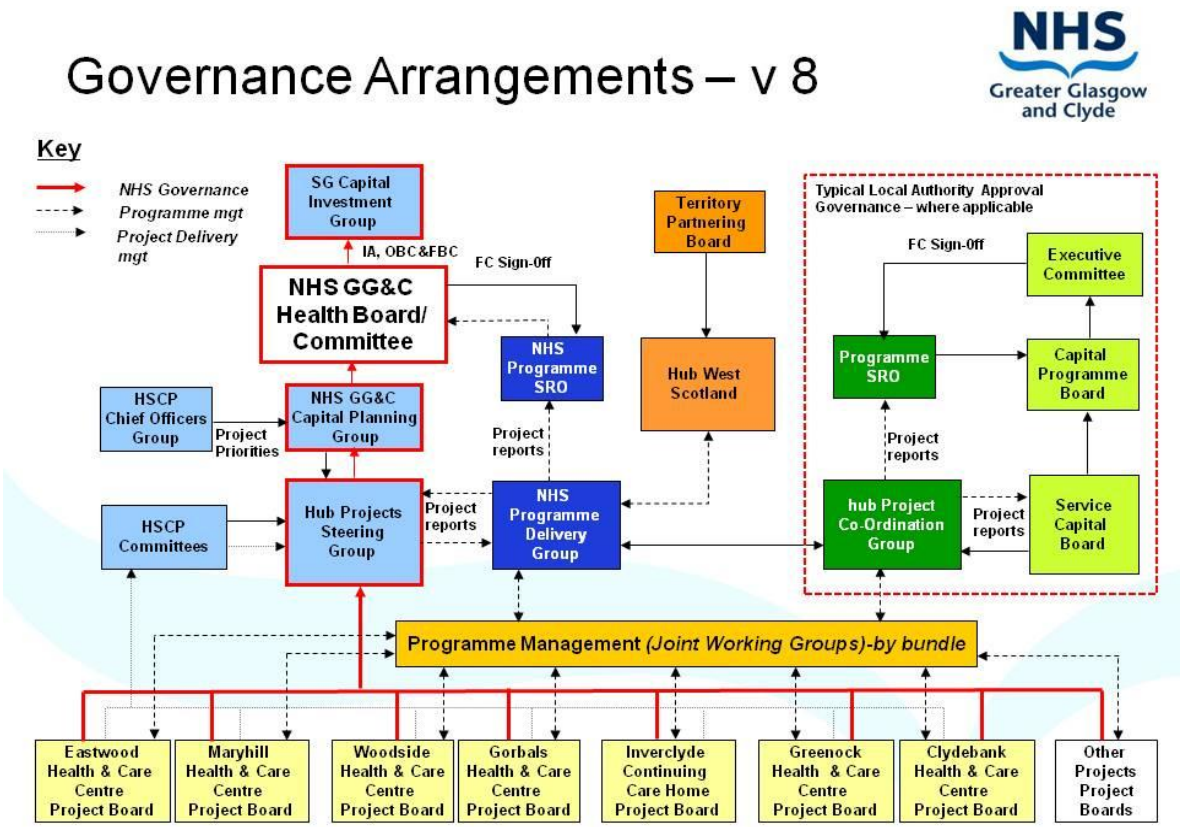
Capital	£'000
Costs	
Site Acquisition	0
Equipment	950
Sub Debt	190
Total Capital Cost	**1,140**
Funded by -	
Formula Capital	**1,140**
Revenue	£'000
Costs	
Annual Service Payment	2,069
Running Costs	476
Depreciation Equipment	95
IFRS Depreciation	760
Total Costs	**3,400**
Funded by -	
SG Funding	1,880
IFRS - SGHCD	760
Existing Revenue Budgets	515
Additional GP Funding	73
Review of Estate/Redesign	122
Council Revenue Funding	50
Total Funding	**3,400**
Surplus	**0**

Management Case

6.12 The NHSGGC Hub Project Steering Group has established governance and reporting structure which will be implemented to deliver this project. The structure is illustrated in the diagram below and has been used to successfully manage the NHSGGC Hub projects to date. Project Boards report and approve through to the Hub Steering Group to the NHS Capital Planning Group and then NHSGGC.

6.13 Programme Delivery Group is responsible and accountable to the Senior Responsible Officer (SRO) for successful delivery of the programme of Hub projects. The Delivery Group will work alongside the Hub Steering Group and the existing governance arrangements, but with a day to day role to focus on delivery, working directly through key interfaces with HubCo West Scotland.

6.14 The Clydebank Health and Care Centre Project Board reports to the NHSGGC Hub Steering Group which oversees the delivery of all NHSGGC Hub projects. The Project Board is chaired by the WD HSCP Chief Officer, and comprises representatives from the senior management of WD HSCP and NHSGGC (including Capital Planning and Finance); the services that will be operating within the new Centre; and West Dunbartonshire Council. The Project Board represents the wider ownership interests of the project and maintains co-ordination of the development proposal.



Project Management Arrangements

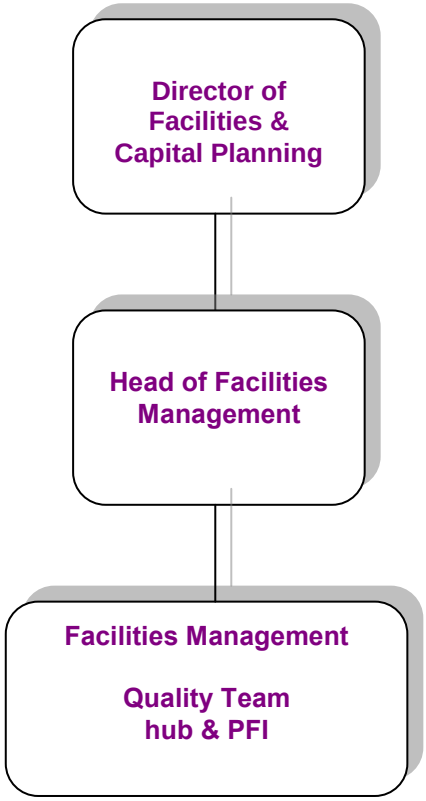
Clydebank Health and Care Centre		
Parties	NHSGGC Hub West Scotland	NHSGGC HubCo
Project Sponsor	Keith Redpath	WD HSCP
Project Director	Chris McNeill	WD HSCP
Capital Planning Project Manager	Ian Docherty	NHSGGC
Finance Managers	Marion Speirs	NHSGGC
Private Sector Development Partner – Project Manager	Gary Smithson	HubCo
Private Sector Development Partner - Tier 1 contractor	To be appointed	
Legal	Procurement Process underway	
Financial	Procurement Process underway	
Technical	Procurement Process underway	
Architectural Adviser	Part of TA team	
M&E Adviser	Part of TA team	
Civil/ Structural Adviser	Part of TA team	

6.15 The Hub Project Steering Group has developed a revised governance and reporting structure which impacts on this project. The key change has been to establish a Programme Delivery Group (PDG), which will have overall responsibility and accountability to the Senior Responsible Officer (SRO) for successful delivery of the programme of hub projects. The PDG team will work alongside the Hub Steering Group and the existing governance arrangements, but with a day to day role to focus on delivery, working directly through key interfaces with Hub West Scotland and Local Authority leads.

6.16 NHSGGC has created an expert team to support the operational management of its Hub and Private Finance Initiative (PFI) contracts, with the aim of ensuring that there is a consistent, appropriately informed and robust approach to contract management across the Health Board area. Areas of activity include:

- Detailed knowledge of contract documentation, service specification requirements, performance requirements – reactive, planned preventative maintenance (ppm) and life cycle, Paymech, contract variation and the overarching legal framework in which the contracts operate.
- Provide a link to national contract support initiatives and activity, including Scottish Futures Trust.
- Locally, supporting managers dealing with the operational interface and co-ordinating the Boards approach to technical evaluation of performance in terms of quality, statutory ppm, condition and lifecycle.
- Provide a presence at all Paymech and Liaison Committee meetings to reinforce consistency and focus.
- The team is directly managed by the Head of Facilities within the NHSGGC Facilities & Capital Directorate.

Indicative Reporting Structure:



6.17 Five key roles have been identified comprising:

- Senior Responsible Officer - David Louden
- Overall Project (Programme) Director - Keith Redpath
- Commercial Lead - Tony Curran
- Finance Lead - Jeanne Middleton
- Technical Lead - John Donnelly
- Facilities Management PFI/NPD Lead – Karen Connolly

6.18 Readiness to Proceed CHECKLIST

Clydebank Health and Care Centre	
Is the reason made clear why this proposal needs to be done now?	Section 2 Section 4
Is there a good strategic fit between this proposal, NHS Scotland's Strategic priorities, the Health Board's and the HSCP Board's own strategies?	Section 3
Have the main stakeholders been identified and are they supportive of the proposal?	Section 3 Appendix B
Is it made clear what constitutes a successful outcome?	Section 4 Appendix C
Are realistic plans available for achieving and evaluating the desired outcomes and expected benefits to be gained, including how they are to be monitored?	Section 4 Appendix C
Have the main project risks been identified, including appropriate actions taken for mitigating against them?	Section 4 Appendix D
Does the project delivery team have the right skills, leadership and capability to achieve success?	Section 6
Are appropriate management controls explained?	Section 6
Has provision for the financial and other resources required been explained?	Section 6

6.19 The proposal should be taken forward now due to the condition of the building and the overcrowding of staff accommodation which is preventing multi-disciplinary professional teams working together. Stakeholders involved include the six GP practices; community health and social care services; NHS Acute Services; service users and carers; and Community Planning partners (including the Council and community representatives).

6.20 In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. NHSGGC have undertaken this on all recent Hub projects. Given the background to this project, the Scottish Government's Capital Investment Group agreed that Scottish Futures Trust should be invited to engage with NHSGGC to examine the available options against the project's benefits realisation and investment objectives. Appendix B summarises the process and outcome of the workshop. Following this process, the Queen's Quay Regeneration Development site in Clydebank was confirmed as the optimal available site for delivering on the project's investment objectives. Furthermore, the terms of the site's provision by the Council means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In locating the new facility on this prime site, the regeneration benefits of the project will be considerably enhanced and further deliver a positive effect on the heath and wellbeing of the people of Clydebank.

7. Is This Still a Priority?

7.1 With changing demographics and increasing levels of need, over the next 10 years the health and social care landscape will change significantly. Those changing demographics (including an ageing population), an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

7.2 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the Do Nothing option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is “money hungry”. The asbestos that is integral to the building’s structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million. NHSGGC has made provision within its capital resource limit for such a project dependant on confirmation of Hub funding, with the revenue costs calculated as break even at this time.

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

7.4 Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank. As such, the proposed new health and care centre is not just about the construction of a new asset, but more importantly how such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Clydebank area more broadly.

7.5 We are confident that the anticipated benefits described above and throughout this Initial Agreement will be realised; and that this will deliver genuinely transformed care for the people of Clydebank.

APPENDICES

APPENDX A - AEDET Workshop

APPENDIX B - Site Options

APPENDIX C - Benefits Realisation Plan (Draft)

APPENDIX D - Risk Register

APPENDIX E - Design Statement

APPENDIX F - Programme Schedule

APPENDIX G - Communication and Engagement Plan

APPENDIX A - AEDET WORKSHOP

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	2	YES
A.02	The design facilitates the care model	1	2	YES
A.03	Overall the design is capable of handling the projected throughput	1	1	YES
A.04	Work flows and logistics are arranged optimally	1	1	
A.05	The design is sufficiently adaptable to respond to change and to enable expansion	1	1	YES
A.06	Where possible spaces are standardised and flexible in use patterns	1	1	YES
A.07	The design facilitates both security and supervision	1	1	YES
A.08	The design facilitates health promotion for staff, patients and local community	2	1	YES
A.09	The design has a clear strategy to respond to changing needs and functions	1	1	YES
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	2	1	YES
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2	1	YES
B.03	The approach and access for ambulances is appropriately provided	1	1	YES
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	1	YES
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	1	YES
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	1	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	1	YES
B.08	Car parks should not visually dominate entrances and green routes	1	2	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	1	YES
C.02	The ratio of usable space to total area is good	1	5	YES
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	2	2	YES
C.04	Any necessary isolation and segregation of spaces is achieved	2	2	YES
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	2	1	YES
C.06	There is adequate storage space	1	1	YES
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	1	YES
C.08	The relationships between internal spaces and the outdoor environment work well	1	1	YES
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	1	YES
D.02	The building and grounds are easy to clean	1	1	YES
D.03	The building and grounds have appropriately durable finishes	1	1	YES
D.04	The building and grounds will weather and age well	1	1	YES
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2	1	YES
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	YES
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	YES
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	1	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	1	
E.03	The engineering systems are energy efficient	1	1	YES
E.04	There are emergency backup systems that are designed to minimise disruption	1	3	YES
E.05	During construction disruption to essential services is minimised	0		
E.06	During maintenance disruption to essential healthcare services is minimised	1	1	YES
E.07	The design layout contributes to efficient zoning and energy use reduction	1	1	YES

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	0		
F.04	The building and grounds can be readily maintained	0		
F.05	The construction is robust	0		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0		
F.09	The construction contributes to being a good neighbour	0		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	2	3	YES
G.02	The building and grounds are interesting to look at and move around in	1	1	YES
G.03	The building, grounds and arts design contribute to the local setting	1	1	YES
G.04	The design appropriately expresses the values of the NHS	1	1	
G.05	The project is likely to influence future designs	1	1	
G.06	The design provides a clear strategy for future adaptation and expansion	1	1	YES
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	1	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2	2	YES
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	2	1	YES
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	2	2	YES
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	1	YES
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	1	YES
H.06	The design maximises the site opportunities and enhances a sense of place	1	1	YES
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

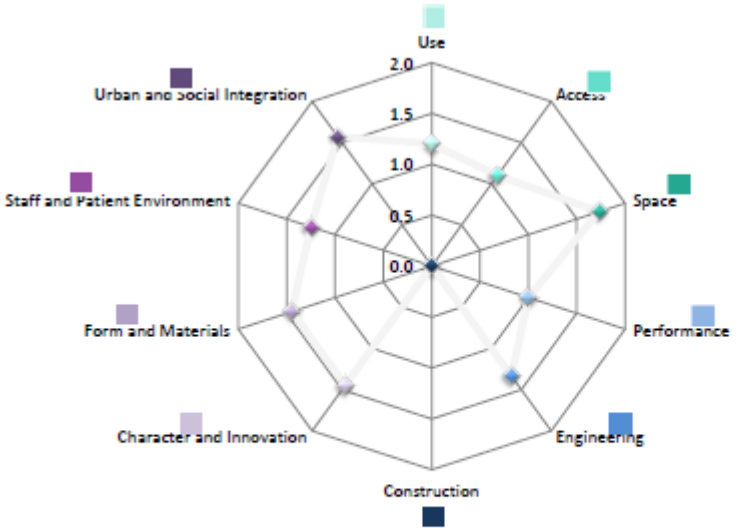
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2	1	YES
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	1	YES
I.03	The design maximises the opportunities for access to usable outdoor space	1	1	YES
I.04	There are high levels of both comfort and control of comfort	1	1	YES
I.05	The design is clearly understandable and wayfinding is intuitive	2	1	YES
I.06	The interior of the building is attractive in appearance	1	1	
I.07	There are good bath/ toilet and other facilities for patients	1	2	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2	2	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	1	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The design contributes positively to its locality	1	1	
J.03	The building and grounds design lift the spirits and raise aspirations	2	1	YES
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	3	YES
J.05	There is a clear vision behind the design, its setting and outdoor spaces	2	1	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

AEDET Refresh Benchmark Summary



		Benchmark
	Use	1.2
	Access	1.1
	Space	1.7
	Performance	1.0
	Engineering	1.3
	Construction	0.0
	Character and Innovation	1.4
	Form and Materials	1.4
	Staff and Patient Environment	1.3
	Urban and Social Integration	1.6

Weighting	=	Target
2	= >	5 - 6
1	>	3 - 4
0	<	3

Ref	Note
A.01	Very poor, functions reaqsonably well but dated. Getting to the building is poor. Access to building is mixed. Access to rooms not ideal.capacity issue.
A.02	community services model poor. Space issues, cannot be expanded some elements 3
A.03	not anymore as no scope of expansion
A.04	
A.05	not at all no scope of expansion
A.06	big problem some clinic rooms left handed difficutl and awkward to see patients,
A.07	security is poor, easy for people to to go to areas
A.08	no natural light in some areas, no space to do any health promotion activities.
A.09	no natural light in some areas, unpleasent environment, poor ventilation
A.10	
B.01	not suitable access from carpark, outside enviornment provide difficult access to building, lift access poor, drop off zone is not ideal,
B.02	definitely not, can never fulfill the need, often full, carpark is used by others who actually not using HC,
B.03	no
B.04	not safe, very narrow road to access building, also service access is inbetn the carpark and building so is inconvenient at times.
B.05	no it is not very uneven and access to the building for pedestrians is not suitable as ground not level.
B.06	no
B.07	not used fully
B.08	
B.09	patient been able to get through one full jouney and better ambulance access,
C.01	room sizes are very generous, waiting rooms are small,
C.02	space is overally utilised, very well used. Expansion overtime and worked well with it.
C.03	not really, overly complexed
C.04	converted into cl and waiting areas
C.05	none
C.06	none
C.07	none
C.08	few rooms have poor ventilation
C.09	
D.01	and then care has to go and look for parking space.
D.02	automatic door at west thomson street has no weather barrier, cannot be closed when it is too windy or open sometimes.
D.03	roof of the building is in poor state of repal and has been water damaged over the years,
D.04	building has aged well but has its own restictions, roof is beyond repair and hasbeen temporarily fixed over years.
D.05	not every room has natural light,
D.06	not really, overly complexed
D.07	lot of issues related to maintenance due to its clasp nature and strict asbestos regulations. Not cost effective at all as everything has to be done under controlled conditions
D.08	
E.01	
E.02	
E.03	no energy efficiency as old system of heating which cannot be chnaged and has no individual controls
E.04	ups for phones, remote GP IT backup, plug in points,
E.05	
E.06	extra cost , under controlled condition as due to its clasp nature
E.07	systems are not efficient in use, e.g. no zoning, heating is either all on or off.
G.01	when it was opened it was quite sufficient, but over the years not fit for purpose.
G.02	not really
G.03	doesnot have any appeal looks old and dated
G.04	
G.05	
G.06	no scope of expansion
G.07	
G.08	
H.01	staff welcoming but building doesnot.
H.02	not appropriate
H.03	kilbowie rd is functional but carpark entrance is not ideally located
H.04	external material is difficult to maintain as we have leaks when it rainy heavy.
H.05	It has aged well but
H.06	It used to when it inittially opened, now no further scope of expansion clinically or office accomodation.
H.07	
I.01	not appropriate, reception has no privacy, also some consulting rooms face into waiting areas which lacks privacy
I.02	lot of rooms have no natural daylight,
I.03	no outside space
I.04	poor heating in winter and too hot in the summer as not enough natural ventillation.
I.05	
I.06	
I.07	disabled toilets are good but not general toilets
I.08	no contact/ space for informal clinical consultations, good staff room,
I.09	not applicable
I.10	
J.01	
J.02	
J.03	not really
J.04	local people use it for lot of reasons- toilets, carpark
J.05	

Weighting

High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring

Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Site Options Paper, New Clydebank Health and Care Centre - 27th October 2015

1. Purpose

In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. NHS GG&C have undertaken this on all recent hub projects. In this instance due to background we sought guidance from SCIG on whether this would be necessary given the clear planning support, political support and additional regeneration benefits that would accrue from locating on the Queen's Quay site. It was agreed that the Board would seek confirmation from Scottish Health Council (SHC) that it was satisfied in relation to community consultation requirements, and that Scottish Futures Trust (SFT) should be invited to test whether a full options appraisal would be required to ensure value for money was delivered through the project. This paper summarises the process and outcome of the workshop held to test this.

2. Approach

A review of potential sites was undertaken by key stakeholders from NHS Capital Planning, West Dunbartonshire Health & Social Care Partnership leaders and leads from WDC's planning and technical team. The requirement is for a site capable of accommodating circa 2500m2 footprint and 200 car parking spaces in Clydebank. This requires a site of circa 3 acres. Five potential sites were identified: the existing HC site (expanded), Queens Quay site and three sites of former schools. The sites were examined by Anderson Bell Christie (ABC) architects, who have been selected to deliver the project. They tested each site for capacity to accommodate the requirements physical requirements.

3. Benefits Realisation

In order to deliver the benefits for which it is being built the Centre must enable and support:

- Improved services meeting the local demographic needs.
- Service redesign, of which it is an integral part.
- Easy access, especially by public transport.
- Opportunities for greater collaboration with partners.
- Visibility of the importance of wellbeing.
- Leverage for wider area regeneration.

Upon reviewing the available sites it became clear that due to the dispersed nature of the population served by the centre (circa 50,000 people) a location on primary public transport routes would be essential. It became clear that whilst two of the school sites could easily accommodate the physical requirements, their location within residential areas was not sufficiently visible to the wider community, nor easily accessible by public transport.

It was also clear that the existing health centre location, whilst on a main route, was divorced from the centre of Clydebank. Not only would this site require significant compromise in design development options due to the long narrow nature of the site, it crucially lacked the potential for the collaboration that is essential to meet the service redesign objectives.

Only two sites had the potential to meet the benefits realisation requirements: these were Queens Quay and the former St Andrews School at North Douglas Street.

4. Site Assessment

A set of site selection criteria were then discussed which had been developed to align with the Investment Objectives:

1. Public and Staff Access – 30%.
2. Co-location with other public services – 20%.
3. Contribution to regeneration – 20%.
4. Environmental Quality – 20%.
5. Future Expansion – 10%.

By comparing both remaining locations against these key criteria a round of consensus scores were awarded by the group against each site. The weighted total of these scored 97% vs 67%, producing a preferred option by a wide margin. Whilst it was agreed that the St Andrews site could be developed satisfactorily, albeit at a cost, on every criteria Queens Quay offered a significantly stronger response. It was apparent that due to the long-term planning exercise, undertaken by WDC, the key requirements had effectively been designed into the masterplan, leading to very high scores in each category.

5. Finance

In discussion WDC outlined the known contamination issues at both front-runner sites. In the case of Queens Quay the site will be remediated and levelled by the developer, which would reduce hub development costs. The development agreement also requires the developer to provide the key infrastructure elements of spine access road and utilities as part of an enabling works element. On the St Andrews site it was clear that road improvements would be required, and remediation would need to be addressed through the hub development.

WDC has undertaken to provide the Queens Quay site to NHS free of charge. The St Andrews site would need to be acquired in the normal way using agreed DV valuations.

6. Regeneration

Queens Quay is West Dunbartonshire Council's key regeneration project. Its aim is to provide a better environment for the people of Clydebank and importantly to attract new residents and families to a regenerated riverside location. At the heart of the plan is public investment which to date has seen the relocation of West Of Scotland College to a riverside location, the redevelopment of Clydebank Town Hall and gallery, and currently the development of a new leisure centre, which is under construction. The Council has further committed to locating its new residential care-home and day facility on the site too. The location of the town's principle health facility in this location is seen as the final fundamental investment to consolidate what has been committed to date.

7. Conclusion

From examining the available options against the project's benefits realisation and investment objectives, Queen's Quay most clearly meets all of the criteria. Further, the terms of the site's provision by WDC means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In doing so, it will also underpin a significant regeneration project which will have a positive effect on the heath and wellbeing of the people of Clydebank.

On this basis it is proposed that the new Health & Care facility at Clydebank is located on the Queens Quay site.

APPENDIX C – BENEFITS REALISATION PLAN (DRAFT)

Benefits Realisation Plan								
1. Identification						*2. Impact (RAG)*		
Ref. No.	***Main Benefit***	***Financial / Non-Financial***	***As measured by:***	***Baseline Measure***	***Target Measure***	***Impact (size)***	***Importance***	***Likelihood***
1.	It will improve quality of life through the care provided by the co-location of integrated teams enabling speedy access to, modernised services.	Non-financial	Number of ACPs in place Reduce the number of acute bed days consumed by each long term conditions (crude bed days rate per 100,000) Increase number of people with diagnosis of dementia on the dementia register	2015/16 Outturns	+ 10% by 2020 - 10% by 2020 TBC			
2.	It will improve support to people to live independently	Non-financial	Number of people receiving homecare during annual census week. Number of Homecare hours per 1,000 population aged 65+ Percentage of Homecare clients aged 65+ receiving Personal Care	2015/16 Outturns	TBC TBC TBC			
3.	It will increase the proportion of people with intensive needs being cared for at home.	Non-financial	Percentage of Homecare clients aged 65+ receiving Personal Care Number of people supported by community staff to die at home	2015/16 Outturns	TBC TBC			
4.	It will ensure timely discharge from hospital.	Non-financial	Number of acute bed days lost to Delayed Discharge (inc AWI)	2015/16 Outturns	TBC			
5.	It will improve the functional suitability of the healthcare estate.	Non-financial Financial	BREEAM rating. Reduce running costs.	2015/16 Outturn	Excellent TBC			
6.	It will improves access services and contribute to regeneration of Clydebank	Non-financial Financial	TBC	TBC	TBC			

Benefits Realisation Plan							
1. Identification		**3. Control**		**4. Realise**			
Ref. No.	**Main Benefit**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
1.	It will improve quality of life through the care provided by the co-location of integrated teams enabling speedy access to, modernised services.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	From completion onwards
2.	It will improve support to people to live independently.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
3.	It will increase the proportion of people with intensive needs being cared for at home.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
4.	It will ensure timely discharge from hospital.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
5.	It will improve the functional suitability of the healthcare estate.	Service Users, Carers and Practitioners.	Management	2,3,4 and 5	New Centre	New Centre	From completion onwards
7.	It will improves access services and contribute to regeneration of Clydebank	Organisation	Management	1 and 5	New Centre	New Centre	From completion onwards

APPENDIX D – RISK REGISTER

			1. Identification				3. Control	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Owner	Proposed Treatment / Mitigation	Action Taken
CLIENT / SERVICE RISKS								
1.0	**Business risk**							
1.1	Independent Contractors disengage with the Project	**Financial**	5	3	Med	Hub West	Provide clear financial information at earliest opportunity and engage with discussion re space	Meetings arranged
1.2	Client doesn't have the capacity or capability to deliver the project	**Non - Financial**	4	2	Low	NHS/ Hub West	Develop appropriate governance arrangements for the project including resource planning and individual skills review	NHS and Hub West have reviewed resources and are satisfied.
1.3	The project's objectives are not clearly defined	**Non - Financial**	5	2	Med	NHS	Set out clear objectives for the project as part of the Initial Agreement, linking them to clearly defined & measurable benefits and outcomes	Complete
1.4	The anticipated benefits from the project are not achieved following project completion	**Non Financial**	5	2	Med	NHS	Set out a realistically achievable benefits realisation plan as part of the Initial Agreement	Benefits realisation plan drafted and subject to refinement through engagement process.
1.5	Different stakeholders have different expectations of the outcome of the project	**Non Financial**	5	3	Med	NHS	Consult with all stakeholders to gain a consensus on the strategic brief for the project at IA stage and project brief at OBC stage	Communication and Engagement Plan developed.
1.6	Poor stakeholder involvement will result in a lack of support for project	**Non - Financial**	3	2	Low	NHS	Prepare and implement an appropriate communication and engagement plan, which includes engaging with all appropriate stakeholders at appropriate stages of the project	Communication and Engagement Plan developed.
1.7	Funding arrangements remain unclear in relation to ESA 10, creating uncertainty and delay.	**Financial**	4	4	High	SG	Seek assurances and underwriting to early stage work by SG to allow progress in advance of final solution.	Discussions on-going.

			1. Identification				3. Control	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Owner	Proposed Treatment / Mitigation	Action Taken
2.0	**Reputational risk**							
2.1	Adverse publicity occurs due to an operational issue	**Non - Financial**	4	2	Med	NHS	Review ongoing operational arrangements associated with the project and ensure that any specific risks are encapsulated into the project risk register	Risk register will be reviewed on a regular basis by Project Board
2.2	Communication strategy does not consider public perception / consultation feedback / media interest / parliamentary interest / organisational reputation	**Non - Financial**	4	2	Medium	NHS	Ensure that the communication and engagement plan covers these issues	Communication and Engagement Plan developed and subject to review.
3.0	**Demand risk**							
3.1	Demand for the service does not match the levels planned, projected or presumed	**Non - Financial**	5	2	Med	NHS	Carry out sensitivity testing of assumptions behind service demand projections to understand and manage any underlying risks	On-going
4.0	**Occupancy risk**							
	Failure to agree lease terms with Independent contractors i.e. GPs	**Financial**	5	3	Med	NHS	Early discussion with GPs detailing estimated lease\running costs	On-going
5.0	**Operational risk**							
5.1	The available accommodation is unable to support the proposed service model	**Financial**	4	2	Med	All	New service model arrangements should be considered and properly tested at the early design planning stages of a project and then further tested throughout the development of the project	On-going
6.0	**Decant risk**							
6.1	Unable to decant staff / clients from one site to another in a timely manner	N\A	N\A	N\A	N\A	N\A	N\A	N\A

APPENDIX E - DESIGN STATEMENT

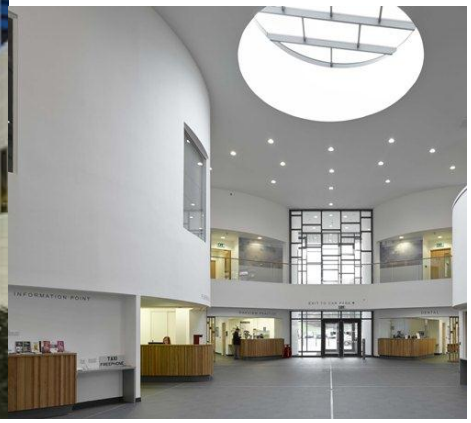
In order to deliver the investment objectives and benefits described within the Initial Agreement, the new Clydebank Health and Care Centre development must possess the following attributes.

In reading the text below, the journeys and environments described are for all people, and the use of best practice in relation to inclusive design (physical accessibility, sense sensitive design and design for cognitive impairments) will be part of the detailed briefing (to follow) of how these experiences are to be achieved.

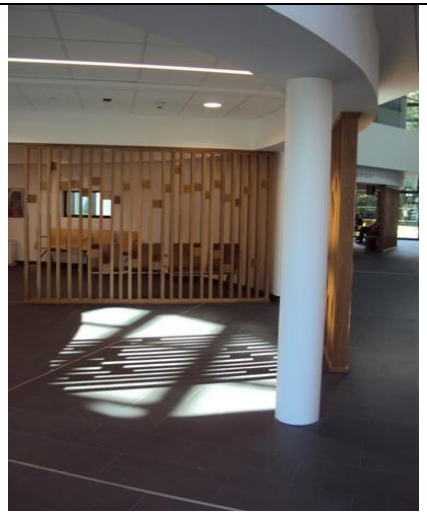
1 Non Negotiables for Service Users

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
1.1 It must be easier to get to the new facility than the existing one and the experience of arriving must feel safe and welcoming.	• The entrance must be close to public transport; within 5min of bus stops with routes serving a broad number of housing schemes and 10 min from train station. • Pedestrian routes (from street and within parking) should have priority over vehicle routes, be easily accessible (barrier free standard, not steep) and direct with line of sight to the entrance, supported by signage to reassure. They must be well lit and observable (you can see people in nearby buildings and they can see you) so that you don't feel you're alone or no-one would spot if there's a problem. Walking routes from the street and public transport must not be dominated by parking. Any routes within the site longer than 5min must have rest points included. • Parking areas must be easy and intuitive to use, with the layout designed to manage different levels of need and to discourage misuse. Disabled parking and pick-up/drop-off spaces to be within 20 metres of the entrance, clearly overlooked by staff areas and have different surface treatment (more like pedestrian areas) to signal different use. • Soft/green landscaping to be incorporated into external routes and spaces to provide shelter and welcome.   

	   
1.2 The facility (both building and grounds) must feel part of Clydebank, with an open/public feel that encourages, and copes well with, use both to access services and for other reasons (community use, recreation etc). It must be welcoming, with some open useable space, not institutional, clinical or overpowering in its impression.	• External areas, such as parking, landscape and paving areas, must be designed to have a civic feel and allow use by the community both 'out of hours' (use of larger areas such as parking for events etc) and (for landscape/paving areas) during normal operation without impacting use/privacy of the building. • Clear intuitive way finding from out with the site to indicate presence of facility and route to it(even during hours of darkness).

	  
1.3 All service users – irrespective of which service(s) they're using that day -must arrive into the same space. This must be light and welcoming, with direct view to help, and a clear route to the service being sought.	• Welcoming reception desk visible on entry that can check you into most services and guide you to other areas such as GP, Community services. • Route to each service should be clearly visible/ signposted. Stairs and lifts clearly marked for ease of access. • The Main entrance / foyer should be designed to be able to deal with heavy traffic within the during peak times.   
1.4 Walking routes for service users – both to and between services - must be short, easy, pleasant and intuitive.	• Routes to have line of sight connection between destination points for each part of the journey so the way can be understood. Any stairs and lifts needed to be visible from the initial orientation point. • Routes/destination points to have good day lighting and identity (a space, view or installation that you would recognised when seen again), supported by signage for reassurance. • Waiting areas within 10m of all consulting/treatment rooms to reduce walking distance for patients and allow option of staff

	collection for initial assessment of mobility/health.  
1.5 The ‘check in’ experience must provide for personal preferences and privacy. Reception facilities must be open and calm to promote trust and confidence.	• Electronic check in at main arrival space, close to someone who can help if you’re experiencing problems. • Reception desks to manage security unobtrusively (they must not to have glazing/barriers, but use deep lunge desks and easy escape to safety), and be acoustically separated from admin areas to reduce noise. Heating and ventilation must be managed to allow staff to sit in comfort. • There must be space close by to take any sensitive conversations. • Waiting areas should not be immediately adjacent to receptions so that all discussions cannot be easily overheard.   

	
1.6 The waiting experience must allow for personal preferences and provide a comfortable, safe, calm and reassuring environment with distractions and access to information. (*see also 2.? for other uses of this space*)	• Waiting areas must have good daylight, fresh air and views to external green space. • There must be options for where you wait, allowing people to wander and still feel connected, join in social groups, occupy children in play, or sit more quietly. • The spaces must deal well with noise (lower it) so that the place feels calm. • Staff areas must be visible (to feel connected with the appointment and safe) and there must be no hidden corners. • There should be access to safe external space for a breath of fresh air and a secured place for children to run around (courtyard). • wifi access/information points should be available for longer patient waiting times.
1.7 Consulting and treatment areas must feel private and inspire confidence.	• Fixtures/surfaces/furnishing must feel of good quality – that they will last and look/be clean and convey professional impression. • There must be good sound separation to other building areas. To be supportive of open and confidential/ sensitive discussions, assessments & treatments. • Daylight and natural ventilation must be able to be maintained alongside privacy of conversations.

2 Non Negotiables for Staff

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
2.1 Staff must be able to arrive and leave reliably and safely.	• Routes to be to standard with ease of access. • Discrete staff entrance away from main public areas which allows them easy access to staff changing facilities and staff room. • Equipment store adjacent to drop-off area or where staff can bring and park their vehicle. Staff entrance should be well lit and secure out of hours.
2.2 The layout of the facility must maximise the potential for out of hours/community use.	• Entrance areas, meeting rooms, waiting areas and external spaces to be located and designed together to be used flexibly for community events and special functions such patient group sessions/ advice clinics/ no smoking groups/ baby clinics.
2.3 The facility must be designed to encourage staff out of individual rooms and to come together to share learning/experiences develop support and combat isolation.	• IT system to support hot-desking and ability to work on admin tasks in meeting/staff social spaces. • Meeting and social spaces to be placed where accessible to all services and designed to encourage use • Staff room to be located where it is easy to access.

2.4 The external environment must be designed to maximise its therapeutic use, both for formal therapies and social/respite uses.	• No unusable courtyards. External spaces to be briefed to use for formal and informal physiotherapy (requiring privacy from public areas). • Social and respite purposes for service users. • Third sector and out of hours secured use.
2.5 The design of the facility must support staff wellbeing and personal needs.	• The grounds and facilities should encourage green travel and exercise (showers, bike racks) • space must be available for quiet support conversations and counselling • Staff rest areas must be away from public spaces to allow staff to feel off duty. There must be a space staff can get a breath of fresh air in their day. • Lockers and changing areas must be positioned so that they are easily accessed as part of normal routes around the building.
2.6 materials and waste must be able to be managed unobtrusively.	• Delivery and waste collection entrance should be separate. • FM and facilities areas should be away from public/ patient areas.

3 Non Negotiable for Visitors

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
3.1 The facility must support the communication of health promotion and information on services for those visiting to support carers/ patients or in maintaining their own well being	• Display information through screens and information points. Information should be updated regularly and timely. • Information stands by Health improvement teams on up-to-date information.

4 Alignment of Investment with Policy

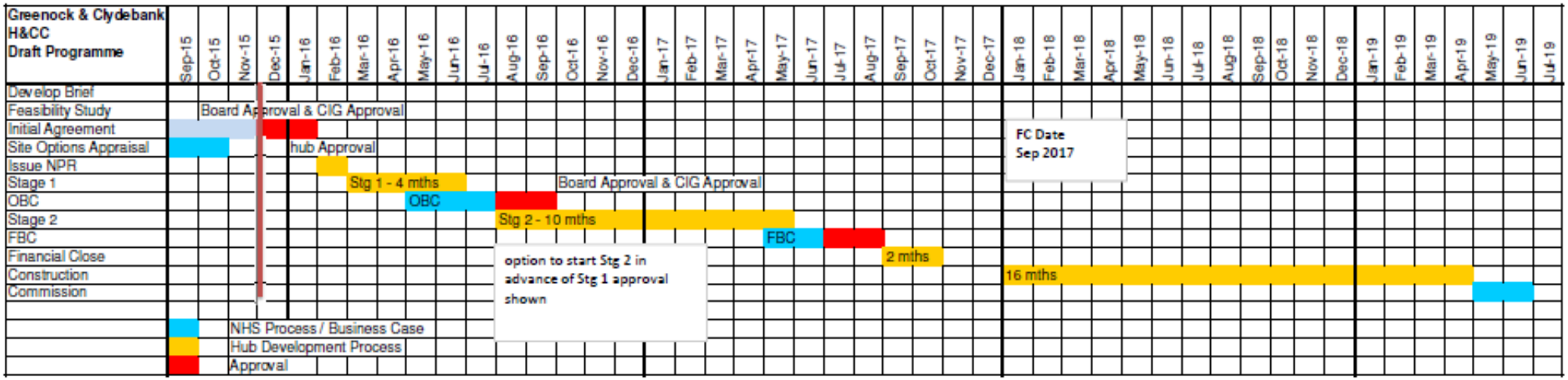
Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
4.1 The development (both building and external) through its location and appearance contribute to regeneration of Clydebank.	The facility will be a part of regeneration of Queen's Quay and will be a facility to be used by local population to be easily accessible & available to use. Continuous community engagement and involve health improvement team for various health promotion activities.
4.2 Flexibility/ Adaptability for growing/ aging/ changing population	The building design and construction will enable flexibility. Safety, accessibility and equality will be the foundation of the design and construction. Will also have Build usable grounds/ courtyards; lot of green space to reduce CO2 emissions that will encourage physical activity for community and staff as well. There will be repeated group sessions involving all users from community and existing building to develop space internal / external to develop areas to achieve flexibility and soft spaces for all. We will also have changing places/ toilets for severely disabled and bariatric members of the community.
4.3 Sustainability	Building will promote health, social, environmental and economic sustainability. It will be based on current BREEAM at all stages.

The above statement was drafted through the participation of the following stakeholders/groups:
Karen McElwee - Practice Manager, Red Wing; Dr Bell - GP, Red Wing; Pauline MacWhirter - Practice Manager, Red Wing; Ralph Cunningham - GP, Blue Wing; Jane McNiven - Practice Manager, Green Wing; Neil Murray - GP, Green Wing; Beverley McCartney - Practice Manager, Orange Wing; Katrina Moffat - GP, Orange Wing; Murray Fleming - GP , Yellow Wing; Irene True - Practice Manager, Purple Wing; Dr Rai - GP, Purple Wing; Valerie McIver - District Nursing; Jackie Hamill - Health Visiting; Tracy Cassidy and Fiona Wright - Physiotherapy Team Leaders; David Bisset - Podiatry Team Leader; Mary Angela McKenna – Older People Operations Manager; Wendy Cox - Mental Health Services; Lynne McKnight - Integrated (Adult Services) Operations Manager; Kim McNab - Carers of West Dunbartonshire; Anne MacDougall - Clydebank Locality Engagement Network; Jackie Maceira - Access Panel.

Decision Point	Authority of Decision	Additional Skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation.
Site Selection	Decision by Health Board with advice from Project Board	Comment to be sought from National Design Assessment Process (NDAP) to inform Boards Consideration	Risk / benefit analysis considering capacity of the sites to deliver a development that meets the criteria above.	Site feasibility studies (inc. sketch design to RIBA Stage B) for alternate sites or completed masterplan (for site with the potential for multiple projects). Cost Estimates (both construction & running costs) based on feasibility
Completion of brief to go to market	Decision by Health Board with advice from Project Board	Peer review by colleague with no previous connection to project	Is the above design statement included in the brief? Can the developed brief be fulfilled without fulfilling the above requirements?	
Selection of Delivery / Design Team	Decision of HUBco Operations & Supply Chain Director with input from NHSGGC PM.	HUBCo , Participant (NHSGGC) & Territory Programme Manager	The potential to deliver 'quality' of the end product in terms of the above criteria shall be greater that the aspects of the quality of service in terms of delivery. Compliance with service standards (such as PII levels) shall be criteria for a compliant bid and not part of the quality assessment.	Sketch 'design approach' submitted with bid (the stage & detail of these to be appropriate to procurement route chosen). Representatives will visit 2 completed buildings by Architects in shortlisted team.
Selection of early design concept from options developed	Decision by Health Board with advice from Project Board	Comment to be sought from NDAP	Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	Sketch proposals developed to RIBA Stage C coloured to distinguish the main use types (e.g.circulation treatment and staff facilities).
Approval of Design Proposals to be submitted to Planning Authority	Decision by Health Board with advice from Project Board		Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	
Approval of Detailed Design proposals to allow construction	Decision by Health Board with advice from Project Board		Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	
Post Occupancy Evaluations	Consideration by Health Board – lessons to SGHD		Assessment of completed development by representatives of the stakeholder groups involved in establishing the investment objectives.	

APPENDIX F – PROGRAMME SCHEDULE

hub - Draft Greenock & Clydebank Timeline - Dec 2015 2



APPENDIX G - COMMUNICATION AND ENGAGEMENT PLAN

Purpose: To pro-actively support the Project Board to deliver and realise all of the specified benefits identified for this project (as articulated within the approved Vision and Design Statement for the Centre and its Benefits Realisation Plan).

At the heart of this strategy is an appreciation that the successful delivery of this project hinges on providing credible assurance and fostering enthusiastic support amongst a wide set of stakeholders (i.e. those individuals/groups/constituencies with varying degrees of interest and influence in the project).

The strategy has four sequential components, which feed back into the benefits realisation plan separately agreed, i.e.:

- Identifying stakeholders
- Analysing stakeholders
- Effective communication
- Assessing effectiveness

In accordance with NHS CEL (Chief Executive Letter) 4 (2010) *Informing, Engaging And Consulting People In Developing Health And Community Care Services*, effective communication and engagement is recognised as a core element of stakeholder management within this project. As such, the requirement here is not solely to communicate in order just to inform or raise awareness, but to also:

- Generate confidence in and enthusiasm for the project and thereby foster a receptive and positive *authorising environment* for the project at each key decision point.
- Solicit high quality observations/suggestions/feedback on the design and site plan so as to ensure an optimal end product as per the Design Statement.
- Ensure that the varying expectations of different stakeholders are realistically tempered and fairly balanced throughout.

The approach for communication and engagement with respect to the Clydebank Health and Care Centre Project builds on the best practice utilised during the development and delivery of the award winning Vale Centre for Health and Care as emphasised in the feedback and recommendations from the latter project's OCG Gateway Review:

"*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care". In praising the above, the Review highlighted that this learning should be recorded and shared both to learn how this facility can be a catalyst for further change for services provided from it, as well as for use on other projects and with other project teams*."

Securing, sustaining and justifying trust is at the heart of this approach, which means that the process, the products and those explicitly associated with delivery need to make the effort to demonstrate themselves to be credible amongst stakeholders in order to be perceived and treated as credible by said stakeholders.

Key points to remember:

- Stakeholder groups are not homogenous.
- Stakeholder groups overlap in "membership"; and will interact (and influence) one another (i.e. the boundaries between groups are porous).
- The "agendas" and expressed views of stakeholders can change over time.
- The degree of interest and influence that any one stakeholder group has in the project will change over the course of the project.
- Communication is not just about clear transmission, but being thoughtfully receptive and respectfully responsive as a matter of routine.
- Constructive and informed dialogue with stakeholders will both assist with realistic expectation management and (importantly) with developing a high quality design: on-going testing of and feedback on the design is an important quality assurance element.
- Stakeholder management is not a on-off or peripatic activity: it is an on-going process involving a combination of reciprocally reinforcing formal and informal interactions.
- All of the stakeholders identified (below) also have a varying interests and/or influence in relation to other (and different) areas of the HSCP's operations (and indeed in many cases that of NHSGGC as a body corporate).
- A number of the stakeholder groups identified (e.g. HSCP Board as well as a number of individual members of some groups) have a role in the formal governance and/or wider scrutiny of the HSCP's operations.

The latter two bullet points are particularly worthy of emphasis as how well this strategy is enacted not only has implications for this project, but for other issues/areas of "live" concern for the HSCP. As such stakeholder management has to be undertaken with due cognisance to the rest of the HSCP's work and plans.

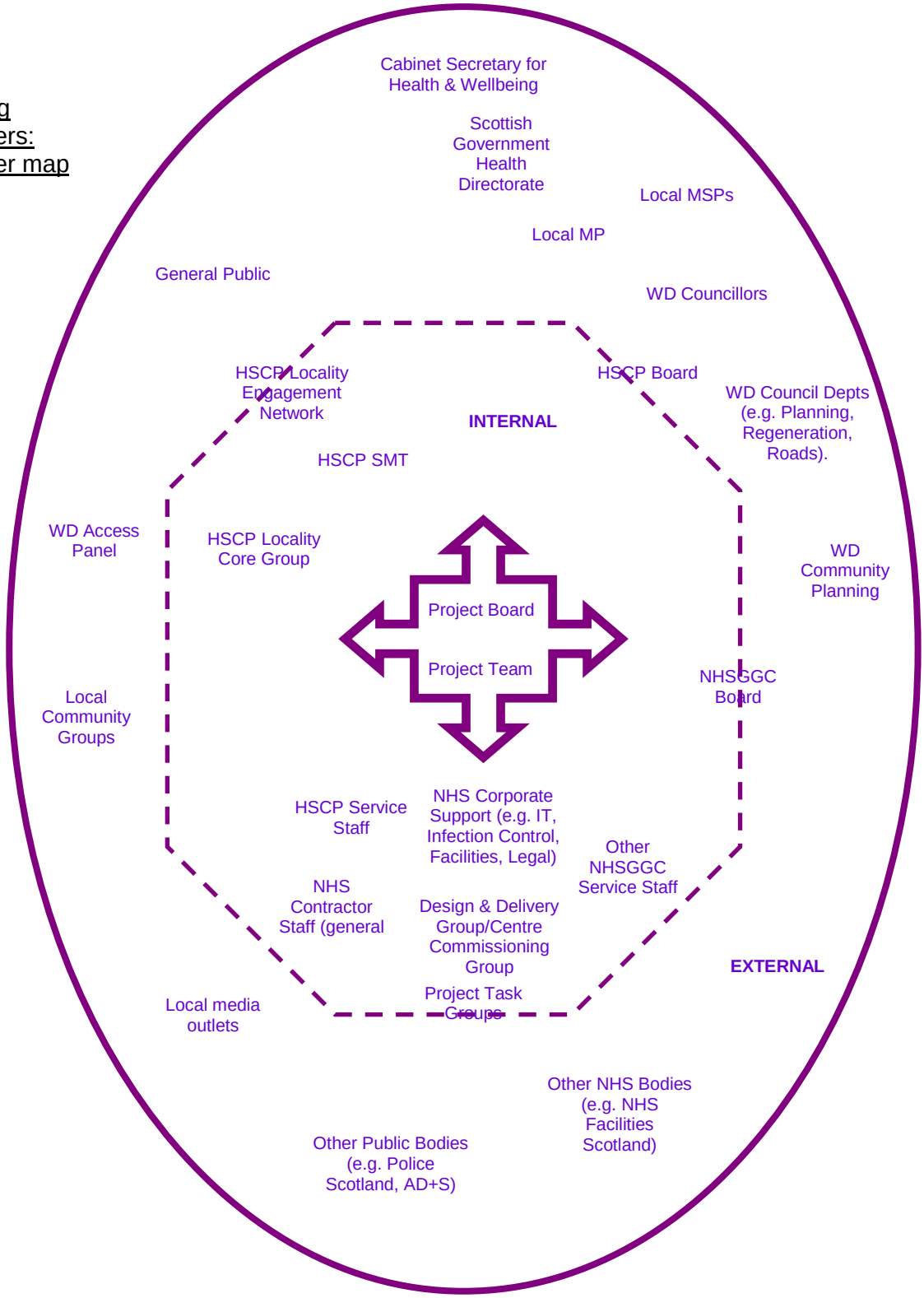
Lack of attention to the content of this strategy may result in the following "failures", any one of which may create risk for the project i.e.:

- Engaging with stakeholder too late so their views cannot be considered without substantial revision and delay.
- Inviting stakeholders to participate too early resulting in a complicated decision making process that causes delays.
- Inviting the wrong stakeholders to participate thereby reducing the value of the contribution and leaving the door open to damaging external criticism.
- Treating the participation of stakeholders as insignificant and inconsequential resulting in poor stakeholder "buy-in" when needed.

Failure to deliver this project properly will also create proportionate risk for the HSCP, given that the Centre is identified as its top capital priority within its Strategic Plan and a key component of the HSCP contributing to the NHSGGC Clinical Services Strategy. Given the high visibility associated with this project, failure to deliver will also generate a high degree of reputational risk for both the HSCP and NHSGGC.

Important as the process of communication and engagement is, it must be remembered that building a *winning coalition* of the sort necessary to achieve the intent and purpose set out above is heavily dependent on the actual quality of the product, e.g. how "good" the design is for the Centre. It is more realistic to build support for, create enthusiasm and secure positive participation in a design if it captures the imagination as something fit-for-purpose, bespoke and special.

Indentifying Stakeholders: Stakeholder map



Communication and Engagement Plan

Strategic Activity	*Which Stakeholders to Approach by Which Means*				
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
	Promise: we will keep you involved.	*Promise: we will keep you informed, listen to you, and provide feedback on how your input influenced the decision.*	*Promise: we will work with you to ensure your concerns are considered and reflected in the alternatives considered and provide feedback on how your input influenced the decision.*	*Promise: we will incorporate your advice and recommendations to the maximum extent possible.*	*Promise: we will implement what you decide.*
Organising participation. *Creating ideas for action/improvement.* *Building a winning coalition around project.* *Implementing, monitoring and assessing success of actions.*	Local media outlets; Access Panel; General public.	WD Councillors; Local MP; Local MSPs; WD CPP; HSCP Locality Group; Local community groups.	HSCP Service staff; NHS Contractor staff (general practice); Other NHSGGC Service Staff (Acute Services); Locality Engagement Network.	Design & Delivery /Centre Commissioning Group; Project Task Groups; HSCP Board; HSCP SMT; WD Council; NHSGGC Corporate Support; Other NHS bodies; Other Public bodies; WD Access Panel.	Cabinet Secretary for Health & Wellbeing; Scottish Govt Health Directorate; NHSGGC Health Board; Project Board.

Note: The Project Team are not included in the matrix above as it is that group's responsibility to execute it (under the leadership of the identified HSCP officer). However, the Plan recognises lines of communication that critically need to operate within the components of this group.

Stages of consultation with wider public (CEL4 2010)

Planning	
Need for Change	Identify stakeholders/ Establish Project Group
	EQIA
	Communication Plan
Informing	
Inform potentially affected people of planned timetable for engagement, reasons for change and background info	Carry out communication and engagement to inform the engagement and development of options and proposed benefits
	Evaluation of engagement
Engaging	
Development of models with Key stakeholders and Option Appraisal process	Develop options with stakeholders, including patients, service users, carers
	Develop options appraisal process. Agree criteria around weighing options, scoring
	Agree preferred option for consultation and feedback
	EQIA on preferred option
	Seek Approval from Project Board and Scottish Government.
	Seek approval from Scottish Health Council
Consulting	
Major Service Change	Plan for a 3 month consultation period with timescale of analysis of results and report to relevant Boards and committee meetings.
	Produce Consultation Document which is accessible with information on options including the financial implications. Advise on how options appraisal was conducted.
Feedback	
Provide feedback to stakeholders and interested parties on outcome	Explain results of consultation and final process Explain how views were taken into account Provide reasons for not accepting any widely held views Outline plans for implementation and further opportunities for engagement Evaluation of engagement and any action to be followed up Seek ministerial approval (Advice from Scottish Health Council)

Assessing Effectiveness

The following indicators have been identified as headline “measures of success” in relation to stakeholder management:

- Staff/service attendance and participation at routine meetings and at dedicated events – numbers, degree of input and positivity of feedback responses.
- Number of opportunities to present at routine meetings (e.g. community groups) - degree of input and positivity of feedback responses.
- Public turnout for and participation at dedicated events – numbers, degree of input and positivity of feedback responses.
- Nature of feedback from Project Board, and WD HSCP Board.
- Nature of local press coverage.
- Response to proposals by WD HSCP Board, NHSGGC, WD Community Planning Partnership and Scottish Government.